

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

PRINTED: 03/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185142	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ APR 2013	(X3) DATE SURVEY COMPLETED 03/14/2013
NAME OF PROVIDER OR SUPPLIER HERITAGE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 401 INDIANA AVE MAYFIELD, KY 42066	
(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 conducted 03/12/13 through 03/14/13 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	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to identify an assistive device as a physical restraint and assess for the risks and benefits of the device prior to its use for two residents (#5 and #8), in the selected sample of sixteen (16) residents. The facility used the Broda chair with thigh straps, restricting the movement of both residents; however, the facility did not identify and assess the thigh strap as a physical restraint. The findings include: A review of the Restraints policy/procedure, last revised 04/28/09, revealed the definition of a physical restraint was as follows: Any manual method or physical or mechanical device, material, or equipment attached or adjacent to	F 221	F-221 Heritage Manor ensures the right of every resident to be free from any restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. 1. Residents #5 and #8 have now been re-evaluated for restraints including the risks and benefits with regard to the thigh straps on their Broda chairs. 2. All residents will be reviewed by nurse management to include the DNS, Unit Managers, Staff Development Coordinator, Case Manager and MDS Coordinator to ensure that any devices which restrict freedom of movement or normal access to one's body are assessed as restraints including risks and benefits with changes made where necessary. 3. All licensed staff will be in-serviced by the staff development coordinator on the recognition of restraints and proper assessments including risks and benefits by April 24, 2013.	4/24/2013

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

TITLE

(X6) DATE

Cathy Shuler RN

Director Nursing Service

4-15-13

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 221	<p>Continued From page 1</p> <p>the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The policy further revealed in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration would be explained to the resident and/or responsible party. The facility would assess and care plan for restraint use on an ongoing basis.</p> <p>1. A record review revealed Resident #5 was admitted to the facility on 10/28/11 with diagnoses to include Hemiplegia due to Cerebrovascular Disease, Paralysis Agitans, and Senile Dementia with Delusional Features. A review of the quarterly Minimum Data Set (MDS) assessment, dated 12/26/12, revealed the facility assessed the resident as moderately cognitively impaired and required extensive assistance with bed mobility and transfer. The MDS revealed the resident does not ambulate.</p> <p>A review of the Physician's orders, dated 01/10/13, revealed a thigh strap was added to the Broda chair to promote functional postural alignment. A review of the Physical Restraint Evaluation (Part 1), dated 01/15/13, revealed restraint use was being considered for Resident #5 as the thigh strap was added to the Broda chair. There were no risks discussed in the evaluation related to the use of the thigh strap. Review of the Physical Restraint Evaluation (Part 2), dated 01/17/13, revealed the thigh strap to the Broda chair was not considered a restraint as the resident was non-ambulatory.</p> <p>Observations on 03/12/13 at 2:45 PM, 3:30 PM,</p>	F 221	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>4. The Unit Managers will review physician orders daily for any new orders for mechanical devices conduct a monthly audit of residents with any mechanical device, material, or equipment attached to or adjacent to the resident's body for determination as a restraint and assess for risks and benefits. The Director of Nursing will monitor the results of the audits and report to the Performance Improvement Committee monthly for three months and quarterly thereafter until substantial compliance is achieved.</p>		

