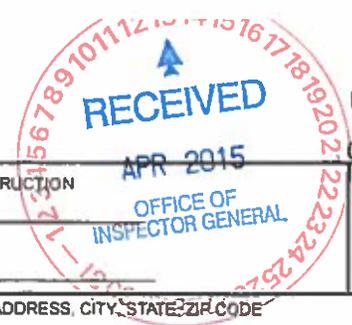


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/03/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/20/2015
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NAME OF PROVIDER OR SUPPLIER  CALVERT CITY CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029
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F 000	INITIAL COMMENTS  A Recertification Survey was conducted on 03/17/15 through 03/20/15 to determine the facility's compliance with Federal Requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "E".	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention, a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2), or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update	F 157	1. Resident #1's physician was notified regarding failure to follow orders for treatment to the right lateral ankle and new orders were received to change the treatment to leave open to air on 3/19/2015. Nurses involved in the failure to notify the physician were verbally in-serviced by the Director of Nursing (DON) and Registered Nurse (RN) Unit Manager during the annual survey on proper physician notification related to current treatment orders that are ineffective.  Resident #7's physician was notified regarding weight loss greater than 5% in 30 days. New orders were received to change diet to mechanical soft and to increase Megace dosage. Weekly weights are being obtained and monitored and the resident is included in a weight loss performance improvement plan (PIP) through Quality Assurance And Performance Improvement (QAPI). The RN Unit Manager was verbally educated by the DON that she must notify the physician if a resident has greater than a 5 percent weight loss in one month and/or any noted dietary recommendations.  2. All residents have the potential to be affected by the deficient practice.	

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

TITLE

ADMINISTRATOR

(X6) DATE

4/10/15

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 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to notify the physician of the need to alter treatment for two (2) residents in the selected sample of 19. Resident #1 in regard to wound care and Resident #7 with a 7.13% weight loss in thirty (30) days. The findings include:</p> <p>1. Review of the facility's Notification of Physician policy, not dated, revealed it is the facility's policy to notify the attending physician or an alternate of any changes in the resident's condition, signs and symptoms of any illness, or accidents, with or without injury.</p> <p>Review of Resident #1's clinical record revealed the facility's licensed staff initialed "open to air" (OTA) for seven (7) consecutive days on Resident #1's March 2015 Treatment Administration Record (TAR), when the physician ordered a medical treatment for the wound to the resident's lateral right ankle that required cleansing, medication application, and covering and securing the wound with a dressing and tape.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 03/19/15 at 9:00 AM, revealed she failed to complete wound care treatments on Resident #1's right lateral ankle wound as ordered. LPN #5 stated she left the wound open to air because it was healing well, and the treatment did not seem appropriate anymore. She further stated the</p>	F 157	<p>3. An in-service is scheduled on 4/15/2015 for all licensed nurses. Nurses will be educated by the Director of Nursing (DON) regarding physician notification. Education to include the importance of contacting the physician every time there is a need for change in a treatment. The physician must be notified if the current ordered treatments aren't healing properly. Prior treatment orders should be discontinued and the new physician's order written on both the physician's order sheet and on the Treatment Administration Record (TAR). All residents TAR's will be reviewed by licensed nurses to ensure current treatments are being completed as ordered and will be revised and updated, if indicated. Education will also include proper physician notification related to weight loss and dietary recommendations. All resident's weight and dietary recommendation records for the last month will be reviewed to ensure the physician has been notified of any noted dietary recommendations or weight loss greater than 5 percent in one month if indicated.</p> <p>4. Bi-weekly audits of TARS, physician orders, and notification related to treatments will be completed by the DON for two months followed by monthly QAPI audits to monitor performance and maintain sustained compliance. The Dietician will monitor weight reports monthly for weight loss greater than 5 percent in one month and report results to the DON or Designee. All dietary recommendations will also be reported to the DON to perform audits to ensure the physician has been notified and any orders have been implemented to maintain compliance. Any employees found to be in non-compliance will be re-educated or disciplined per the personnel policy handbook guidelines if indicated by the DON or Designee.</p>	4/20/2015
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F 157	<p>Continued From page 2</p> <p>expectations were to notify the physician with a change in status or a need for more appropriate treatment due to a change in his/her wound condition; however, she failed to notify the physician.</p> <p>Interview with Registered Nurse (RN) #1 (Unit Manager of East Wing), on 03/19/15 at 9:10 AM, revealed she expected the licensed staff to notify the physician if he or she felt the wound care order for Resident #1 was no longer appropriate.</p> <p>Interview with the Director of Nursing (DON), on 03/19/15 at 9:15 AM, revealed she was unaware that licensed staff did not complete ordered wound care treatments on Resident #1. She stated she expected her licensed staff to communicate with the physician if he or she felt that a current wound care treatment was no longer appropriate.</p> <p>2. Review of the facility's Nutrition at Risk (NAR) policy and procedure, dated 02/27/12, revealed it is the facility's policy to ensure residents receives adequate nutrition. Further review revealed residents with a weight change of 5% in one (1) month will be weighed weekly and significant weight losses/gains will be reported to the Physician and responsible party.</p> <p>Record review revealed the facility admitted Resident #7 on 01/27/15 with diagnoses which included Anemia, Atrial Fibrillation, Dysphagia, Heart Failure, Osteoporosis, Adult Failure to Thrive, and Hypertension.</p> <p>Review of Resident #7's care plan, dated 02/12/15, revealed to monitor his/her weight weekly, and notify the physician of weight loss as</p>	F 157			

