

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

PRINTED: 12/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/12/2013
NAME OF PROVIDER OR SUPPLIER J J JORDAN GERIATRIC CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A Standard Recertification Survey and an Abbreviated Survey investigating KY#00021033 were initiated on 12/10/13 and concluded on 12/12/13. Deficiencies were cited with the highest scope and severity cited at an "E". KY#00021033 was unsubstantiated with no deficiencies cited.	F 000	DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY RESERVES THE RIGHT TO TAKE FURTHER ACTION, INCLUDING ALL LEGAL MEANS NECESSARY, TO RESOLVE ANY DISPUTES ABOUT THE ACCURACY OF THIS INFORMATION.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of eighteen (18) sampled residents (Resident #2). Resident #2 had a Physician's Order for oxygen at two (2) liters per minute via nasal cannula; however, observation on initial tour on 12/10/13 at 2:45 PM and again at 5:15 PM revealed the resident's oxygen was at five (5) liters per minute. The findings include: Review of the facility's, "Oxygen Therapy" policy, undated, revealed the purpose of the policy was the flow of oxygen was to be started and regulated as ordered by the Physician. Review of Resident #2's medical record revealed	F 281	The oxygen flow rate for resident # 2 was set at 2liters per minute via nasal cannula on 12/10/13 as ordered by the physician. The resident was re-educated by the nursing staff about the risks of adjusting oxygen flow rate on 12/14/13. The plan of care was updated for resident # 2 on 12/14/13 to include: provide frequent monitoring of oxygen flow rate by nursing staff during rounds throughout each shift. The oxygen flow rate for all residents receiving oxygen was assessed on 12/12/13 to ensure that the oxygen flow rate was set as ordered by the physician. The nursing staff was in-serviced by the Staff Development Coordinator on 01/03/14 and 01/06/14 on monitoring oxygen flow rates as ordered by the physician. The Nursing Supervisors will monitor all residents receiving oxygen throughout each shift to ensure the flow rates are set as prescribed by the physician. The DON or ADON will monitor residents receiving oxygen during monthly surveillance rounds to ensure oxygen is being administered as ordered by the physician. The DON or ADON each month will randomly sample five percent of resident's physician orders to ensure that care is provided as specified by the physician (see monitoring tool A). Findings will be reported to the Performance Improvement Committee quarterly for 6 months.	01/07/14	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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

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F 281

Continued From page 1

diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly Minimum Data Set (MDS) dated 10/14/13, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) of a fifteen (15) which indicated the resident was cognitively intact.

Review of the Comprehensive Plan of Care dated 01/30/13, revealed Resident #2 had a Care Plan for altered respiratory status secondary to COPD. Review of the Care Plan revealed Resident #2 turned the oxygen up. Continued review of the Care Plan revealed the goal stated the resident was not to exhibit signs and symptoms of respiratory distress. Further review revealed the interventions included administering oxygen per current Physician's Orders, and educating the resident as needed with the dangers of increasing his/her oxygen.

Review of the Physician's Orders dated December 2013, revealed orders for oxygen at two (2) liters per nasal cannula, for oxygen saturation levels less than 89 % (eighty-nine percent).

Observation of Resident #2 on initial tour on 12/10/13 at 2:45 PM, revealed the resident was receiving oxygen per nasal cannula (NC) at five (5) liters. Another observation on 12/10/13 at 5:15 PM, revealed Resident #2 had oxygen per NC at five (5) liters. Interview with the resident at the time of the observation, revealed he/she turned the oxygen up to five (5) liters on his/her own.

Interview on 12/10/13 at 5:17 PM, with Licensed Practical Nurse (LPN) #3, revealed Resident #2

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F 281	<p>Continued From page 2</p> <p>was receiving oxygen at five (5) liters per NC; however, had orders to have oxygen at two (2) liters. LPN #3 stated she was unaware of Resident #2 turning the oxygen up on his/her own in the past. Continued interview with LPN #3 revealed she checked the oxygen three (3) to four (4) times a day to ensure it was set at what was ordered; but, was unaware of when she had last checked Resident #2's oxygen.</p> <p>Interview on 12/12/13 at 4:30 PM, with the Director of Nursing (DON) revealed staff needed to move the oxygen concentrator out of Resident #2's reach; and, needed to monitor the oxygen more closely. She stated her expectation was Physicians' Orders were to be followed.</p>	F 281		
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's "General Safety Handbook", it was determined the facility failed to provide a safe environment as evidenced by a space heater plugged into an electrical outlet in beauty shop on initial tour on 12/10/13 at 2:30 PM. The space heater remained plugged into the electrical outlet during an additional tour on 12/11/13 at 4:30 PM.</p>	F 323	<p>The space heater observed in the beauty shop was removed on 12/11/13 by the Environmental Service Director.</p> <p>Subsequently, the Environmental Service Director inspected all the other areas of the facility on 12/11/13 to ensure no other space heaters were present.</p> <p>On 12/20/13, 1/2/14, and 1/3/13 the Staff Development Coordinator held in-service meetings with all of the staff on all shifts and rotations to reinforce and reiterate the facility policy/prohibition concerning space heaters in the facility.</p> <p>On 1/7/14 the beautician who is a contract service employee was in-serviced by the Staff Development Coordinator regarding the prohibition of space heaters in the facility.</p>	01/09/14

