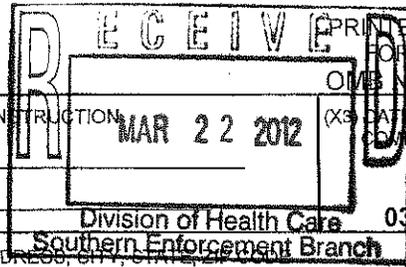


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 03/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/01/2012
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NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP 235 NEW WILSON LANE, PO BOX 2640 MIDDLESBORO, KY 40965
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F 000	INITIAL COMMENTS	F 000	Disclaimer Middlesboro Nursing and Rehabilitation Facility does not believe and does not admit that any deficiencies existed before, during or after survey. Middlesboro Nursing and Rehabilitation Facility reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings, or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is meant to establish any standard of care, contract obligation or position. And, Middlesboro Nursing and Rehabilitation Facility reserves all rights to raise all possible contentions and defenses or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Middlesboro Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim action or proceeding.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of nineteen sampled residents (Resident #8) received services with reasonable accommodations of the resident's individualized needs. Observations conducted on 02/28/12, at 12:41 PM, 3:30 PM, and 5:30 PM, revealed the resident's call light was not placed within the resident's reach and, as a result, the resident was unable to call for assistance from staff when needed. The findings include: An interview with the Facility Administrator on 02/29/12, at 3:00 PM, revealed the facility did not	F 246	It is and was on the day of the survey the policy and practice of Middlesboro Nursing and Rehabilitation Facility to ensure residents receive services	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Becc Maddox</i>	TITLE <i>Administrator</i>	(X6) DATE <i>3-22-12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	<p>Continued From page 1</p> <p>have a policy related to the use of call bells within the facility.</p> <p>Review of the medical record for Resident #8 revealed the facility admitted the resident on 10/05/11, with diagnoses of Blindness, Chronic Kidney Disease, and Hypertension. Review of the quarterly assessment for Resident #8 dated 01/17/12, revealed the resident's vision was severely impaired. Further review of the quarterly assessment revealed the facility had assessed Resident #8 to require extensive assistance with bed mobility, transfers, toileting, and personal hygiene.</p> <p>Review of Resident #8's comprehensive care plan, last revised date of 01/17/12, revealed facility staff was to frequently reinforce the use of the call light with the resident and was to ensure the call light was within the resident's reach. Review of Resident #8's CNA worksheet revealed staff was to keep a call bell clipped to the resident's shirt or to the top of the sheet on the resident's bed.</p> <p>Observations conducted on 02/28/12, at 12:41 PM, 3:30 PM, and 5:35 PM, revealed Resident #8's call light was attached to the side rail of the bed at the top and behind the resident. During the observations conducted at 12:41 PM and 3:30 PM, Resident #8 attempted to locate the call light within his/her immediate surroundings on the bed and was unable to do so due to his/her impaired vision. The resident requested assistance from the surveyor during both observations and stated, "I can't find it; can you tell me where it is?"</p> <p>An interview with Certified Medication Technician</p>	F 246	<p>with reasonable accommodations of the resident's individual needs.</p> <ol style="list-style-type: none"> Resident # 8 has received a manufactured approved call bell device to utilize when calling for assistance. The adaptive device is attached to the resident and available when in and out of the room. Likewise, the device can be placed in a consistent location for the resident's ease of access. All residents with visual impairments or limitations affecting call bell usage were assessed for the appropriate device. All other residents will have call bells within reach. Residents with impairments and special call bell needs will be identified through staff observation. All therapy and/or facility staff will report any resident observed having difficulty with call bell location and/or manipulation. All nursing staff, activity staff, housekeeping staff, and therapist have been educated and instructed regarding the placement of the resident's call bell. Staff are to identify any resident experiencing difficulty managing and/or locating call bell. Each staff member has signed a call bell pledge acknowledging responsibilities of call bell monitoring, usage, and accessibility. All newly hired staff members will be oriented to the call bell pledge per department. Nurse Managers complete rounds daily. Call bell placement is audited. The continuous quality assurance program monitors compliance of call bells monthly. This includes auditing the resident's ability to locate the call bell. Any resident with difficulty noted is assessed for need of an appropriate adaptive call device. Compliance date March 21, 2012. (Attachments) 	

