



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

PRINTED: 10/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185150	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  09/23/2010
NAME OF PROVIDER OR SUPPLIER  KNOTT COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822		
(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 279	<p>Continued From page 1</p> <p>the results of the Minimum Data Set Assessment to develop an individualized comprehensive care plan for two (2) of twenty-five (25) sampled residents (resident #2 and resident #6). Resident #1 and resident #6 were assessed to have oxygen ordered without a care plan developed to identify quantifiable objectives for the highest level of functioning.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Resident #2 was readmitted to the facility on August 24, 2010, with medical diagnoses of Hepatic Encephalopathy, Cryptogenic Cirrhosis with history of Ascites, Diabetes Mellitus, Increased Ammonia Level, Hypersplenism, Hyperlipidemia, Coronary Artery Disease, and Acute Bronchitis.</li> </ol> <p>Observations conducted on September 21, 2010, at 2:55 p.m. and 4:00 p.m., and on September 22, 2010, at 9:45 a.m., revealed resident #2 in bed with oxygen in use per nasal cannula at two liters per minute.</p> <p>An interview conducted on September 22, 2010, at 3:45 p.m., with the MDS Coordinator (Minimum Data Set Coordinator) revealed any time a resident is admitted to the facility with a physician's order for oxygen, the oxygen should be care planned as part of the master care plan or added as a care plan update with the resident's admission care plan. The MDS Coordinator further stated resident #2 was assessed for oxygen therapy and had a physician's order for oxygen when admitted to the facility. The MDS Coordinator revealed resident #2 did not have a care plan for oxygen, however, resident #2 should have had a care plan for oxygen therapy when</p>	F 279	<ol style="list-style-type: none"> <li>The Unit Supervisor and/or MDS Coordinator will review all new admissions and readmissions from an acute hospital stay. When a resident is identified to have a new onset of a respiratory condition or an exacerbation of an existing respiratory condition, staff will initiate a care plan which will include goals and interventions for that resident specific problem and will be placed with the working care plan for review. All Unit Supervisors/MDS Coordinators were inserviced 9/30/2010 by the Administrator on the RAI/Care Planning Process as well as how to care plan for residents with oxygen.</li> <li>The facility will perform weekly chart audits of residents with O2 orders that will consist of 3 resident charts per unit. The CQI Committee Designee will review these charts for medical conditions requiring the use of oxygen and check the care plan to ensure appropriate interventions and attainable goals are in place and individualized. Chart audits will be conducted weekly for one month and then monthly for one quarter. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow up.</li> <li>Completion Date: September 30, 2010.</li> </ol>		

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F 279	<p>Continued From page 2 admitted to the facility.</p> <p>Review of resident #2's record revealed a physician's readmission order dated August 24, 2010, for oxygen at two liters per minute via nasal cannula. Further record review revealed a current physician's order for resident #2 dated September 1, 2010 through September 30, 2010, for oxygen at two liters per minute. Additional record review of the Minimum Data Set Assessment dated September 6, 2010, revealed resident #2 was assessed for oxygen therapy. However, record review of the resident's care plans revealed no comprehensive care plan for the oxygen.</p> <p>2. A review of the medical record for resident #6 revealed the resident had been admitted to the facility on September 4, 2003, with diagnoses to include Parkinson's Disease, Alzheimer's Disease, and Dysphagia. The record further revealed a physician's order dated September 1, 2010, for oxygen to be administered at two liters per minute by nasal cannula. A review of the care plan for resident #6 revealed no care plan had been implemented to address the resident's required oxygen therapy. A review of the comprehensive assessment for resident #6, dated August 13, 2010, revealed the resident had been assessed to require oxygen therapy.</p> <p>Observations of resident #6 on September 21, 2010, at 2:40 p.m. through September 22, 2010, at 4:30 p.m., revealed the resident was receiving oxygen administered by nasal cannula.</p> <p>An interview was conducted with the MDS Coordinator on September 22, 2010, at 3:40 p.m. The MDS Coordinator revealed there had been</p>	F 279		

