

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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/02/2012
NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071	
(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on 10/30/12 through 11/02/12 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E."	F 000	This plan of correction is submitted as the facility's credible allegation of compliance.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F 164 483.10(e), 483.75(l)(4) PERSONAL SS=D PRIVACY/CONFIDENTIALITY OF RECORDS 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. The resident was provided privacy for physician to continue assessment during survey. Physician was also provided education regarding personal privacy by the Administrator. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility on the days of survey could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: a. Education was provided to Physicians on staff and licensed nurses regarding personal privacy/confidentiality of records policy. b. Medical staff have been given information on availability of Physician Treatment Room for	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Sandra J Dick

Administrator

11-29-12

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

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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071
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F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to provide privacy for one unsampled resident (Resident A). Observation during the lunch meal, on 10/30/12, revealed a physician entered the dining room and listened to Resident A's chest and bowel sounds and checked the pedal pulses on both legs, in view of six other residents and staff.</p> <p>Findings include:</p> <p>A review of the facility's "Privacy and Confidentiality" policy/procedure, last revised 01/09/12, revealed the facility should provide privacy and dignity while providing care. The staff should follow the residents rights by utilizing closing of doors, privacy curtains, and asking visitors to step out to allow care or treatment to be given.</p> <p>Observation of the noon meal in the dining room, on 10/30/12, revealed seven residents were sitting at two half-round tables while two staff assisted them with their lunch meal. A physician entered the dining room and walked over to unsampled Resident A, listened to the resident's chest and bowel sounds with a stethoscope and palpated the resident's pedal pulses. This was completed in full view of six other residents and two staff members.</p> <p>Interview with the physician, on 10/30/12 at 12:15 PM, revealed she did not feel that listening to the resident's chest and bowel sounds, with the</p>	F 164	<p>privacy.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <ol style="list-style-type: none"> Licensed nurses will notify House Supervisor and/or Unit Coordinator when physician is in the building. The House Supervisor or Unit Coordinator will offer assistance to physician for resident privacy. Any variance will be documented on log sheet. Copy of log sheet will be given to Director of Nursing. Director of Nursing will contact physician to request policy be adhered to and offer further education. Variances will be reported in Quality Assurance Meeting on quarterly basis. Action plans will be developed if indicated. <p>5. The facility declares compliance with F164 deficiency effective December 14, 2012.</p>	Completion Date 12/14/2012
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F 164	Continued From page 2 resident being fully clothed, violated his/her privacy. She stated if there was a concern with that, then she hoped someone would inform her so she would not do it again.	F 164		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure review, it was determined the facility failed to provide services in accordance with the written plan of care for one resident (#5), in the selected sample of 24 residents. The facility failed to provide Resident #5 with the assessed needs of a finger food diet, assistance with feeding, and foam boots on his/her feet while in bed, in accordance with the care plan. Findings include: A review of the facility's "Resident Care Plan" policy/procedure, last revised 09/2012, revealed it	F 282	F 282 483.20(k)(3)(ii) SERVICES BY SS=D QUALIFIED PERSONS/PER CARE PLAN 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. Resident #5's care plan was reviewed and communicated with nursing staff. All interventions were implemented for resident #5. b. Facility policy and procedure was revised. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility on the days of survey could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur:	