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F 246	<p>Continued From page 2</p> <p>(CMT) #3 on 02/29/12, at 10:05 AM, revealed she had observed multiple occasions when the resident's call light was not within the resident's reach. Interview revealed CMT #3 had been instructed to ensure the call light was in the resident's hand, and the CMT stated she would place it in the resident's hand when she observed it not to be within reach of the resident.</p> <p>An interview with Certified Nursing Assistant (CNA) #3 on 02/29/12, at 10:15 AM, revealed Resident #1 required assistance from staff for toileting and required the use of a call light to gain staff attention to meet his/her needs. The CNA stated she had observed Resident #8's call light not within the resident's reach on occasion, and would place the call light within reach so the resident could call for assistance when needed.</p> <p>An interview with Registered Nurse (RN) #2 on 02/29/12, at 10:20 AM, revealed facility staff had been instructed to ensure Resident #8's call light was within reach at all times. RN #2 continued to state he made rounds daily to ensure resident call lights were accessible to the residents.</p> <p>An interview with the Director of Nursing (DON) on 03/01/12, at 4:30 PM, revealed facility staff had been instructed to ensure Resident #8's call light was within the resident's reach at all times. Further interview revealed the DON, staff nurses, and CMTs were to make daily rounds to ensure all resident call lights were within reach. The DON stated she was unaware staff had failed to ensure Resident #8's call light was within his/her reach.</p>	F 246		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F279 It is and was on the day of the survey the policy of Middlesboro Nursing to develop a comprehensive care plan for each resident.	

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F 279	<p>Continued From page 3</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and medical record review, it was determined the facility failed to ensure a care plan was developed for one of nineteen sampled residents (Resident #8) that included measurable objectives and timetables to meet the resident's needs. Observation of a skin assessment conducted on 02/09/12, revealed Resident #8 had a reddened area to the coccyx that was slow to blanch and a red area to the right outer ankle. However, the facility failed to develop a care plan related to the resident's risk for the development of pressure areas or to</p>	F 279	<ol style="list-style-type: none"> Resident # 8 has a care plan reflecting the risk of developing a pressure ulcer with appropriate interventions in place. All residents of Middlesboro Nursing & Rehabilitation Facility that are at risk of developing pressure ulcers are care planned for prevention. The care plan computer system will generate the potential for pressure ulcer care plan that will have clinically proven interventions with the opportunity to individualize the care plan for each resident. Nursing staff (RN, LPN, CMT & SRNA) have been educated regarding identifications of reddened areas and completion of a "skin alert" form for staff communication, early identification, and intervention. The care plan will be updated with new interventions. Continuous quality improvement audits are completed monthly to assure residents at risk for pressure ulcer development have a preventative care plan in place. Compliance date March 21, 2012. (Attachments) 	

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F 279	<p>Continued From page 4 address the newly identified reddened areas.</p> <p>The findings include:</p> <p>Review of the medical record for Resident #8 revealed the facility admitted the resident on 10/05/11, with diagnoses that included Blindness, Chronic Kidney Disease, and Hypertension. Review of the quarterly assessment for Resident #8 dated 01/17/12, revealed the resident required extensive assistance with bed mobility, transfers, and personal hygiene. Further review of the quarterly assessment for Resident #8 revealed the resident was at risk for developing pressure ulcers.</p> <p>Review of the comprehensive care plan for Resident #8 last reviewed and updated on 01/17/12, revealed even though the resident had been identified to be at risk for the development of pressure ulcers, the facility failed to identify or develop interventions related to the resident's risk for the development of pressure ulcers.</p> <p>Observation of a skin assessment conducted by facility staff on 02/29/12, at 10:30 AM, revealed Resident #8 had a red, slow to blanch area present to the coccyx. Further observation revealed Resident #8 had a red, blanchable area to the right outer ankle.</p> <p>An interview with Registered Nurse (RN) #2 on 02/29/12, at 10:35 AM, confirmed Resident #8 had been identified in the quarterly assessment to be at risk for the development of pressure ulcers. Further interview revealed RN #2 had observed the redness to Resident #8's coccyx and right outer ankle prior to the skin observation</p>	F 279			