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F 279	Continued From page 3 no care plan developed to address the oxygen therapy for resident #6. The MDS Coordinator further revealed a care plan should have been developed for resident #6 to address the resident's oxygen therapy.  A review of the policy titled Comprehensive Care Plans (not dated) revealed the facility is required to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Record review of the resident's care plan revealed no comprehensive care plan for the oxygen.	F 279		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. During the environmental tour of the facility on September 21-23, 2010, the following areas were observed: a black substance on floor tiles, broken electrical covers, bathroom doors sticking, torn plastic covers on geri-chair arms, cracked plaster, shaky and torn toilet seats, chipped doors and sink countertops, loose sink faucets, sinks with missing caulk, and	F 465	1. All items and areas in need of repair have been repaired or replaced when indicated. The black substance on the floor tiles of rooms 101, 113, 120, 122, 123, 124, and 125 was removed. The metal doorstops on the bathroom doors to room 103, 104, 113, 124, and 162 were replaced. The chipped countertops in rooms 103, 104, 113, 124, and 162 were repaired. Caulking was inserted around sinks in room 103 and 159 where it was missing. The toilet seats were replaced in rooms 104, 160, and 162. Entry doors to rooms 109, 113, 117, 118, 119, 120, 121, 123, 124, 156, 161, and 165 were repaired. Entry door to room 162 was repaired and closes/opens easily. Electrical outlet covers were replaced in rooms 113 and 165. The sink was repaired in room 159 and faucet fixtures were repaired. Plaster was repaired in room 165 where it was cracked. Geri chair was repaired in	

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F 465	<p>Continued From page 4</p> <p>metal doorstops with exposed sharp ends in resident rooms. Cracked files were observed in the IC unit hallway. The women's and the men's bath on both the Skilled and the IC units had worn and dirty nonskid pads in the bathtubs, and grout in need of replacing.</p> <p>The findings include:</p> <p>Observations of the facility from September 21-23, 2010, revealed the following areas were in need of maintenance/housekeeping services:</p> <ul style="list-style-type: none"> <li>-Resident rooms 101, 113, 120, 122, 123, 124, and 125 were observed to have a black substance on the floor tiles in between the resident beds.</li> <li>-Metal doorstops were observed on the bathroom doors of resident rooms 103, 104, and 117 with plastic end pieces missing, leaving sharp metal exposed.</li> <li>-Resident rooms 103, 104, 113, 124, and 162 had chipped sink countertops in need of repair.</li> <li>-Resident rooms 103 and 159 were missing the caulking around the sinks.</li> <li>-Resident rooms 104, 160, and 162 had toilet seats noted to be shaky and had torn foam padding.</li> <li>-Resident rooms 109, 113, 117, 118, 119, 120, 121, 123, 124, 156, 159, 161, and 165 were observed to have chipped rough entry doors in need of repair.</li> <li>-Resident room 162 had an entry door that</li> </ul>	F 465	<p>room 173. The floor tile was replaced in the hall of the IC unit. The bathtubs in the men and women's bath on IC and Skilled units were cleaned and non skid pads were removed. These tubs are not used. The Corporate Foreman and Housekeeping Supervisor verified all areas mentioned have been corrected.</p> <ol style="list-style-type: none"> <li>2. All resident areas are safe functional and sanitary. Thorough environmental rounds have been conducted throughout the facility and identified concerns have been corrected.</li> <li>3. An in service was conducted on 9/30/10 by the Administrator with all staff including housekeeping and maintenance staff regarding the importance of maintaining a safe functional and sanitary environment. The in service specifically addressed reporting items in need of repair/replacement to the Maintenance Department utilizing the CQI referral form or Maintenance Repair Request Form. Additional in-services were conducted with housekeeping staff on 9/30/10 by the Housekeeping Supervisor regarding maintaining a safe, clean, sanitary environment. Additional in-services were conducted with maintenance staff on 9/30/10 by the Maintenance Foreman regarding maintaining a safe, functional and sanitary environment. This in-service also included a review of the Preventative Maintenance Log Sheet to ensure tile, doors, sinks, electrical outlet covers, plaster, bathtubs, chairs, toilet seats, etc. are periodically</li> </ol>		

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F 465	<p>Continued From page 5.</p> <p>became stuck on the floor, and was hard to close/open.</p> <p>-Resident rooms 113 and 165 were observed to have cracked/exposed electrical outlet covers where the air conditioner was plugged in.</p> <p>-Resident room 159 was observed to have a sink that was loose from the wall, and loose faucet fixtures.</p> <p>-Resident room 166 had cracked plaster in the corner by the bathroom door.</p> <p>-Resident room 173 had a geri-chair with the plastic covering on the arms noted to be torn and rough.</p> <p>-A hump in the hallway was observed on the IC unit of the facility. The floor tile over the hump was observed to be cracked.</p> <p>-The men's and women's Bath on the Skilled Unit was observed to have a bathtub with worn, faded, dirty nonskid pads in the bathtub.</p> <p>-The men's and women's Bath on the IC Unit of the facility was observed to have a bathtub with worn, faded, dirty nonskid pads in the bathtub.</p> <p>An interview was conducted with the Maintenance Supervisor (MS) and the housekeeping Supervisor (HS) on September 23, 2010, at 10:30 a.m. The MS stated he/she did make maintenance rounds on a regular basis and if staff found any areas needing repair they were required to complete a maintenance request form and send it to the Maintenance Department. The HS stated he/she made random checks of</p>	F 465	<p>checked for proper functioning, are in safe working order and pose no danger to the residents.</p> <p>4. The CQI Committee designee will conduct thorough walking rounds on a weekly basis for one month, then monthly for one quarter, then quarterly thereafter to observe for items in need of repair or replacement or areas in need of cleaning. These rounds will focus on resident care areas as well as common areas and shower rooms. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow up and review.</p> <p>5. Completion: September 30, 2010.</p>		

