

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

2nd SOD

PRINTED: 11/27/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/18/2012
NAME OF PROVIDER OR SUPPLIER  ROCKCASTLE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 371 WEST MAIN STREET BRODHEAD, KY 40409		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	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 health survey was conducted on 10/16-18/12. Deficient practice was identified at "E" level.	F 000	1. Reference checks and/or Nurse Aide Abuse Registry has been completed for the employees identified in the statement of deficiencies to include: Housekeeper #1, Speech pathologist #1, State Registered Nurse Aide #1, and Registered Nurse #1. The date of completion for the abuse registry/reference checks was completed on 11-28-12.	11/29/12
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, review of employee files, and a review of the facility's Abuse, Neglect and Misappropriation policy the facility failed to implement the policy to conduct reference checks and Nurse Aide Abuse Registry checks on all employees. The facility failed to conduct reference checks on four of five sampled employees (Housekeeper #1, Speech Pathologist #1, State Registered Nurse Aide #1, and Registered Nurse #1) and failed to check the Nurse Aide Abuse Registry for three of five sampled employees (Housekeeper #1, Speech Pathologist #1, and Registered Nurse #1).  The findings include:  A review of the facility's Abuse, Neglect and Misappropriation Policy (dated December 2010) revealed reference checks and state Nurse Aide Abuse Registry checks would be conducted prior to employment.	F 226	2. An audit was completed by the Human Resources Director on 11-05-12 for employees that were hired within the last 30-days to ensure reference checks had been completed as required. Abuse Registry checks will be completed by the Human Resources Director on all newly hired stakeholders, prior to employment start date.  3. The Human Resources Director received education provided by the Administrator on 11-01-12 regarding the requirement of completion of reference checks and abuse registry checks prior to start date. The Human Resources Director will utilize an audit tool to ensure that reference checks and abuse registry checks are completed for all potential employees prior to start date. The completed audit tool will be	

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

TITLE

(X6) DATE

*Robert E. Hogan*

*Administrator*

*12-6-12*

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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F 226	<p>Continued From page 1</p> <p>A review of employee files revealed Housekeeper #1 was hired on 04/11/12 but the state Nurse Aide Abuse Registry had not been checked until 06/20/12 and there was no evidence a reference check was conducted.</p> <p>A review of Speech Pathologist (SP) #1's employee file revealed the SP was hired on 06/03/12 but the state Nurse Aide Abuse Registry had not been checked until 10/17/12 and there was no evidence a reference check was conducted.</p> <p>A review of State Registered Nurse Aide (SRNA) #1's employee file revealed the SRNA was hired on 07/31/12 and there was no evidence a reference check was completed.</p> <p>A review of Registered Nurse (RN) #1's employee file revealed the RN was hired on 10/10/12 but a state Nurse Aide Abuse Registry check was not completed until 10/17/12 and there was no evidence a reference check was conducted.</p> <p>Interview on 10/18/12 at 4:14 PM, with the Human Resources Supervisor revealed he/she thought the state Nurse Aide Abuse Registry only had to be checked on direct care nursing staff.</p> <p>Interview on 10/18/12 at 4:40 PM, with the Administrator revealed the Administrator was not aware the reference checks and the Nurse Aide Abuse Registry checks were not being completed.</p>	F 226	<p>forwarded to the Administrator for approval and signature to ensure completion of all required information for new employees prior to start date.</p> <p>4. The audit for completion of reference checks and abuse registry checks will be discussed in the Quality Assurance meeting by the Human Resources Director monthly for 3 months for recommendations and further follow-up as indicated.</p>		

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K 000	INITIAL COMMENTS  BUILDING: 01  PLAN APPROVAL: 1985  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type V (111)  SMOKE COMPARTMENTS: 8  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM	K 000		
K 025 SS=E	FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)  EMERGENCY POWER: Type II diesel generator and Type II propane generator  A life safety code survey was initiated and concluded on 10/18/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.  Deficiencies were cited with the highest deficiency identified at "E" level.  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	K 025		

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

TITLE

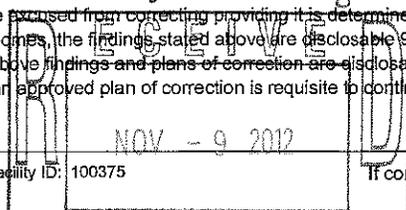
(X8) DATE

*Bonnie Barker*

*RN, Director of Nursing*

*11/9/12*

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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K 025	<p>Continued From page 1</p> <p>terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected two of eight smoke compartments, staff, and approximately fifty-four residents. The facility has the capacity for 104 beds with a census of 95 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 10/18/12, at 1:35 PM, with the Assistant Director of Maintenance (ADOM), unsealed penetrations of electrical wiring and conduit were observed in the attic area above the fire/smoke doors next to room 154. In a fire situation, unsealed penetrations of fire/smoke barriers aid in the spread of smoke and fire to other parts of the building. An interview with the ADOM on 10/18/12, at 1:35 PM, revealed he was aware that fire/smoke barrier walls should be properly sealed; however, he was not aware this area was not properly sealed.</p>	K 025	<ol style="list-style-type: none"> <li>1. The smoke barrier penetration was immediately repaired upon discovery by the Plant Operations Director on 10-18-12.</li> <li>2. All smoke/firewalls were inspected by the Plant Operations Director on 10-19-12 above all fire doors to ensure no penetrations were present.</li> <li>3. All smoke/firewalls will be inspected quarterly by the Plant Operations Director to ensure no penetrations are present. Any smoke barrier penetration identified will be repaired immediately and reported to the administrator immediately by the Plant Operations Director.</li> <li>4. The Plant Operations Director will maintain a log of the quarterly checks and will report findings to the monthly Q/A Committee for review and recommendations and follow up.</li> </ol>	