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F 279	Continued From page 5 conducted on 02/29/12, however, RN #2 stated he had not updated/revised the resident's care plan to address the presence of the reddened areas and failed to identify interventions to be taken by facility staff to prevent worsening of the areas. Continued interview with RN #2 revealed he had not been trained on updating or revising a resident's plan of care. An interview with the Care Plan Coordinator on 03/01/12, at 11:00 AM, revealed she developed, revised, and updated resident care plans based on the comprehensive assessment and/or areas of concern identified by facility staff. Continued interview with the Care Plan Coordinator confirmed Resident #8 had been assessed to be at risk for the development of pressure ulcers. Further interview revealed the Care Plan Coordinator had failed to develop, update, and/or revise Resident #8's care plan to address the risk for the development of pressure sores and failed to identify interventions to be implemented to prevent worsening of the resident's impaired skin integrity.	F 279		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and medical record review, it was determined the facility failed to ensure one of nineteen sampled residents (Resident #1) received food prepared in a form to	F 365	F365 It is and was on the day of the survey the policy of Middlesboro Nursing & Rehabilitation Facility to provide food prepared in a form designed to meet the resident's needs. 1. Resident # 1 is currently receiving food prepared in correct form and texture designed to meet his specific, therapeutic needs related to swallowing difficulties. 2. Residents receiving mechanically altered food specific to the resident is specified on individual tray cards. Special altered diets are identified by the tray card system for both the dietary staff and for the nursing staff to assure resident receives correct texture.	

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F 365	<p>Continued From page 6</p> <p>meet the resident's individual needs. Resident #1 had an order for a pureed diet due to swallowing difficulties. On 02/28/12, at the evening meal, Resident #1 received cookies and coleslaw that had not been pureed.</p> <p>The findings include:</p> <p>The facility provided no policy/procedure related to food consistency.</p> <p>Review of the physician's orders dated 02/24/12, revealed Resident #1 was to receive a pureed diet with nectar-thick liquids. Review of the facility's menu for the evening meal revealed residents on a pureed diet were to receive pureed tuna salad sandwich, mashed potatoes, pureed coleslaw, pureed peaches, and a pureed sugar cookie.</p> <p>Observations of the evening meal on 02/28/12, at 5:15 PM, revealed Resident #1 had been served the evening meal in the South Hall dining room. The resident's tray card from the Dietary Department indicated the resident was to receive a pureed liberal renal diet with nectar-thick liquids. Observations of the foods received by Resident #1 revealed pureed meat and mashed potatoes, nectar-thickened juice and milk. The resident also received a regular non-pureed cookie and regular non-pureed coleslaw which was fed to the resident by a family member.</p> <p>Interview with the family member of Resident #1 on 02/28/12, at 5:15 PM, revealed he/she had fed Resident #1 the coleslaw and the regular cookie. The family member stated he/she thought the foods were okay to give the resident since they</p>	F 365	<p>3. During tray preparation and prior to meal delivery, Dietary Aide # 2 verbalizes tray card information and audits items added to the tray from Dietary Aide # 1. Dietary Aide # 2 has the sole responsibility of a final audit prior to cart placement. Dietary staff, nursing staff, activity staff and therapist have been educated regarding the process of self audit prior to tray delivery to the resident. CNA's were also educated regarding reading tray card before service to assure the diet for the resident being served is accurate per the individual information on tray card.</p> <p>4. Tray accuracy is audited by the CQI process. A sample of trays is audited routinely for accuracy.</p> <p>5. Compliance date March 21, 2012. (Attachments)</p>	

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F 365	Continued From page 7 were on the resident's tray. Interview with Certified Nursing Assistant (CNA) #2 on 02/28/12, at 5:35 PM, revealed he had set up the resident's tray for the evening meal. According to CNA #2, staff was required to check the meal tray card against the food received to ensure the residents received the appropriate diet. CNA #2 stated the resident had previously received a regular diet but had been changed to pureed when the resident returned from a hospital stay. CNA #2 stated he failed to observe the coleslaw and cookie were of regular consistency.	F 365			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F431 It is and was on the day of the survey the policy and practice of Middlesboro Nursing and Rehabilitation Facility to ensure all biologicals do not exceed the manufacturers' recommended expiration dates and are not available for resident use. It is and was on the day of the survey the policy and practice of Middlesboro Nursing and Rehabilitation Facility to ensure resident's have access to biological items that are within the manufacturer's recommended use date. 1. Stored biological, including individually packaged tuberculin syringes, suction instruments and gastronomy tubes and tube feeding formula will be within the manufacturers recommended usage dates for all residents. All items located in the medication room and supply room have been audited to ensure each item has not expired.		