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F 465	Continued From page 6 resident rooms daily; however, he/she did not check every room.	F 465			

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NAME OF PROVIDER OR SUPPLIER  KNOTT COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822	
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K 000	<p>INITIAL COMMENTS</p> <p>42 CFR 483.70(a)</p> <p>K3 BUILDING: 0101 K6 PLAN APPROVAL: 1978, 2000 K7 SURVEY UNDER: 2000 Existing K8 SNF/NF</p> <p>Type of Structure: One story, Type III (200), unprotected ordinary construction with a complete automatic (wet and dry) sprinkler system and six smoke compartments. The dry sprinkler system serves the 2000 wing addition.</p> <p>A Comparative Federal Monitoring Survey was conducted on 11/03/10 following a State Agency Survey on 09/22/10, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Knott County Nursing Home was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000	<p>Rec 11/9/10 in TH meeting TU HO 11/30/10 POL Accepted. w 12/13/10</p>
K 018 SS-E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 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</p>	K 018	

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

TITLE

(X5) DATE

*July A. Sigman*

Administrator

11-24-10

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  KNOTT COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822
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K 018	<p>Continued From page 1</p> <p>the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors that were capable of resisting the passage of smoke. The deficient practice affected two of six smoke compartments, staff and 20 residents. The facility has the capacity for 92 with a census of 91 the day of survey.</p> <p>Findings include:</p> <p>1. Observation on 11/03/10 at 11:07 a.m. revealed that the door to bedroom #122 was blocked from closing by the resident bed, which protruded into the door opening, preventing the door from closing. Interview with the facility Maintenance Director on 11/03/10 at 11:07 a.m. revealed the facility aware that the resident bed in bedroom #122 was of a length that would block the corridor door if the bed was not maintained in place away from the corridor wall.</p> <p>2. Observation on 11/03/10 at 11:49 a.m. revealed that the corridor doors to resident rooms</p>	K 018	<p>K 018</p> <p>1. Beds A &amp; B in room 122 were immediately switched around resulting in the door to room 122 closing without difficulty. Doors to resident rooms 169, 172, 173, and 174 were repaired November 3, 2010.</p> <p>2. The Maintenance Supervisor conducted a physical inspection of all resident room doors for proper closure. All doors close without difficulty.</p> <p>3. An in-service was conducted on November 18, 2010 with all staff by the Administrator regarding safety of proper closure of resident room doors with an emphasis on doors latching completely and closing without obstruction. Staff were instructed to observe for proper functioning of resident doors as they enter and exit resident rooms and if any concerns are noted to alert the Maintenance Supervisor completing a CQI Referral form to inform him of the location and concern. The in-service also included keeping the area near the resident room doors free of clutter to prevent any type of furniture or other objects from obstructing proper closure. The Maintenance Supervisor was in-serviced on November 4, 2010 by the Administrator regarding the importance of ensuring proper latching/closure of all doors.</p>	
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K 018	<p>Continued From page 2</p> <p>169, 172, 173 and 174 failed to close and latch in the door frames. Interview with the facility Maintenance Director on 11/03/10 at 11:49 a.m. revealed the facility was not aware that the doors were not latching to provide the required smoke resistive protection of the door openings in the corridor walls.</p> <p>The census of 91 was verified by the Administrator on 11/03/10. The finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/03/10.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.6.3.1. Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>Actual NFPA Standard: 19.3.6.3.3*. Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.</p>	K 018	<p>4. The CQI Committee designee will make observations of the resident room doors during walking rounds for any concerns with proper latching of the doors and/or obstructed closure of the doors. These observations will occur daily for one week, weekly for one month, then monthly for one quarter. Any irregularities will be corrected immediately and the CQI Committee will be notified for further review and follow-up.</p> <p>5. Completion Date: November 18, 2010.</p>	

