

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

PRINTED: 03/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185475	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2015
NAME OF PROVIDER OR SUPPLIER EASTERN STATE HOSPITAL LONG TERM-ACQUIRED BRAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 BULL LEA ROAD LEXINGTON, KY 40511		
(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 Recertification Survey was initiated on 10/27/15 and concluded on 10/29/15 with no deficiencies cited.	F 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185475	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - EASTERN STATE LTC B. WING _____	(X3) DATE SURVEY COMPLETED 10/28/2015
NAME OF PROVIDER OR SUPPLIER EASTERN STATE HOSPITAL LONG TERM-ACQUIRED BRAIN			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 BULL LEA ROAD LEXINGTON, KY 40511	
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) New Plan approval: 02/04/2011 Facility type: SNF/NF Located on first (1) and third (3) floor Allen Wing Type of structure: II (222) Smoke Compartment: Two (2) Fire Alarm: Complete fire alarm Sprinkler System: Complete sprinkler system (wet) Generator: Type I (Diesel) A life safety code survey was initiated and concluded on 10/28/15. 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 to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3	K 025		

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

TITLE

(X6) DATE

11/18/2015

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	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain fire/smoke barriers with a one (1) hour fire resistance rating as required by National Fire Protection Agency (NFPA) standards. This deficient practice affected two (2) of three (3) smoke compartments, staff and approximately seven (7) residents. The facility had the capacity for forty-four (44) beds with a census of fifteen (15) residents the day of survey. The findings include: During the Life Safety Code survey on 10/28/15, at 10:15 AM, with the Director of Maintenance (DOM), the fire/smoke barrier wall above the ceiling at the third floor unit was observed to have an approximate three (3) inch hole through the barrier. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility in a fire situation. Interview with the DOM on 10/28/15, at 10:15 AM, revealed he was aware the fire/smoke barrier should be properly sealed; however, he was not aware of the hole in this barrier wall. The findings were revealed to the Administrator on exit.	K 025			