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F 323	Continued From page 3 The findings include: Review of the facility's, "General Safety Handbook" dated 05/01/2010, revealed the facility could limit the number of accidents by "removing unsafe conditions and unsafe acts". Further review revealed the use of portable space heaters was prohibited except in emergencies. Observation on initial tour on 12/10/13 at 2:30 PM, revealed the beauty shop on the west hall had a portable space heater plugged into an electrical outlet. Further observation on 12/11/13 at 4:30 PM, revealed the portable space heater continued to be plugged into an electrical outlet in the beauty shop. Interview with the Beautician on 12/11/13 at 5:36 PM, revealed the heater was in a cabinet in the beauty shop when a resident complained of being cold. The Beautician stated she plugged the heater in after the resident's complaint. The Beautician stated she had not had any training on safety within the facility. She indicated she was a contract employee. Further interview revealed she would consider the space heater a safety issue, as it could fall over and start a fire. Interview with the Maintenance Director on 12/11/13 at 5:00 PM, revealed the portable space heater should not have been in the facility as they were a safety hazard. The Maintenance Director stated safety rounds were performed; however, the space heater had not been identified during the safety rounds.	F 323	To ensure future compliance with the facility prohibition of use of space heaters, the Environmental Service Director added on 1/8/14 a check-off during her monthly inspection rounds to detect the presence of any space heater devices. If any are detected they would be removed immediately. Each month the Environmental Services Director uses a monitoring tool during the environmental rounds to ensure that residents environment remains as free of accident hazards as is possible (see monitoring tool D). The results of these surveillance reports will be provided each quarter to the Performance Improvement Committee for 6 months. If non-compliance is identified by the Performance Improvement committee, the committee will identify causes, develop new corrective actions, re-educate staff, increase monitoring and re-evaluate until consistent compliance is met.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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F 328	<p>Continued From page 4</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policies, it was determined the facility failed to ensure respiratory equipment was clean and stored appropriately in a manner to prevent the spread of infection for two (2) of eighteen (18) sampled residents (Resident #2 and #5).</p> <p>Observation on initial tour revealed Resident #2 had a nebulizer machine with tubing and a mask which was uncovered, lying on the chest of drawers beside the bed.</p> <p>Further observation on initial tour revealed Resident #5 had a suction machine with a cannister containing greenish fluid which was uncovered, and a Yankauer (oral suction) catheter, uncovered, lying directly on the chest of drawers by the bed.</p> <p>The findings include:</p> <p>Review of the facility's, "Respiratory Therapy Equipment" Policy, undated, revealed Medication</p>	F 328	<p>The nebulizer tubing and mask for resident # 2 was replaced on 12/12/13. The suction canister and suction catheter was replaced for resident # 5 on 12/12/13. The respiratory equipment for resident # 2 and resident # 5 is being stored in plastic covers while not in use.</p> <p>The respiratory equipment for all residents in the facility was inspected on 12/20/13 to ensure it was clean and stored appropriately.</p> <p>The Infection Control Coordinator in-serviced all nursing staff on the proper storage of respiratory equipment when not in use on 12/20/12, 01/02/14 and 01/03/14.</p> <p>The Nursing Supervisors are monitoring respiratory equipment throughout each shift to ensure it is clean and properly stored when not in use.</p> <p>The Infection Control Coordinator will monitor respiratory equipment during monthly surveillance rounds to ensure equipment is clean and stored appropriately to prevent the spread of infection. The Infection Control Coordinator each month will use a monitoring tool to ensure residents received proper treatment and care for special services (see monitoring tool B).</p> <p>Findings will be reported to the Performance Improvement Committee quarterly for 6 months. If non-compliance is identified by the Performance Improvement committee, the committee will identify causes, develop new corrective actions, re-educate staff, increase monitoring and re-evaluate until consistent compliance is met.</p>	01/07/14
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F 328	<p>Continued From page 5</p> <p>nebulizer masks were to be stored in a plastic bag, marked with the date, and resident's name between uses.</p> <p>Review of the facility's, "Suctioning" Policy, undated, revealed the purpose of the procedure was to provide guidelines to help prevent nosocomial infections associated with suctioning and to prevent transmission of such infections to residents and staff. Further review of the policy revealed it did not address the storage of Yankauer catheters and suction machines when not in use.</p> <p>1. Observation on initial tour on 12/10/13 at 2:30 PM, revealed Resident #5 lying on the bed, and was unable to communicate verbally with the surveyor. Continued observation revealed there was a suction machine with a cannister containing greenish fluid which was uncovered; and, a Yankauer catheter, uncovered, lying directly on top of the chest of drawers by the bed.</p> <p>2. Further observation on initial tour on 12/10/13 at 2:30 PM, revealed Resident #2 had a nebulizer machine with tubing and a mask which was uncovered, lying on the chest of drawers beside the bed.</p> <p>Interview on 12/10/13 at 2:45 PM, with Licensed Practical Nurse (LPN) #3 who was assigned to both Resident #5 and Resident #2, revealed Yankauer catheters were to be stored in a plastic bag when not in use. LPN #3 stated nebulizer tubing and nebulizer masks were also to be stored in plastic bags when not in use.</p> <p>Interview on 12/12/13 at 3:00 PM, with the Infection Control Nurse, revealed the nebulizer</p>	F 328		
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F 328 Continued From page 6
tubing and mask should be stored in a plastic bag when not in use. She further stated the Yankauer catheter, as well as, the suction machine should have been covered in plastic bags when not in use.