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K 027 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain a smoke door that would close and resist the passage of smoke. The deficient practice affected two of six smoke compartments, staff and 20 residents. The facility has the capacity for 92 beds with a census of 91 on the day of survey.</p> <p>Findings include:</p> <p>Observation on 11/03/10 at 1:30 p.m. revealed that during testing of the fire alarm by the facility Maintenance Director, the smoke doors located near bedroom 101 failed to completely close to resist the passage of smoke. One of the two smoke doors did not completely close leaving a gap of 1/2 inch between the doors. Interview with the facility Maintenance Director on 11/03/10 at 1:30 p.m. revealed that the facility was aware of the problem and had ordered replacement closers for the smoke doors that were not completely closing to resist the passage of smoke.</p>	K 027	<p>K 027</p> <ol style="list-style-type: none"> <li>The part that had been ordered was received and the doors were repaired. The fire doors now close properly when the fire alarm is activated.</li> <li>All fire doors throughout the facility have been evaluated by the Maintenance Supervisor and have found them to be closing properly.</li> <li>An in-service was conducted on November 18, 2010 by the Administrator with all staff regarding the importance of the fire doors closing properly to resist the passage of smoke. Staff were educated to notify the Maintenance Supervisor of any doors that are not properly closing for repair and to complete a CQI Referral form to be forwarded the CQI Committee for follow-up and review.</li> <li>A CQI Committee designee will conduct observations to ensure the doors are closing properly to resist the passage of smoke. These observations will be done weekly for one month, then monthly for one quarter. Any irregularities will corrected immediately and forwarded to the CQI Committee for further review and follow-up.</li> <li>Completion Date: November 18, 2010.</li> </ol>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185160	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  11/03/2010
NAME OF PROVIDER OR SUPPLIER  KNOTT COUNTY NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 388 PERKINS MADDEN ROAD HINDMAN, KY 41822	
(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 027	Continued From page 4  The census of 91 was verified by the Administrator on 11/03/10. The finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/03/10.  Actual NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 027	K 066  1. Metal smoke containers were immediately purchased to empty the flip top ashtrays into for safety and fire prevention. These containers were placed in the designated smoking areas for residents, staff, and visitors. The designated smoking area for residents and staff are located in the back of the facility outside on an enclosed patio area and the designated smoking area for visitors is located at the front entrance to the building on the front porch.  2. All areas designated as smoking areas were observed by the Maintenance Supervisor to ensure there were no other safety concerns and to ensure the metal containers were in place and being utilized appropriately.
K 066 SS=E		K 066	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155150</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/03/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>KNOTT COUNTY NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>388 PERKINS MADDEN ROAD HINDMAN, KY 41822</b>	
(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 066	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a metal container with a self-closing cover device into which ashtrays can be emptied for the outside smoking areas. This affected two of six smoke compartments, staff, and 12 residents. The facility has the capacity for 92 beds with a census of 91 the day of survey.</p> <p>Findings Include:</p> <p>Observation on 11/03/10 at 11:30 a.m. revealed that the designated outside smoking areas for staff, visitors, and residents in the courtyard and at the front entrance to the facility were not equipped with metal containers with self-closing covers into which ashtrays could be emptied to permit smoking materials to be completely extinguished prior to disposal with other combustible trash. Interview on 11/03/10 at 11:30 a.m. with the Maintenance Director revealed that the facility was not aware of the requirement for metal containers with a self-closing covers.</p> <p>The census of 91 was verified by the Administrator on 11/03/10. The finding was acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 11/03/10.</p> <p>Actual NFPA Standard: NFPA 101 19.7.4 (3), (4). Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.</p>	K 066	<p>3. An in-service was conducted on November 18, 2010 by the Administrator with all staff regarding the importance of having the metal containers in place in all designated smoking areas for residents, staff, and visitors safety. The housekeepers were in serviced on the purpose of the containers and on a schedule to empty these containers. The housekeepers were also in-serviced regarding the importance of ensuring that all smoking materials were completely extinguished prior to emptying the ashtrays with other combustible trash. The nursing staff were educated regarding the importance of ensuring that the residents' smoking materials were properly extinguished in to the ashtrays and to assist them as indicated.</p> <p>4. A CQI Committee designee will make observations of the designated smoking areas on a daily basis for one week then weekly for one month to ensure that the metal containers are in place and being utilized appropriately. These observations will also include the disposal of the extinguished material/contents with other combustible trash to ensure that it has been properly extinguished. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow-up and review.</p> <p>5. Completion Date: November 18, 2010.</p>