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K 025	Continued From page 2 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.  19.1.1.3 Total Concept. All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development of operating and maintenance procedures	K 025			

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K 025	Continued From page 3 composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building.	K 025		
K 029 SS=D	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 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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a hazardous area door was held open in an approved manner. This deficient practice affected one of eight smoke compartments, residents, staff, and visitors. The facility has the capacity for 104 beds with a census of 95 on the day of the survey.  The findings include:  During the Life Safety Code tour on 10/18/12, at	K 029	<ol style="list-style-type: none"> <li>The magnetic hold open device for this door was immediately removed by the Plant Operations Director.</li> <li>All doors in hazardous areas were checked by the Plant Operations Director on 10-19-12 to ensure they were not being held open via a magnetic hold open device. No other issues were identified.</li> <li>The Plant Operations Director will inspect all doors quarterly to ensure no magnetic holding devices have been added to any door. Any identified issues will be reported to the administrator and repaired immediately.</li> <li>The Plant Operations Director will report any issues related to the doors to the Q/A Committee quarterly for recommendations and follow up.</li> </ol>	

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K 029	<p>Continued From page 4</p> <p>12:00 PM, with the Assistant Director of Maintenance (ADOM), a corridor door to the Medical Records room was observed to be held open with a magnetic hold-open device. Hazardous area doors are to remain closed unless the hold-open device is connected to the fire alarm system. This hold-open device was not connected to the fire alarm system. An interview with the ADOM on 10/18/12, at 12:00 PM, revealed he was not aware of this requirement.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2.1 Hazardous Areas.</p> <p>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:</p> <ol style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft2 (9.3 m2)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> </ol>	K 029			

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K 029	Continued From page 5 (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 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038			
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure exit access doors had signage in accordance with NFPA standards. This deficient practice affected one of smoke compartments, residents, staff, and visitors. The facility has the capacity for 104 beds with a census of 95 on the day of the survey.  The findings include:  During the Life Safety Code tour on 10/18/12, at 12:05 PM, with the Assistant Director of Maintenance (ADOM), two exit doors leading from the physical therapy area were observed to have time delayed magnetic locks. There was no signage on the door on how to release the		1. Necessary signage was immediately ordered for the identified exits on 10-19-12 by the Plant Operations Director.  2. All exit doors were inspected by the Plant Operations Director on 10-19-12 to ensure proper signage was in place.  3. The Plant Operations Director will inspect doors daily during walking rounds. Any identified issues will be reported to the Administrator and repaired immediately.  4. Any issues related to improper signage will be reported to the QA Committee by the Plant Operations Director monthly for recommendations and follow up.		

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K 038	<p>Continued From page 6</p> <p>magnetic door lock in order to leave the facility during an emergency situation as required. An interview with the ADOM on 10/18/12, at 12:05 PM, revealed he was not aware there should be proper signage on these doors.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority</p>	K 038		

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K 038	Continued From page 7 having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. NFFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 076 SS=D	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. This deficient practice affected one of eight smoke compartments, staff, and approximately twenty-seven residents. The facility has the capacity for 104 beds with a census of 95 on the day of the survey.	K 076	1. Excess oxygen tanks were removed from the area by the Plant Operations Director on 10-19-12. 2. All oxygen storage areas were inspected on 10-19-12 by the Plant Operations Director to ensure compliance with this regulation. No other issues were identified. 3. Oxygen tanks were relocated on 10-19-12 by the Plant Operations Director from the area in question with combustibles to a safe location with no combustibles. All nursing staff were in-serviced on 11-01-12 by the SDC/DON as to proper oxygen storage, including the number of tanks that may be stored together. 4. The Plant Operations Director and or the Director of Nursing will monitor for compliance during daily rounding. Any non-compliance will be reported to the administrator and addressed during the monthly Q/A Meeting by the Plant Operations Director or Director of Nursing for recommendations and follow up.	

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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	
K 076	<p>Continued From page 8</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 10/18/12, at 1:40 PM, with the Assistant Director of Maintenance (ADOM), 15 E sized oxygen cylinder tanks were observed to be stored in the oxygen storage room. These tanks were within five feet of combustible storage. Oxygen cylinders while in storage and in quantities greater than 300 cubic feet must be kept five feet from combustibles. An interview with the ADOM on 10/18/12, at 1:40 PM, revealed he was not aware of oxygen storage requirements. Quantities of 300 cubic feet (12 E sized cylinders) and less may follow the requirements of S&amp;C-07-10.</p> <p>Reference: S&amp;C-07-10</p> <p>Up to 300 cu ft (12 E sized cylinders) of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse's station or in a corridor of a healthcare facility.</p> <p>This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in "crash carts" and in use on wheelchairs or gurneys.</p> <p>The term "PRN" means "as needed." An</p>	K 076			

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

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K 076	Continued From page 9 individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room.  Reference: NFPA 99 (1999 Edition).  8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m <sup>3</sup> (300 ft <sup>3</sup> ) but less than 85 m <sup>3</sup> (3000 ft <sup>3</sup> ) (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 rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.	K 076		

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K 076	Continued From page 10  8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING.	K 076			