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F 221	<p>Continued From page 2</p> <p>and 03/13/13 at 1:45 PM, and 03/14/13 at 9:25 AM, revealed Resident #5 was in a Broda chair with a thigh straps attached. The observation on 03/14/13 at 9:25 AM revealed the resident was able to make slight movements upon command; however, the thigh strap restricted the resident's movement.</p> <p>An interview with Licensed Practical Nurse (LPN) #4, on 03/14/13 at 10:55 AM, revealed she completed the Physical Restraint Evaluation on Resident #5. She revealed the resident was assessed for the thigh strap because he/she would "scoot" and "slide" down in the Broda chair. The thigh strap was added to prevent the resident from injury or falling. She stated the thigh strap was not considered a restraint as the resident did not ambulate; however, she verified the thigh strap restricted the resident's movement when up in the Broda chair.</p> <p>An interview with the Director of Nursing (DON), on 03/14/13 at 4:55 PM, revealed she expected the staff to assess devices that restrict a resident's movement as a restraint, per the policy. The assessment should include risks and benefits of using the restraint.</p> <p>2. A record review revealed Resident #8 was admitted to the facility on 04/13/11 with diagnoses to include Huntington's Chorea and history of falls. A review of the quarterly MDS assessment, dated 02/12/13, revealed the facility assessed Resident #8 as severely cognitively impaired.</p> <p>A review of a physician order, dated 05/08/12, revealed the resident should have thigh straps when up in Broda chair for good alignment and</p>	F 221		
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F 221	<p>Continued From page 3 safety in seating.</p> <p>A review of the Interdisciplinary Physical Restraint Evaluation, dated 11/26/12, revealed the Broda chair was assessed as a restraint for Resident #8; however, further review revealed there was no assessment conducted related to the thigh straps.</p> <p>Observation on 03/14/13 at 11:48 AM and 3:45 PM revealed Resident #8 was in a Broda chair in the hall with thigh straps attached to the thighs.</p> <p>Interviews with Certified Nursing Aide (CNA) #3 and CNA #6, on 03/14/13 at 3:45 PM revealed Resident #8 always has the thigh straps on every time he is in the Broda chair.</p> <p>Interview with LPN #4, on 03/14/13 at 4:00 PM, revealed Resident #8 started wearing the thigh straps not long after he/she came to the facility. She stated the straps were on the nursing assessment as a positioning device. She revealed the facility does not consider the straps a restraint but if the resident was having jerking movements related to his/her diagnosis, the straps would restrict the resident's movements.</p> <p>Interview with the DON, on 03/14/13 at 5:09 PM, revealed the Interdisciplinary Team completes an evaluation assessment and determines if the device is a restraint. She stated the thigh straps prevent the residents from sliding and keep residents in a better position. She stated she would have expected the thigh straps to be assessed to determine if they were a restraint for the resident and for the benefits and risks in the use of the straps.</p>	F 221			

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F 281 SS=0	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</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 services provided meet professional standards related to failure to follow the Physician's order for a therapeutic diet for one (1) resident (#4), in the selected sample of sixteen (16) residents.</p> <p>Findings Include: A record review revealed Resident #4 was admitted to the facility with diagnoses to include History of Esophageal Dilatation, Muscle Weakness and Depression. Review of a Minimum Data Set (MDS) significant change assessment, dated 01/25/13, revealed the facility had assessed Resident #4 with mild cognitive impairment. Speech Therapy evaluated Resident #4 on 01/21/13 and placed the resident on a fortified regular puree diet. The diet order was changed on 02/08/13 to a full liquid regular diet and smooth pudding and yogurt when the resident and family refused to consider a feeding tube or esophageal dilatation.</p> <p>A review of Physician's orders, dated 03/01/13, revealed Resident #4's prescribed diet order was for FULL LIQUID DIET, regular liquids and may</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F-281 The services provided or arranged by Heritage Manor Health Care Center will meet professional standards of quality.</p> <ol style="list-style-type: none"> 1. Resident #4 is now being served meals as prescribed by the resident's physician. 2. All residents with therapeutic diets will be audited by nurse management to include the DNS, Unit Managers, Staff Development Coordinator, Case Manager and MDS Coordinator to ensure all residents are being served meals as prescribed by their physician. 3. All dietary staff, CNAs and licensed nurses will be in-serviced on or before April 24, 2012 by the Staff Development Coordinator on the importance of serving meals in accordance with physician's prescribed diets. Quality checks will be made on all therapeutic diets both at the serving line and point of service for all meals. Licensed nurses will be instructed to view trays upon delivery to ensure they have been 	4/24/13
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F 281	Continued From page 5 have smooth yogurt and smooth pudding. Observation on 03/13/13 at 12:45 PM revealed staff had served Resident #4 soup with noodles and pieces of meat. Resident #4 did not eat the soup and stated the staff knew he/she could not eat what was served. An interview with the Director of Nursing (DON), on 03/13/13 at 1:30 PM, revealed Resident #4 was not to have anything but full liquid with pudding and yogurt as prescribed by the resident's physician. An interview with the Registered Dietician (RD), on 03/13/13 at 2:10 PM, revealed she expected Resident #4 to be served a full liquid diet as the Physician had prescribed.	F 281	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> prepared according to the resident's prescribed diet to ensure this deficiency does not reoccur.. 4. Tray accuracy checks will be performed on ten trays weekly for four weeks and monthly thereafter by the ED, DNS and/or Registered Dietitian with results reported to the performance improvement committee monthly for three months then quarterly thereafter until substantial compliance is achieved with overall monitoring of this process being completed by the Director of Nursing.		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure it was determined the facility failed to ensure their system to ensure residents received food prepared in a form designed to meet the individual needs for one (1) resident (#4), in a selected sample of sixteen (16) residents. An observation on 03/13/13 revealed the resident was served soup with noodles and chunks of meat instead of a full liquid diet with pudding and	F 365			