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F 282	<p>Continued From page 3</p> <p>did not address staff implementing the care plan. Interview with the Director of Nursing (DON), on 11/02/12 at 11:00 AM, revealed she expected the staff to follow the care plan for each resident.</p> <p>A record review revealed the facility admitted Resident #5 on 09/25/12 with diagnoses to include left hemispheric Cerebral Vascular Accident and Alzheimer's Dementia.</p> <p>A review of the Initial Minimum Data Set (MDS) assessment, dated 10/02/12, revealed the facility assessed Resident #5's cognitive skills as severely impaired, required extensive assistance of one staff with eating, and was at risk for skin breakdown.</p> <p>A review of the Comprehensive Care Plan, dated 10/01/12, revealed a care plan for Resident Feeding with interventions for Nursing and Certified Nurse Aides (CNAs) to remove plate, drinks, and food from the tray to prevent the resident from becoming distracted, and encourage the resident to feed himself/herself. Additionally, when using utensils, encourage the resident to feed himself/herself by using hand-over-hand technique for the first few bites, and the resident was to be on a finger food diet (everything on his/her tray should be something he/she can pick up with his/her hands and feed himself/herself). Further review of the Comprehensive Care Plan for a Stage II right and left heel blister, dated 10/15/12 and 10/16/12, and a CNA Care Plan, dated 10/2012, revealed interventions for the staff to place a foam boot on the right and left foot while in the bed. Additionally, a review of the CNA Care Book revealed the feeding instructions were with the</p>	F 282	<ol style="list-style-type: none"> a. Resident care plan policy and procedure have been reviewed, revised, and in-serviced. This includes staff implementation and given the appropriate treatment and services to maintain or improve resident's abilities. b. Facility therapy staff coordinator will give copy of in-services daily to Director of Nursing or Assistant Director of Nursing. c. Facility Therapy Staff Coordinator will give copy to Dietary Manager if it involves food requests and specific needs. <ol style="list-style-type: none"> 4. The facility plans to monitor its performance to ensure that solutions are sustained by: <ol style="list-style-type: none"> a. The Unit Coordinator will perform weekly audits to ensure adherence to policy. b. Results of audits will be given to Director of Nursing weekly. c. Unit Coordinator will report results of finding and corrective actions at quarterly Quality Assurance meetings. d. Action plans will be developed if indicated. 5. The facility declares compliance with F282 deficiency effective December 14, 2012. 	Completion Date 12/14/2012
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F 282	<p>Continued From page 4 CNA care plan.</p> <p>Observation, on 10/30/12 at 5:00 PM, during the evening meal revealed staff served Resident #5's meal tray which contained a beef patty with gravy, macaroni with cheese, steamed vegetables, and vanilla pudding. The only finger food the resident was able to pick up and eat was an oatmeal cream pie. After the staff set up the resident's tray, Registered Nurse (RN) #1 sat down and began feeding the resident with a fork. The staff made no attempt to remove the resident's plate, drinks, and food from the tray, and made no attempt to encourage the resident to feed himself/herself, or use the hand-over-hand technique for the first few bites.</p> <p>Interview with RN #1, on 11/02/12 at 11:25 AM, revealed he was not aware Resident #5's care plan had specific instructions on how to feed the resident (hand-over-hand technique, remove items from the tray) at the time he fed the resident on 10/30/12; however, he was aware of it now.</p> <p>Observation, on 10/31/12 at 12:15 PM, during the noon meal revealed staff served Resident #5's meal tray which contained ground meat, cooked carrots, cream corn, and strawberry ice cream. The only finger food was the cooked carrots. After setting up the tray, the staff sat down to feed the resident. The plate, drinks and food were not removed from the food tray and the staff did not encourage the resident to feed himself/herself or use the hand-over-hand technique with the first few bites.</p> <p>Observations, on 10/31/12 at 10:15 AM, 2:10 PM,</p>	F 282		
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F 282	<p>Continued From page 5</p> <p>3:00 PM, and 3:55 PM, revealed Resident #5 was asleep in the bed with no foam boots on his/her feet. The foam boots were on the bed side table.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 and CNA #4, on 11/02/12 at 10:20 AM and 10:30 AM, respectively, revealed they were not aware Resident #5 was suppose to be encouraged to feed himself/herself. Drinks and food were suppose to be removed from the tray and the hand-over-hand technique should be used with the resident's utensils for the first few bites. She stated staff were suppose to look at the CNA care plan in the CNA book each day. LPN #4 and CNA #4 stated Resident #5 should have foam boots on feet while in the bed.</p> <p>An interview with the Dietary Manager, on 11/02/12 at 9:50 AM, revealed Resident #5 should be receiving finger foods on his/her tray. She stated finger foods consisted of sandwiches, cookies, carrots, and green beans. She stated that the food should be items he/she could eat with his/her fingers, without messing up his/her fingers. She stated she had problems in the past with the kitchen staff not providing finger foods.</p> <p>Interview with the DON, on 11/02/12 at 11:00 AM, revealed staff should have followed the care plan for Resident #5 related to finger foods, feeding techniques, and foam boots on his/her feet while in the bed.</p>	F 282		
F 311 SS=D	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p>	F 311	F 311 483.25(a)(2) TREATMENT/	