F 328

F 441
SS=D 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

F 441

The Infection Control Coordinator in-serviced LPN #2 on 12/17/13 and RN # 1 on 01/02/14 concerning hand washing hygiene and gloving techniques to prevent the spread of infection.

01/07/14

The Infection Control Coordinator observed all treatments and skin assessments done by the treatment nurse on 12/17/13 to ensure proper hand washing hygiene and gloving techniques were followed.

The Infection Control Coordinator in-serviced all staff on 01/02/14 and 01/03/14 concerning proper hand washing hygiene and gloving techniques to prevent the spread of infection.

The Nursing Supervisors are monitoring hand washing hygiene and gloving techniques of the nursing staff throughout each shift. In addition the Nursing Supervisors will randomly monitor four nursing staff members during procedures and or care each week to ensure proper hand washing and gloving technique is used to prevent the spread of infection. Findings will be reported to the Infection Control Coordinator (see monitoring tool C).

- (a) Infection Control Program
The facility must establish an Infection Control Program under which it -
 - (1) Investigates, controls, and prevents infections in the facility;
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
 - (3) Maintains a record of incidents and corrective actions related to infections.
- (b) Preventing Spread of Infection
 - (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
 - (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
 - (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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F 441	<p>Continued From page 7</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of facility policy, it was determined the facility failed to maintain an infection control prevention program to prevent the spread of infection and communicable disease for two (2) of eighteen (18) sampled residents (Resident #3 and #8) as evidenced by staff failed to wash or sanitize their hands and apply new gloves during the skin assessments for Resident #3 and Resident #8.</p> <p>1. Observation on 12/11/13 at 9:45 AM, of Resident #8's head to toe skin assessment, performed by Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #2, revealed both of the nurses were observed to start the skin assessment at the top of the resident's head and proceeded to Resident #8's perineal and rectal area. Continued observation revealed both nurses opened the resident's incontinence brief, assessed and touched the perineal skin and rectal skin areas. Observation revealed both nurses continued assessing other areas of Resident #8's body without removing their contaminated gloves, washing or sanitizing their hands and donning new gloves. Further observation revealed after completing the skin assessment both nurses touched and pulled up Resident #8's sheet and blanket, before removing their contaminated gloves and washing their</p>	F 441	<p>The Infection Control Coordinator will monitor hand washing hygiene and gloving techniques to prevent the spread of infection during monthly infection control rounds. The Infection Control Coordinator makes monthly surveillance rounds to help identify, investigate and prevent to the extent possible the onset and spread of infections throughout the facility. The Infection Control Coordinator utilizes a monitoring tool during these surveillance rounds (see monitoring tool B). Findings will be reported to the Performance Improvement Committee quarterly for 6 months.</p>		