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F 365	Continued From page 6 yogurt. Findings include: A review of the facility's policy titled, Basic Resident Meal Service, dated 10/31/09, revealed for staff to check tray card with meal being served for appropriate diet, liquids, likes/dislikes and condiments. A record review revealed Resident #4 was admitted to the facility with diagnoses to include History of Esophageal Dilatation and Muscle Weakness. A review of a Minimum Data Set (MDS) significant change assessment, dated 01/25/13, revealed the facility had assessed Resident #4 with mild cognitive impairment. A review of a Dysphagia Evaluation/Swallowing Profile, dated 01/21/13, revealed Resident #4 was placed on a fortified regular pureed diet. A review of a nurse's notes, revealed the diet was changed to a full liquid diet on 01/25/13 and pudding and yogurt were added on on 02/07/13. Further review revealed the resident and family refused to consider a feeding tube or esophageal dilatation. A review of Physician's orders, dated 03/01/13, revealed Resident #4's prescribed diet order was a FULL LIQUID DIET, regular liquids and may have yogurt and smooth pudding. An observation, on 03/13/13 at 12:45 PM, revealed staff had served the resident soup with noodles and pieces of meat. Resident #4 stated he/she could not eat what was served and that the staff knew he/she could not eat it. Resident #4 did not eat the soup.	F 365	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> F-365 Heritage Manor Health Care Center will ensure the facility provides food prepared in a form designed to meet individual needs. 1. Resident #4 is now being served meals as prescribed by the resident's physician. 2. All residents with therapeutic diets will be audited by nurse management to include the DNS, Unit Managers, Staff Development Coordinator, Case Manager and MDS Coordinator to ensure all residents are being served meals as prescribed by their physician. 3. All dietary staff, CNAs and licensed nurses will be in-serviced on or before April 24, 2012 by the Staff Development Coordinator on the importance of serving meals in accordance with physician's prescribed diets. Quality checks will be made on all therapeutic diets both at the serving line and point of service for all meals. Licensed nurses will be instructed to view trays upon delivery to ensure they have been prepared according to the resident's prescribed diet to ensure this	4/24/13	

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F 365	Continued From page 7 An interview with the Director of Nursing (DON), on 03/13/13 at 1:30 PM, revealed Resident #4 was on a full liquid diet and kitchen staff should not have put soup with noodles and meat chunks on the resident's tray and additionally, the staff serving the tray should have looked at the diet card and recognized the resident was not to have anything but full liquid with pudding and yogurt as prescribed by the resident's physician. An interview with the Registered Dietician (RD), on 03/13/13 at 2:10 PM, revealed she expected Resident #4 to receive a full liquid diet as prescribed. The RD stated the potential outcome of consuming food that was not full liquid as prescribed would be choking and aspiration. She stated the kitchen staff should have followed what was on the resident's dietary card when plating the food. She revealed noodles and pieces of meat in the soup were not part of a liquid diet and could be potentially hazardous for the resident due to the risk for choking or aspiration. She stated staff serving the resident trays should have observed the resident diet card and ensured what was being served was appropriate. An interview with the Speech Language Pathologist (ST), on 03/13/13 at 2:25 PM, revealed Resident #4 had been referred to her for evaluation on 01/21/13 because the resident had not been eating and was complaining of food "getting stuck". The ST stated she determined the resident had moderate to severe esophageal stricture as the resident had a suction sound when attempting to swallow as food was not passing correctly. The ST changed the	F 365	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> deficiency does not reoccur. 4. Tray accuracy checks will be performed on ten trays weekly for four weeks and monthly thereafter by the ED and/or DNS and/or Registered Dietitian with results reported to the performance improvement committee monthly for three months then quarterly thereafter until substantial compliance is achieved with overall monitoring of this process being completed by the Director of Nursing.		