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F 311	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one resident (#5), in the selected sample of 24 residents, received the appropriate treatment and services to maintain or improve his/her abilities. The facility failed to ensure staff implemented the care plan related to Resident #5's assessed needs for finger foods and feeding assistance.</p> <p>Findings include:</p> <p>Interview with the Director of Nursing (DON), on 11/02/12 at 11:00 AM, revealed no evidence of a policy and procedure related to provision of care to improve eating skills, but she expected the staff to follow the care plan for each resident.</p> <p>A record review revealed the facility admitted Resident #5 on 09/25/12 with diagnoses to include left hemispheric Cerebral Vascular Accident and Alzheimer's Dementia.</p> <p>A review of the initial Minimum Data Set (MDS) assessment, dated 10/02/12, revealed the facility assessed Resident #5's cognitive skills as severely impaired, and required extensive assistance of one staff with eating.</p> <p>A review of the Comprehensive Care Plan, dated 10/01/12, revealed a care plan for Resident Feeding with interventions for Nursing and Certified Nurse Aides (CNAs) to remove plate, drinks, and food from the tray to prevent the</p>	F 311	<p>SS=D SERVICES TO IMPROVE/ MAINTAIN ADLS</p> <ol style="list-style-type: none"> 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: <ol style="list-style-type: none"> a. Resident #5's care plan was reviewed and communicated with nursing staff. All interventions were implemented for resident #5. b. Facility policy and procedure was revised. 2. Identification of other residents having the potential to be affected by the same deficient practice: <ol style="list-style-type: none"> a. It was determined that all residents residing in the facility on the days of survey could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: <ol style="list-style-type: none"> a. Resident care plan policy and procedure have been reviewed, revised, and in-serviced. This includes staff implementation and given the appropriate treatment and services to maintain or improve resident's abilities. b. Facility therapy staff coordinator will give copy of in-services daily to Director of Nursing or Assistant Director of Nursing. c. Facility Therapy Staff Coordinator will give copy to Dietary Manager if it involves food requests and specific needs. 4. The facility plans to monitor its performance to ensure that solutions are sustained by: <ol style="list-style-type: none"> a. The Unit Coordinator will perform 	
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F 311	<p>Continued From page 7</p> <p>resident from becoming distracted, and encourage the resident to feed himself/herself. Additionally, when using utensils, encourage the resident to feed himself/herself by using hand-over-hand technique for the first few bites, and the resident was to be on a finger food diet (everything on his/her tray should be something he/she can pick up with his/her hands and feed himself/herself).</p> <p>Observation, on 10/30/12 at 5:00 PM, during the evening meal revealed staff served Resident #5's meal tray which contained a beef patty with gravy, macaroni with cheese, steamed vegetables, and vanilla pudding. The only finger food the resident was able to pick up and eat was an oatmeal cream pie. After the staff set up the resident's tray, Registered Nurse (RN) #1 sat down and began feeding the resident with a fork. The staff made no attempt to remove the resident's plate, drinks, and food from the tray, and made no attempt to encourage the resident to feed himself/herself, or use the hand-over-hand technique for the first few bites.</p> <p>Interview with RN #1, on 11/02/12 at 11:25 AM, revealed he was not aware Resident #5's care plan had specific instructions on how to feed the resident (hand-over-hand technique, remove items from the tray) at the time he fed the resident on 10/30/12; however, he was aware of it now.</p> <p>Observation, on 10/31/12 at 12:15 PM, during the noon meal revealed staff served Resident #5's meal tray which contained ground meat, cooked carrots, cream corn, and strawberry ice cream. The only finger food was the cooked carrots.</p>	F 311	<p>weekly audits to ensure adherence to policy.</p> <p>b. Results of audits will be given to Director of Nursing weekly.</p> <p>c. Unit Coordinator will report results of finding and corrective actions at quarterly Quality Assurance meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with F311 deficiency effective December 14, 2012.</p>	Completion Date 12/14/2012
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F 311	<p>Continued From page 8</p> <p>After setting up the tray, the staff sat down to feed the resident. The plate, drinks and food were not removed from the food tray and the staff did not encourage the resident to feed himself/herself or use the hand-over-hand technique with the first few bites.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 and CNA #4, on 11/02/12 at 10:20 AM and 10:30 AM, respectively, revealed they were not aware Resident #5 was suppose to be encouraged to feed himself/herself. Drinks and food were suppose to be removed from the tray and the hand-over-hand technique should be used with the resident's utensils for the first few bites. She stated staff were suppose to look at the CNA care plan in the CNA book each day.</p> <p>An interview with the Dietary Manager, on 11/02/12 at 9:50 AM, revealed Resident #5 should be receiving finger foods on his/her tray. She stated finger foods consisted of sandwiches, cookies, carrots, and green beans. She stated that the food should be items he/she could eat with his/her fingers, without messing up his/her fingers. She stated she had problems in the past with the kitchen staff not providing finger foods.</p> <p>An interview with the Speech Therapist, on 11/02/12 at 9:35 AM, revealed Resident #5 had a tendency to grab and try to eat everything on the meal tray to include straws, napkins, etc. She thought it would be best for the resident to have finger foods so the resident could pick them up and put in his/her mouth so the resident could be as self sufficient with feeding as possible. She revealed she wanted everything removed form the tray because the resident was easily</p>	F 311		
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F 311	Continued From page 9 distracted. She wanted the staff to use the hand-over-hand technique with the utensils for the first few bites to assist the resident to eat. She stated the resident was having problems recognizing the purpose of the utensil. She stated she expected the nursing staff to follow the care plan with each meal, and revealed she trained the staff on feeding techniques. A review of a feeding instructions sheet, no date, revealed staff read and signed the sheet indicating they were trained; however, the only staff who signed the sheet were those who worked the first weekend. Further interview with the Speech Therapist revealed that was the only training sheet she could provide.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was	F 314	F 314 483.25(c) TREATMENT/SVCS TO SS=D PREVENT/HEAL PRESSURE SORES 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. Resident #5 received a head-to-toe skin assessment. b. The foam boots were applied to both feet when in the bed. 2. Identification of other residents having the potential to be affected by the same deficient practice:	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/02/2012
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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 314	<p>Continued From page 10</p> <p>determined the facility failed to ensure one resident (#5) with pressure sores, in the selected sample of 24 residents, received the necessary treatment and services to promote healing and prevent new sores from developing. The facility failed to ensure staff applied foam boots to both of Resident #5's feet while in bed.</p> <p>Finding include:</p> <p>A review of the "Skin Integrity and Pressure Ulcer Risk Assessment and Management," policy/procedure, last revised 05/2012, revealed it did not address interventions that were implemented on the care plan; however, an interview with the Director of Nursing (DON), on 11/02/12 at 11:00 AM, revealed she expected the staff to follow the care plan for each resident.</p> <p>A record review revealed the facility admitted Resident #5 on 09/25/12 with diagnoses to include left hemispheric Cerebral Vascular Accident and Alzheimer's Dementia.</p> <p>A review of the initial Minimum Data Set (MDS) assessment, dated 10/02/12, revealed the facility assessed Resident #5's cognitive skills as severely impaired and at risk for skin breakdown.</p> <p>A review of an Altered Skin Integrity Management Protocol, dated 10/15/12, revealed a Stage II blister was identified on the resident's left heel.</p> <p>A review of the Comprehensive Care Plan for a Stage II left heel blister, dated 10/15/12, and a review of the Certified Nurse Aide (CNA) Care Plan, dated 10/2012, revealed an intervention for staff to place a foam boot on the left foot while in</p>	F 314	<p>a. It was determined that all residents residing in the facility on the days of survey could have been affected by the same deficient practice.</p> <p>3. The measures and systemic changes to ensure that the deficient practice will not recur:</p> <p>a. Resident care plan policy and procedure have been reviewed, revised, and in-serviced. This includes staff implementation of the care plan and giving the appropriate treatment and services to maintain or improve resident's abilities.</p> <p>4. Resident Skin Integrity and Pressure Ulcer Risk Assessment management policy and procedure has been reviewed, revised, and in-serviced. This includes the facility providing necessary treatment and services to promote healing and preventing new sores from developing</p> <p>5. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Unit Coordinator will perform weekly audits to ensure adherence to policy.</p> <p>b. Results of audits will be given to Director of Nursing weekly.</p> <p>c. Unit Coordinator will report results of finding and corrective actions at quarterly Quality Assurance meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>6. The facility declares compliance with F314 deficiency effective December 14, 2012.</p>	<p>Completion Date 12/14/2012</p>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/02/2012
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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 314	<p>Continued From page 11 the bed.</p> <p>A review of an Altered Skin Integrity Management Protocol, dated 10/16/12, revealed a Stage II blister was identified on the resident's right heel.</p> <p>A review of the Comprehensive Care Plan for a Stage II right heel blister, dated 10/16/12, and a review of the CNA Care Plan, dated 10/2012, revealed an intervention for staff to place a foam boot on the right foot while in the bed.</p> <p>Observation, on 10/31/12 at at 10:15 AM, 2:10 PM, 3:00 PM, and 3:55 PM, revealed Resident #5 was asleep in the bed with no foam boots on either foot. The foam boots were laying on the bed side table.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 and CNA #4, on 11/02/12 at 10:20 AM and 10:30 AM, respectively, revealed Resident #5 should have foam boots on both feet while in the bed.</p> <p>Interview with the DON, on 11/02/12 at 11:00 AM, revealed the staff should have followed the care plan for Resident #5 related to foam boots on both feet while in the bed.</p>	F 314		
F 334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the Influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza</p>	F 334	<p>F 334 483.25(n) INFLUENZA AND SS=D PNEUMOCOCCAL IMMUNIZATIONS</p> <ol style="list-style-type: none"> The corrective action accomplished for those residents found to have been affected by the deficient practice: <ol style="list-style-type: none"> Resident #5 was given the pneumococcal vaccine. Physician and family were both notified. The facility policy and procedure was updated and in-service was provided. Identification of other residents having 	