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F 441	<p>Continued From page 8 hands.</p> <p>2. Observation on 12/11/13 at 11:30 AM, of Resident #3's head to toe skin assessment, performed by RN #1 and LPN #2, revealed both nurses started the skin assessment at the top of the resident's head and proceeded to the rectal area. Observation revealed RN # 1 opened the resident's incontinence brief which contained feces. RN #1 was observed to, touch the rectal area and continued the skin assessment with the contaminated gloves. Continued observation revealed RN #1 touched Resident #8's bilateral lower extremities; removed the resident's sock; assessed, touched and separated the resident's bilateral toes. RN #1 was then observed to touch Resident #8's Broda (reclining) chair, the treatment cart which she opened and touched a tube of ointment. Observation revealed RN #1 changed her gloves; however, did not wash her hands prior to applying the new gloves. RN #1 was observed to perform perineal care, apply barrier cream ointment and then remove her gloves. RN #1 was not observed to wash her hands after removing her gloves. Further observation revealed RN #1 reapplied an incontinence brief with her bare hands; pulled up the resident's pants; disposed of the contaminated gloves in the garbage bag; and, then washed her hands.</p> <p>Interview, on 12/12/13 at 11:25 AM, with RN #1 revealed she was knowledgeable of the facility's infection control policies related to proper hand washing hygiene and gloving technique. RN #1 stated she did not know why she did not follow the facility's policies. She indicated she was nervous related to being watched and attributed her actions during the skin assessments to this.</p>	F 441			

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F 441	Continued From page 9 Interview, on 12/12/13 at 11:40 AM, with the Assistant Director of Nursing (ADON) revealed all nursing personnel were instructed on the facility's infection control policies which included hand washing and gloving techniques during orientation and throughout the year at monthly in-services. Continued interview with the ADON, revealed it was her expectation that all nursing personnel followed the facility's infection control policies in regards to correct hand washing and gloving techniques at all times during the nursing care of all residents.	F 441			

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NAME OF PROVIDER OR SUPPLIER THE JORDAN CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230		
(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>An On-site Revisit was conducted on 03/18/14 which found the facility was now meeting the minimum requirements for participation in the Medicare and Medicaid program as alleged in the POC on 01/11/14.</p>	{K 000}		

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

TITLE

(X6) DATE

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

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

PRINTED: 12/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185131	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2013
NAME OF PROVIDER OR SUPPLIER J J JORDAN GERIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 270 E CLAYTON LN LOUISA, KY 41230	
(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)

K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

Building: 01

Plan Approval: 1974

Survey under: NFPA 101 (2000 Edition) Chapter 19 (existing health care)

Facility type: SNF/NF

Smoke Compartment: 7

Fire Alarm: Complete fire alarm with smoke detectors in corridors

Sprinkler System: Complete automatic sprinkler system

Generator: Type II, Natural Gas

A standard Life Safety Code survey was conducted on 12/12/13. JJ Jordan Geriatric Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was eighty-nine (89). The facility is licensed for one hundred four (104) beds.

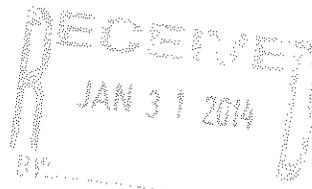
The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

K 018: NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 018

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or

DISCLAIMER: THE COMPLETION AND SUBMISSION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION THAT THE FACILITY AGREES WITH THE DEFICIENCIES AS STATED IN THE 2567. THE FACILITY IS COMPLETING THE PLAN OF CORRECTION BECAUSE IT IS REQUIRED BY STATE AND FEDERAL LAW. THE FACILITY RESERVES THE RIGHT TO TAKE FURTHER ACTION, INCLUDING ALL LEGAL MEANS NECESSARY, TO RESOLVE ANY DISPUTES ABOUT THE ACCURACY OF THIS INFORMATION.



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

TITLE

(X5) DATE

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K 018 Continued From page 1
hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure resident room doors were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, forty eight (48) residents, staff and visitors.

The findings include:

Observation on 12/12/2013 at 10:50 AM, with the Maintenance Director revealed Resident Room 123 would not latch when tested. Doors must latch to prevent the spread of smoke and fire. Further observations revealed the same for

K 018

The doors for room numbers 108, 123, and 206 were adjusted on 12/12/13 by maintenance to ensure they latched properly to meet standards.

On 12/13/13 all doors to all the patient rooms in the facility were examined by the Environmental Service Director and maintenance to ensure they latched properly as well. Any doors found out of compliance were immediately adjusted on 12/13/13.

The nursing and housekeeping staff were in-serviced by Staff Development Coordinator on 1/8/14, and will also be in-serviced on 1/10/14 to observe and report any patient room doors that do not latch properly.

Going forward, the Environmental Service Director will examine each door in all of the patient rooms during her monthly surveillance rounds to ensure they latch properly. The monthly reports of these results will be submitted each quarter to Performance Improvement Committee for 6 months.

1/11/14

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K 018	<p>Continued From page 2</p> <p>Resident Rooms 108 and 206.</p> <p>Interview on 12/12/2013 at 10:50 AM, with the Maintenance Supervisor revealed the rooms were just checked prior to survey and were checked on a weekly basis. Further interview revealed staff had not completed any work orders regarding the doors and maintenance staff were unaware the doors were not working properly.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.</p>	K 018	