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F 365	Continued From page 8 resident's diet order to full liquid for safety and to prevent aspiration. The ST additionally stated Resident #4 should not have been served soup with noodles and meat chunks as solids couldn't pass correctly and the resident could have experienced a sensation of the food being stuck which could have caused vomiting and the risk for aspiration.	F 365			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with (57) smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 03/13/13 and 03/14/13. Heritage Manor Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred (100) beds and the census was seventy-nine (79) on the day of the survey.</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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cathy Sheehan</i>	TITLE Director Quality Service	(X5) DATE 4-15-13
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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 000	Continued From page 1	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 038 SS=E	Deficiencies were cited with the highest deficiency identified at "E" level. NFFPA 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFFPA standards. The deficiency had the potential to affect five (5) of twelve (12) smoke compartments, seventy-six (76) residents, staff and visitors. The facility is certified for one hundred (100) beds and the census was seventy-nine (79) on the day of the survey. The facility failed to ensure all egress doors had the proper signage for delayed egress doors. The findings include: Observation, on 03/14/13 at 9:05 AM with the Maintenance Director, revealed three doors in the facility were equipped with signage for the delayed egress doors with no contrasting background on the signs. Interview, on 03/14/13 at 9:05 AM with the	K 038	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K 038 Heritage Manor Health Care Center will ensure exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. The signage on the exit doors now have a contrasting background so they are readily visible. 2. All exit doors in the facility have been examined for proper signage and corrections made where necessary. 3. Maintenance will include exit doors during weekly facility rounds to ensure appropriate signage remains in place. 4. The Executive Director will monitor preventative maintenance rounds performed by maintenance director weekly for 90 days, then quarterly for continued door signage compliance.	4/24/13

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K 038	Continued From page 2 Maintenance Director, revealed he was unaware the signs must have a contrasting background. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 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	K 038		

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K 038	Continued From page 3 42, provided that the following criteria are met. (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. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (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 having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device,	K 038		

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K 038	Continued From page 4 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	K 038	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 051 SS=D	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	K 051 Heritage Manor Health Care Center will ensure the building fire alarm system is installed as required by NFPA standards. 1. A manual pull station has been installed within 5 feet of the exit door. 2. All exit doors throughout the facility will be examined to ensure a manual pull station is located within 5 feet of the exit doors. 3. Pull stations on exit doors will be a part of the Maintenance Director's weekly rounds to ensure this deficiency does not reoccur. 4. The Executive Director will review daily preventative maintenance rounds for 90 days, then quarterly for continued compliance.	4/24/13

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K 051	<p>Continued From page 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 fire alarm system was installed as required by NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, residents, staff and visitors. The facility is certified for one hundred (100) beds and the census was seventy-nine (79) on the day of the survey. The facility failed to ensure the one (1) exit had a manual fire alarm pull station located within five (5) feet.</p> <p>The findings include:</p> <p>Observation, on 03/14/13 at 10:55 AM with the Maintenance Director, revealed the exit at the back of the facility next to the laundry room, through the break room, did not have a manual pull station located within 5 feet of the exit door.</p> <p>Interview, on 03/14/13 at 10:55 AM with the Maintenance Director, revealed the facility made the exit path through this door since the last survey and was unaware a manual fire alarm pull must be at every exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.4.2* Initiation. Initiation of the required fire alarm systems shall be by manual means in accordance with 9.6.2 and by means of any required sprinkler system waterflow alarms, detection devices, or detection systems.</p> <p>Exception No. 1: Manual fire alarm boxes in patient sleeping areas shall not be required at</p>	K 051		
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K 051	Continued From page 8 exits if located at all nurses' control stations or other continuously attended staff location, provided that such manual fire alarm boxes are visible and continuously accessible and that travel distances required by 9.6.2.4 are not exceeded.	K 051	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, twenty-six (26) residents, staff and visitors. The facility is	K 143	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K 143 Heritage Manor Health Care Center will assure the room being used to transfer liquid oxygen is rated per NFPA requirements. 1. A new door frame will be installed for the oxygen room which has a label proving it is in compliance with NFPA requirements. 2. All Oxygen room doors throughout the building will be examined to ensure they are in compliance with state and federal regulations and NFPA requirements. 3. Oxygen room doors will be a part of the Maintenance Director's weekly rounds to ensure compliance is maintained. 4. The Executive Director will review preventative maintenance rounds for oxygen supply room compliance for 90 days and quarterly for continued compliance..	4/24/13

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K 143	<p>Continued From page 7</p> <p>certified for one hundred (100) beds and the census was seventy-nine (79) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire rated door frame that had a 1 hour fire resistive rating.</p> <p>The findings include:</p> <p>Observation, on 03/14/13 at 10:10 AM with the Maintenance Director, revealed the oxygen trans-filling room did not have a fire rated door frame installed. The door frame is steel but there have been modifications made since the frame was installed new.</p> <p>Interview, on 03/14/13 at 10:10 AM with the Maintenance Director, revealed he was under the impression if the door had the rating tag the frame would be rated the same.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <ul style="list-style-type: none"> a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. <p>Transferring shall be accomplished utilizing</p>	K 143		

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K 143	Continued From page 8 equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		