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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071
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F 334	<p>Continued From page 12</p> <p>immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding</p>	F 334	<p>the potential to be affected by the same deficient practice:</p> <p>a. It was determined that all residents residing in the facility on the days of survey could have been affected by the same deficient practice.</p> <p>3. The measures and systemic changes to ensure that the deficient practice will not recur:</p> <p>a. The facility policy and procedure for influenza/pneumococcal vaccine was updated.</p> <p>b. The facility has in-serviced staff on policy and procedure.</p> <p>c. The facility now has pneumococcal vaccines readily available at each nurse's station.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Unit Coordinator will perform weekly audits to ensure adherence to policy.</p> <p>b. Results of audits will be given to Director of Nursing weekly.</p> <p>c. Unit Coordinator will report results of finding and corrective actions at quarterly Quality Assurance meetings.</p> <p>d. Action plans will be developed indicated.</p> <p>e. The facility declares compliance with F334 deficiency effective December 14, 2012.</p>	Completion Date 12/14/2012
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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42074
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 334	<p>Continued From page 13</p> <p>the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure one resident (#12), in the selected sample of 24 residents, received a pneumococcal immunization. Resident #12 was admitted to the facility on 09/05/12 and the responsible party signed the request for the administration of a pneumococcal vaccine; however, the staff failed to administer the vaccine.</p> <p>Findings include:</p> <p>A review of the facility's "Influenza/Pneumococcal Vaccine" policy/procedure, revised 10/12, revealed each resident is informed of the benefits and risks of immunizations and has the opportunity to receive unless medically contraindicated or refused or already immunized.</p>	F 334		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/02/2012
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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 334	<p>Continued From page 14</p> <p>A record review revealed the facility admitted Resident #12 on 09/05/12 with diagnoses to include Left Hip Fracture, Dementia, and Hypertension.</p> <p>Record review revealed Resident #12 signed immunization forms indicating he/she wished to receive the Pneumonia Vaccine. However, there was no documented evidence Resident #12 received the pneumonia vaccine. There was no evidence in the immunization record regarding the date that the last pneumonia vaccine was administered.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 11/02/12 at 8:55 AM, revealed she completed the admission process with the resident. She reported the pneumococcal vaccine was not administered to the resident after the consent form was signed by the family. She reported it was an accidental omission on her part.</p> <p>An interview with the Unit Coordinator for Hall 1, on 11/02/12 at 11:55 AM, revealed the Admission Coordinator asked the resident if he/she has had or wanted to receive the pneumococcal vaccine during the admission process. Once the consent was obtained, then the nurse received an order, documented it on the Medication Administration Record (MAR), and administered the vaccine to the resident. The omission of the pneumococcal vaccine was an oversight by the nurse and should have been administered.</p>	F 334		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	<p>F 371 483.35(i) FOOD PROCURE, STORE SS=E PREPARE/SERVE-SANITARY</p> <p>1. The corrective action accomplished for those residents found to have been affected by the deficient practice:</p>	

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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071
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F 371	<p>Continued From page 15</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to prepare and serve food under sanitary conditions. The facility failed to ensure the can opener was clean and plate holders were dry before storage.</p> <p>A review of the facility's Census and Condition, dated 11/03/12, revealed the census was 158 with one tube feeder in the facility.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Storage of equipment and supplies-Drying clean dishes," last revised 10/30/12, revealed wet dishes breed bacteria which can be passed on to the resident. A disposable paper towel should be used to dry off excess water before dishes are put away, or when possible, dishes should be air dried. The can opener should be cleaned after each use.</p> <p>Observation during the initial tour of the kitchen, on 10/30/12 at 10:15 AM, revealed:</p>	F 371	<p>a. No specific resident was found during survey to be affected by the deficient practice.</p> <p>2. Identification of other resident having the potential to be affected by the same deficient practice:</p> <p>a. It was determined that all residents residing in facility on the days of survey could have been affected by the same deficient practice.</p> <p>3. The measures and systemic changes to ensure that the deficient practice will not recur:</p> <p>a. Plate holder drying racks have been purchased and are currently being used to ensure excess water is removed.</p> <p>b. The can opener was cleaned during survey and is on a daily/after every use cleaning schedule.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. The Dietary Manager will perform weekly audits for cleanliness of can opener and dishes to be free of excess water.</p> <p>b. Results of audits will be available to Administrator.</p> <p>c. The Dietary Manager will report results of finding and corrective actions at quarterly Quality Assurance meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with F371 deficiency effective December 14, 2012.</p>	Completion Date 12/14/2012
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2012
NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(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 371	Continued From page 16 1) The can opener with a build-up of a black substance behind the blade. 2) Approximately 100 plate holders were stacked with water between the plate holders. Interview with the Dietary Manager, on 11/02/12 at 9:50 AM, revealed the can opener should be cleaned after every use and the plate holders should be dried before stacking and being stored.	F 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Amended 11/29/12 Deleted K27 related to the cross-corridor doors at the breezeway</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1964, 71, 83 and new building in 2006.</p> <p>SURVEY UNDER: 2000 Existing and 2000 New.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1964 upgraded in 2012, with 86 smoke detectors and 1 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system in the old part and a dry system installed in 1967 and 2006.</p> <p>GENERATOR: Two (2) Type II generators installed in 2006 and 2011. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/30/12 and 10/31/12. Spring Creek Healthcare was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for</p>	K 000	This plan of correction is submitted as the facility's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sandra J. Dick TITLE: Administrator (X6) DATE: 11-30-12