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F 431	<p>Continued From page 8</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure expired biologicals were not available for resident use. Observations conducted on 03/01/12, revealed numerous biological items stored in medication rooms on the Southeast and Northwest Halls had exceeded the manufacturer's recommended expiration dates and were available for resident use.</p> <p>The findings include:</p> <p>An observation on 03/01/12, at 2:30 PM, of the medication/supply storage room on the Southeast Hall revealed numerous biological supplies that had exceeded the manufacturer's recommended expiration dates and included:</p> <p>1. A box of 100 individually packaged tuberculin syringes with needles had a manufacturer's expiration date of July 2011 and remained available for resident use six months after the expiration date.</p>	F 431	<p>2. All nurses, SRNA's have been instructed and educated about medical supplies and formulas with expiration dates. Nurse will identify expiration date and assure it is acceptable prior to use for a patient.</p> <p>3. To assure rotation of stock, the SRNA assigned to stock delivery and shelf placement will complete an inventory form monthly. The inventory form will list the nearest expiration date to assure all supplies are in date.</p> <p>4. Pharmacy provides a monthly QA check of each medication room. Nursing management will complete a monthly audit of the supply room to check for any expired biologicals. Utilizing a checklist will assure all biological items will be in compliance with usage dates.</p> <p>5. Compliance date March 21, 2012. (Attachments)</p>	

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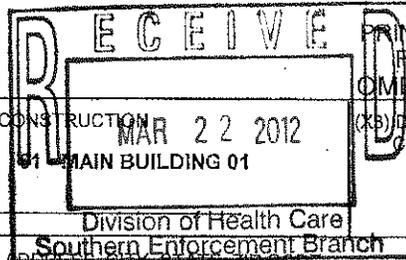
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F 431	<p>Continued From page 9</p> <p>2. A box of 100 individually packaged tuberculin syringes with needles had a manufacturer's expiration date of September 2011 and remained available for resident use four months after the expiration date.</p> <p>3. Eleven suction instruments had a manufacturer's expiration date of May 2007 and remained available for resident use four years and nine months after the expiration date.</p> <p>4. Four suction instruments had a manufacturer's expiration date of November 2007 and remained available for resident use four years and three months after the expiration date.</p> <p>5. Six gastrostomy tubes had a manufacturer's expiration date of March 2011 and remained available for resident use one year after the expiration date.</p> <p>In addition, an observation on 03/01/12, at 3:30 PM, of the medication/supply storage room on the Northwest Hall revealed nine bottles of 1.5 calorie Glucerna (tube feeding formula) with a manufacturer's recommendation to use the product before 03/01/12. The product remained available for resident use one day past the expiration date.</p> <p>An interview on 03/01/12, at 2:35 PM, with RN #1 confirmed all supplies in the Southeast medication/storage room were available for resident use.</p> <p>An interview on 03/01/12, at 3:35 PM, with CMT #4 revealed she ordered supplies two times per</p>	F 431		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/01/2012
NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE, PO BOX 2640 MIDDLESBORO, KY 40965		
(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 431	Continued From page 10 month and checked for expired items at that time. CMT #4 also stated she rotated "older" items to the front of the shelf and "newer" items to the back of the shelf. According to CMT #4, she did not realize the items had expired. An interview on 03/01/12, at 3:40 PM, with RN #3 confirmed all supplies in the Northwest medication storage room were available for resident use. However, according to RN #3, there were no residents on Glucerna on the day of the observation.	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185240	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/28/2012
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NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE, PO BOX 2640 MIDDLESBORO, KY 40965
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Two</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 02/28/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000		
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in</p>	K 025	<p>1. The smoke barrier is in accordance with Section 8.3 and has been corrected with Fire rated approved JACO chaulking which is capable of maintaining the smoke resistance of the smoke barrier.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dee Maddox</i>	TITLE <i>administrator</i>	(X6) DATE <i>3-22-12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER MIDDLESBORO HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 235 NEW WILSON LANE, PO BOX 2640 MIDDLESBORO, KY 40965		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 1</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with a half-hour fire resistance rating as required. The facility failed to ensure that penetrations at smoke barrier walls were properly sealed. This deficient practice affected two of two smoke compartments, staff, and 94 residents. The facility has the capacity for 97 beds with a census of 94 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 02/28/12, at 12:10 PM, with the Director of Maintenance (DOM), the fire/smoke barrier wall in the West Hall attic area was observed to have gaps around piping and wiring that were penetrating this wall. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility in a fire situation. An interview with the DOM on 02/28/12, at 12:10 PM, revealed the DOM had trusted another workman to repair this wall when wiring was installed about three months ago.</p>	K 025	<ol style="list-style-type: none"> 2. Maintenance will complete a thorough inspection following any repairs, wiring or installation of equipment to assure the fire wall remains a smoke barrier. 3. All maintenance staff have been educated regarding the smoke barrier and what is considered a breach of the fire wall. 4. Inspections will be conducted quarterly and after any repairs. 5. 3/21/2012 (attachment) 	

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K 025	<p>Continued From page 2</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 	K 025		