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

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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of nine (9) smoke compartments, one-hundred thirty-five (135) residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds	K 025	K 025 NFPA 101 LIFE SAFETY CODE SS=F STANDARD 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No residents were affected by this deficient practice. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: a. The facility will be divided into four (4) smoke zones. b. The smoke barriers to remain will be upgraded to current code. c. Intumescent sealants will be utilized by having the penetrations and the top of wall conditions at the roof deck smoke stopped.	

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NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(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 2</p> <p>with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed to ensure five (5) smoke barriers were sealed around wires, through pipes extending through the smoke barriers, and to the roof decking. This deficiency was cited on the survey last year on 07/29/11.</p> <p>The findings include:</p> <p>Observations, on 10/30/12 between 10:30 AM and 10:50 AM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the smoke partitions, extending above the ceiling located throughout the facility except the one located next to 312, were penetrated by wires and pipes. Further observation revealed the smoke barrier next to room # 200 did not extend to the roof decking.</p> <p>Interview, on 10/30/12 between 10:30 AM and 10:50 AM with the Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were unaware of the penetrations in the smoke barriers but he did reveal the facility had ran new cable recently due to the fire alarm panel.</p> <p>Interview, on 10/30/12 at 10:50 AM with the Administrator, revealed she was unaware of the penetrations in the smoke barriers. The facility followed the plan of correction conducting a wall inspection four times a month. The facility had an outside company conduct the work of sealing the barriers in the attic. She was very confused as to how there were penetrations in the smoke barriers because there was such an emphasis on this particular life safety code.</p>	K 025	<p>d. The remaining existing barrier walls will be declassified as they will no longer be in operation.</p> <p>e. The cross corridor doors will be removed.</p> <p>f. The remaining doors through these barriers after changes are complete will be inspected. This includes removal of astragals, operation of closers and proper installation of protective plates.</p> <p>g. A vendor for smoke stop products has visited the site and recommended the appropriate materials to meet K 025 life safety code standard.</p> <p>h. Drawing is attached to further show facility intent.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. New policy and procedure has been created for facility establishing a process that now requires the issuance of a permit authorization work in a protective barrier.</p> <p>b. Policy and procedure has been developed and in-serviced.</p> <p>c. Maintenance Coordinator will require inspection prior to completion of work.</p> <p>d. Maintenance Coordinator will monitor the performance by conducting monthly inspections.</p> <p>e. If any variances are found, immediate action will be taken to rectify.</p> <p>f. Maintenance Coordinator will report results at quarterly Quality</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROMOVER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 025	Continued From page 3 This is a repeat deficiency. Reference: NFPA 101 (2000 Edition). 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: (a) The space between the penetrating item and the smoke barrier shall 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. (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 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. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 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	Assurance meeting. g. Action plans will be developed if indicated. 5. The facility declares compliance with K 025 deficiency effective 12/17/2012	Completion Date 12/17/2012	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	K 029	K 029 NFPA 101 LIFE SAFETY CODE SS=F STANDARD 1. The corrective action accomplished for those residents found to have been affected by the deficient practice:		

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K 029	<p>Continued From page 4</p> <p>doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect eight (8) of nine (9) smoke compartments, one-hundred thirty-five (135) residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed to ensure fifteen (15) rooms with hazardous storage had the proper door closer for separation.</p> <p>The findings include:</p> <p>Observation, on 10/30/12 between 2:30 PM and 4:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed:</p> <ol style="list-style-type: none"> 1) The activities office did not have a door closer installed due to storage. 2) The environmental services office did not have a door closer installed due to storage. 3) Room # 216 did not have a door closer installed due to storage. 4) Room # 218 did not have a door closer installed due to storage. 	K 029	<ol style="list-style-type: none"> a. No residents were found to be affected by this deficient practice during survey. 2. Identification of other residents having the potential to be affected by the same deficient practice: <ol style="list-style-type: none"> a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: <ol style="list-style-type: none"> a. Door closing devices have been ordered for all doors cited to resist the passage of smoke except for #1 activities office. b. Stored combustible materials have been removed from activity office area. c. Closures will be installed as soon as received. d. Facility policy and procedure has been created to address any room larger than 50 square feet with combustible material will have door that resists the passage of smoke and a closure device. e. Policy and procedure has been in-serviced to appropriate staff. 4. The facility plans to monitor its performance to ensure that solutions are sustained by: <ol style="list-style-type: none"> a. Maintenance staff will perform monthly building inspections regarding combustible materials. b. If any variances are found, immediate action will be taken to rectify. c. Maintenance Coordinator will 		

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K 029	<p>Continued From page 5</p> <p>5) Room # 220 did not have a door closer installed due to storage.</p> <p>6) Shower room station 3 did not have a door closer installed due to storage.</p> <p>7) The medical records office did not have a door closer installed due to storage.</p> <p>8) The solarium did not have a door closer installed due to storage.</p> <p>9) Station 3 storage did not have a door closer installed due to storage.</p> <p>10) The billing office did not have a door closer installed due to storage.</p> <p>11) The dry storage room in the kitchen did not have a door closer installed due to storage.</p> <p>12) The station 4 rehab closet did not have a door closer installed due to storage.</p> <p>13) The station 4 medicine room did not have a door closer installed due to storage.</p> <p>14) The station 4 linen room did not have a door closer installed due to storage.</p> <p>15) The social worker office did not have a door closer installed due to storage.</p> <p>Any room larger than 50 square feet with substantial combustible material must have a door that resists the passage of smoke and a closing device.</p> <p>Interview, on 10/30/12 between 2:30 PM and 4:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>Reference:</p>	K 029	<p>report monitors and variance results at quarterly Quality Assurance meeting.</p> <p>d. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with K 029 deficiency effective 12/14/2012</p>	Completion Date 12/14/2012	

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K 029	Continued From page 6 NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 045		

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K 045	<p>Continued From page 7</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, eighty-five (85) residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at two (2) exits.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 at 1:15 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the exterior exits at the Ambulance Entrance and the Kitchen Dock area only had a single light for illumination of the outside of the exit.</p> <p>Interview, on 10/31/12 at 1:15 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the</p>	K 045	<p>K 045 NFPA 101 LIFE SAFETY CODE SS=D STANDARD</p> <ol style="list-style-type: none"> 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: <ol style="list-style-type: none"> a. No residents were found to be affected by this deficient practice during survey. 2. Identification of other residents having the potential to be affected by the same deficient practice: <ol style="list-style-type: none"> a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: <ol style="list-style-type: none"> a. Lighting fixtures have been replaced with fixtures containing 2 bulbs for illumination of the path of egress. 4. The facility plans to monitor its performance to ensure that solutions are sustained by: <ol style="list-style-type: none"> a. The Maintenance staff will perform monthly building inspections to ensure all appropriate lighting fixtures are operable. b. Maintenance staff will correct any variances at time of inspections. c. Monitors and variances will be reported at quarterly Quality Assurance meetings. d. Action plans will be developed if indicated. 5. The facility declares compliance with 	Completion Date	

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K 045	Continued From page 8 egress path. Further interview revealed the building had passed the building codes when it was built and did not understand why this was not found at that point. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	K 045 deficiency effective 11/29/2012	11/29/2012	
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	K051 NFPA 101 LIFE SAFETY CODE SS=F STANDARD 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No residents were found to be affected by this deficient practice during survey. 2. Identification of other residents having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: a. The fire alarm control panel annunciator will be relocated from		

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K 051	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building fire alarm system was installed as required by NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed to ensure the fire alarm annunciator was in an area that is monitored 24 hours a day and 7 days a week. The findings include: Observation, on 10/31/12 at 9:30 AM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the Fire Alarm Control Panel (FACP) Annunciator was located at the entrance to the 4 Northwest corridor. The panel is monitored by an office that is over 20 feet away and around a corner. The panel is not visible from the monitoring location. Interview, on 10/31/12 at 9:30 AM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were unaware the annunciator must be installed in an area that is monitored 24 hours a day seven days a week.	K 051	the entrance at Station 4 Northwest corridor to a visible location at Station 4 nurse's station. b. Staff will be in-serviced regarding relocation of annunciator. 4. The facility plans to monitor its performance to ensure that solutions are sustained by: a. The maintenance staff will perform monthly building inspections to visually check the annunciator panel. b. Maintenance staff will correct any variances at time of inspections. c. Monitors and variances will be reported at quarterly Quality Assurance meetings. d. Action plans will be developed if indicated. 5. The facility declares compliance with K 051 deficiency effective 11/29/2012	Completion Date 11/29/2012

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K 051	Continued From page 10 Reference: NFPA 72 (1999 Edition). 1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated. 1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard. 5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions: (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone. 5-5.3.2.1.6.2	K 051			

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K 051	Continued From page 11 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.	K 051		
K 056 SS=E	3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056	K 056 NFPA 101 LIFE SAFETY CODE SS=E STANDARD 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No specific resident was found to be affected by the deficient	

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K 056	<p>Continued From page 12</p> <p>switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect six (6) of nine (9) smoke compartments, one-hundred forty-eight (148) residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed to ensure resident closets in the old part of the building had proper sprinkler coverage and sprinklers not blocked by fixtures in the new part of the building.</p> <p>The findings include:</p> <p>Observation, on 10/30/12 between 2:30 PM and 4:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the resident closets at station 1, station 2 south, station 2 east hall north side, 3 south, 3 main hall, and north hall station 3 did not have proper sprinkler coverage. The closets had shelves and were closed in at the top of the closet.</p> <p>Interview, on 10/30/12 between 2:30 PM and 4:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were unaware the closets were not properly sprinkler protected</p>	K 056	<p>practice.</p> <p>2. Identification of other resident having the potential to be affected by the same deficient practice:</p> <p>a. It was determined that all residents residing in the facility could have been affected by the same deficient practice.</p> <p>3. The measures and systemic changes to ensure that the deficient practice will not recur:</p> <p>a. Rooms cited in K 056 deficiency will have top shelf removed from closets.</p> <p>b. Sprinkler heads identified as obstructed by light fixtures installed within (1) foot will be replaced with new heads and will extend below light fixtures in question.</p> <p>c. The two sprinkler heads too close to walls will be relocated.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. Maintenance staff will perform monthly building inspections for clearances around sprinklers.</p> <p>b. Any variances will be corrected at time of inspection.</p> <p>c. Monitors and variances will be reported at quarterly Quality Assurance meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with K 056 deficiency intended completion 01/25/2013.</p> <p>Please refer to attached letter from</p>	Completion Date 1/25/2013	

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K 056	<p>Continued From page 13 since they had been this way for a long time.</p> <p>Observations, on 10/30/12 between 2:30 PM and 4:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed a sprinkler head located two (2) inches from the wall located in the station 1 shower room and the rehab area at station 4.</p> <p>Interview, on 10/30/12 between 2:30 PM and 4:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were not aware the sprinkler heads were located to close to a wall.</p> <p>Observations, on 10/31/12 between 9:00 AM and 3:30 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the sprinkler heads located in resident room# 431, resident bathroom of 431, 434 resident bathroom, rehab area, rehab office, rehab bathroom, station 4 supply, station 4 linen closet, station 4 shower room 1, station 4 shower room 2, occupational therapy closet, ES closet, 2 heads outside station 4 in corridor, quiet lounge, and quiet lounge closet were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads.</p> <p>Interview, on 10/31/12 between 9:00 AM and 3:30 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were unaware that sprinkler heads could have no obstructions below the deflector within 12 inches of the head. They also were unaware of how the sprinklers</p>	K 056		

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K 056	<p>Continued From page 14</p> <p>passed the initial inspections before the building was occupied.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 ed.)</p>	K 056			

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K 056	Continued From page 15 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)	K 056																								
	<p style="text-align: center;">Maximum Allowable Distance</p> <table border="0"> <tr> <td>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td>of Deflector Obstruction (in.) (B)</td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18			
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.) (B)																									
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4 ft 6 in. to less than 5 ft	16 1/2																									
5 ft and greater	18																									
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, 9.7.6	K 062	K 062 NFPA 101 LIFE SAFETY CODE SS=F STANDARD 1. The corrective action accomplished for those residents found to have been																							

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K 062	Continued From page 16 This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed to ensure the inside of the sprinkler piping and the gauges on the sprinkler risers were inspected every five (5) years. The findings include: Observation and record review, on 10/30/12 between 10:50 AM and 1:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the facility failed to provide documentation that the gauges on the sprinkler risers had been calibrated or replaced within the last 5 years. Interview, on 10/30/12 between 10:50 AM and 1:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were not aware the gauges on the sprinkler riser had to be calibrated or replaced once every 5 years. Observation and record review, on 10/30/12 between 10:50 AM and 1:00 PM with the	K 062	affected by the deficient practice: a. No specific resident was found to be affected by the deficient practice. 2. Identification of other resident having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: a. Sprinkler riser gauges have been replaced. b. Sprinkler internal pipe inspections are complete. c. Vendor service agreement has been updated to include fire prevention measures to prevent further deficiencies. d. Vendor will provide required documentation for all service and inspection work. 4. The facility plans to monitor its performance to ensure that solutions are sustained by: a. Maintenance staff will perform monthly building inspections to ensure internal pipe inspections are completed per life safety code standard. b. Monitors and variances will be reported at quarterly Quality Assurance meetings. c. Action plans will be developed if indicated. 5. The facility declares compliance with K 062 deficiency 12/14/2012	Completion Date 12/14/2012

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K 062	<p>Continued From page 17</p> <p>Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the wet sprinkler system had no internal inspection within the last 5 years. Further observation of the records revealed last interior pipe was unknown.</p> <p>Interview, on 10/30/12 between 10:50 AM and 1:00 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were unaware the internal sprinkler piping was to be inspected once every five (5) years. They revealed they relied on their vendors to keep the facility in compliance.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>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.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p>	K 062		

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K 062	Continued From page 18 Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3	K 062			

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K 062	Continued From page 19 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction Investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, eighty-five (85) residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed to ensure nine (9)	K 070	K 070 NFPA 101 LIFE SAFETY CODE SS=D STANDARD 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No specific resident was found to be affected by the deficient practice. 2. Identification of other resident having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: a. All portable heaters were removed the day of the survey.	

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K 070	Continued From page 20 space heaters in employee areas did not exceed 212 degrees Fahrenheit. This deficiency was cited on the survey last year on 07/29/11. The findings include: Observation, on 10/30/12 at 12:15 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed nine (9) space heaters throughout offices that were provided by the facility. The heater in the Administrator's office was tested with a thermometer and was stopped after it went to 230 degrees Fahrenheit. Interview, on 10/30/12 at 12:15 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were under the impression after the last survey that the dial on the space heater could not exceed 212 degrees. The facility kept all paperwork on the heaters because they believed they were in compliance. This is a repeat deficiency. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). NFPA 101 LIFE SAFETY CODE STANDARD	K 070	b. Portable heaters are no longer allowed to be purchased for facility. 4. The facility plans to monitor its performance to ensure that solutions are sustained by: a. Maintenance staff will perform monthly building inspections for unauthorized heaters. b. Monitors and variances will be reported at quarterly Quality Assurance meetings. c. Action plans will be developed if indicated. d. The facility declares compliance with K 070 deficiency intended completion 12/1/2012. K 076 NFPA 101 LIFE SAFETY CODE K 076=D STANDARD	Completion Date 12/1/2012
K 076 SS=D				

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K 076	<p>Continued From page 21</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, ten (10) residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles and electrical sources were five (5) from the floor.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 at 2:35 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed over thirty (30) oxygen</p>	K 076	<ol style="list-style-type: none"> 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: <ol style="list-style-type: none"> a. No specific resident was found to be affected by the deficient practice. 2. Identification of other resident having the potential to be affected by the same deficient practice: <ol style="list-style-type: none"> a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: <ol style="list-style-type: none"> a. Appropriate oxygen storage area has been properly stored and secured. b. The area is clearly labeled. 4. The facility plans to monitor its performance to ensure that solutions are sustained by: <ol style="list-style-type: none"> a. Facility Assistant will perform monthly oxygen audits for approved, appropriate and secure storage. b. Corrective action will be taken if found to be out of compliance. c. Monitors and variances will be reported at quarterly Quality Assurance meetings. d. Action plans will be developed if indicated. 5. The facility declares compliance with K 076 deficiency intended completion 12/14/2012 	Completion Date 12/14/2012

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185005	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER SPRING CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1401 SOUTH 16TH STREET MURRAY, KY 42071		
(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 076	<p>Continued From page 22</p> <p>tanks in the nsg store m room on the facility map. The oxygen tanks were being stored within five (5) feet of combustible items and electrical outlets were not five (5) feet from the floor.</p> <p>Interview, on 10/31/12 at 2:35 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were unaware oxygen tanks could not be stored within five (5) feet of combustible materials once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection</p>	K 076			

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K 076	Continued From page 23 rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
K 135 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.	K 135	K 135 NFPA 101 LIFE SAFETY CODE SS=D STANDARD 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No specific resident was found to be affected by the deficient practice. 2. Identification of other resident having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility could have been affected by the same deficient practice.	

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K 135	<p>Continued From page 24</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to properly store flammable and combustible liquids in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, eight (8) residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The facility failed to ensure that seventy-six cans of aerosol were stored properly.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 at 9:30 AM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed seventy-six (76) cans of flammable aerosol stored on a shelf in the Environmental Services Storage room. All flammable materials in bulk shall be stored in a flammable proof cabinet if stored in the facility.</p> <p>Interview, on 10/31/12 at 9:30 AM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were aware that flammable items could not be stored outside a flammable cabinet but did not know so many items were being stored outside of the cabinets.</p> <p>NFPA 99, 10-7.2.1* Flammable and Combustible liquids shall be used from and stored in approved containers in accordance with, NFPA 30- 4.3.3</p> <p>Storage cabinets that meet at least one of the</p>	K 135	<p>3. The measures and systemic changes to ensure that the deficient practice will not recur:</p> <ul style="list-style-type: none"> a. An approved container has been purchased and placed into service. b. The flammable materials have been stored in the provided container. c. New policy and procedure has been developed and implemented. d. Environmental Services Staff has been in-serviced. <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <ul style="list-style-type: none"> a. Environmental service staff will perform monthly building inspections for bulk flammable materials storage. b. Any variances will be corrected at time of inspection. c. Monitors and variances will be reported at quarterly Quality Assurance meetings. d. Action plans will be developed if indicated. <p>5. The facility declares compliance with K 135 deficiency intended completion 12/14/2012</p>	Completion Date 12/14/2012

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K 135	Continued From page 25 following sets of requirements shall be acceptable for storage of liquids: (a) Storage cabinets that are designed and constructed to limit the internal temperature at the center of the cabinet and 1 in. (25 mm) from the top of the cabinet to not more than 325°F (162.8°C), when subjected to a 10-minute fire test that simulates the fire exposure of the standard time-temperature curve specified in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, shall be acceptable. All joints and seams shall remain tight and the door shall remain securely closed during the test.	K 135			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility is certified for two-hundred twenty-six (226) beds with a census of one-hundred fifty-nine (159) on the day of the survey. The	K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 1. The corrective action accomplished for those residents found to have been affected by the deficient practice: a. No specific resident was found to be affected by the deficient practice. 2. Identification of other resident having the potential to be affected by the same deficient practice: a. It was determined that all residents residing in the facility could have been affected by the same deficient practice. 3. The measures and systemic changes to ensure that the deficient practice will not recur: a. The gallon of oil was removed from inside the generator enclosure.		

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K 144	<p>Continued From page 26</p> <p>facility failed to ensure the generator enclosure did not have any storage inside and the annunciator for the Kohler generator was in a monitored location.</p> <p>The findings include:</p> <p>Observation, on 10/31/12 at 2:30 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the facility was equipped with an emergency generator. The enclosure for the Generac generator had a gallon of 15w40 oil stored inside.</p> <p>Interview, on 10/31/12 at 2:30 PM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were not aware the flammable item was being stored inside the generator enclosure. They revealed the contractor for the generator must have left the item in the enclosure.</p> <p>Observation, on 10/31/12 at 9:30 AM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed the facility was equipped with two (2) emergency generators. The Kohler generator has an annunciator installed at nurses station 2 which is not used 24 hours a day 7 days a week.</p> <p>Interview, on 10/31/12 at 9:30 AM with the Administrator, Maintenance Supervisor, Environmental Services Supervisor, and Maintenance, revealed they were not aware the generator needed an annunciation panel to</p>	K 144	<p>b. The service vendor has been instructed that flammable materials may not be left within the generator enclosure.</p> <p>c. An additional generator annunciator panel will be installed at Station 3 Nurse's Station.</p> <p>4. The facility plans to monitor its performance to ensure that solutions are sustained by:</p> <p>a. Maintenance staff will perform weekly inspections during weekly generator run tests for flammable materials.</p> <p>b. Any variance will be corrected at time of inspection.</p> <p>c. Monitors and variances will be reported at quarterly Quality Assurance meetings.</p> <p>d. Action plans will be developed if indicated.</p> <p>5. The facility declares compliance with K 144 deficiency intended completion 12/14/2012</p>	Completion Date 12/14/2012

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K 144	Continued From page 27 Inform staff of alarm conditions of the emergency power source at a monitored location. Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room. Reference: NFPA 99 (1999 Edition) 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning	K 144			

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K 144	Continued From page 28 b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144			