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F 157	<p>Continued From page 3</p> <p>indicated. Further review of the monthly vital signs and weights record revealed the resident weighed 88.3 pounds (lbs) upon admission on January 27, 2015. In February 2015 (no specific date), his/her weight was recorded at 88 lbs, and on March 18, 2015, his/her weight was recorded at 82 lbs., with a 6.3 lb weight loss in thirty (30) days.</p> <p>Interview with the Registered Dietician, on 03/19/15 at 10:15 AM, revealed an Nutrition at Risk (NAR) was implemented on 02/24/15 for Resident #7. Further interview revealed the nursing staff should notify the physician to obtain an order for increased calorie supplements per dietary recommendations.</p> <p>Interview with the Dietary Manager, on 03/19/15 at 1:10 PM, revealed the facility's policy/procedure for residents assessed nutritionally at risk was to increase calorie supplements. Further interview revealed the Unit Managers attend the NAR meeting, and contact the resident's physician to obtain an order for increased calorie supplements.</p> <p>Interview with RN #1 and LPN #5, on 03/20/15 at 11:20 AM and 2:25 PM, respectively, each revealed he or she should have notified the physician about Resident #7's weight loss or dietary recommendations; however, neither staff member was able to provide an explanation as to why this was not completed.</p> <p>Interview with the resident's Primary Physician, on 03/20/15 at 3:05 PM, revealed he was not notified about Resident #7's significant weight loss and would have ordered increased calorie supplements per dietary recommendations.</p>	F 157		
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F 157	Continued From page 4	F 157		
F 253 SS=E	<p>Interview with the DON, on 03/20/15 at 5:00 PM, revealed she expected the physician to be notified of any changes in a resident's condition. Further interview revealed she also expected the nursing staff to notify the physician regarding dietary recommendations.</p> <p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to provide the housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>The findings include:</p> <p>Review of the facility's policy for "Environmental Rounds," undated, revealed the staff were to observe for improperly stored resident personal items and put away and store all chemicals in a secure area, as chemicals were not to be left unattended in open areas in housekeeping carts, medication carts, treatment carts or utility rooms.</p> <p>Observation, during a tour of the facility with the Maintenance Supervisor and the Housekeeping Supervisor, on 03/18/15 at 3:30 PM, revealed unlocked, rolling, metal, shopping cart-like containers in both shower rooms on the East</p>	F 253	<ol style="list-style-type: none"> <li>The metal carts and supplies were removed from both East Wing and West Wing shower rooms. Locking cabinets were placed in both shower rooms. Staff on duty at the time were verbally in-serviced to never leave any supplies out of the unlocked cabinet when not in use and the supply cabinet must be locked at all times when not in use. Education also included: Never share residents personal items such as make up or brushes; No aerosol items are to be utilized; Sharps containers must be closed and discarded when ¾ full, replaced, and always stored in the locked cabinet. The DON verbally instructed the supply manager to order mouthwash, anti-perspirant, and hand sanitizer that's alcohol free to replace all alcohol based products.</li> <li>All residents have the potential to be affected by the deficient practice.</li> <li>The metal carts were replaced with locking cabinets in both shower rooms. A mandatory in-service to be conducted by the DON is scheduled for 4-15-2015 for all nursing, housekeeping, maintenance, and supply management staff. Education to include: All products with labels that state "Keep out of the reach of</li> </ol>	

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F 253	Continued From page 5 Wing and West Wing. Contents of the carts included gallon sized containers of shampoo, cream rinse and body wash. In addition, there was a large can of aerosol hair spray, a sharps container full of used razors, open make-up containers of blush, and a worn and discolored make-up brush. Products with labels that stated "Keep out of the reach of children. If ingested, call the Poison Control Center," included medicated shampoos, antiperspirants, mouthwashes, and a spray bottle of Lysol. Interview with the Maintenance Director revealed there were no showers in progress on either wing.  Interview with State Registered Nurse Aide (SRNA) #9, on 03/18/15 at 4:05 PM, revealed the carts were left in the shower rooms for as long as she has been at the facility, which was approximately ten (10) months. She stated this could be a problem for confused residents.  Interview with the Maintenance Director, on 03/18/15 at 4:00 PM, revealed he had spoken with the staff about the issue and the carts were to be taken to the near-by, locked storage room, in between showers, and were not ever intended to stay in the shower rooms.  Interview with the Administrator, on 03/18/15 at 4:05 PM, revealed he was unaware the carts remained in the shower room and stated the carts were not to be in the shower area after the resident's shower. He stated the staff were made aware of this concern, and these expectations were to be followed. In addition, rounds were made to assess for these things and he expected this concern to be addressed.	F 253	children. If ingested call the Poison Control Center should never be left in an unlocked area: No aerosol items are to be utilized; All products must be kept in the locked cabinets in the shower rooms when not in use; Keep supplies you are using during showers in your vision the entire utilization time; Never share residents personal items such as make up or brushes; No aerosol items are to be utilized; Sharps containers must be closed and discarded in the appropriate biohazard box when ¾ full; Sharp containers must be stored in the locked cabinets at all times; No products should be left out of the locked cabinet in the shower room when not in use.  4. Maintenance and Housekeeping Staff will visually check the shower rooms daily to ensure compliance is maintained. Any non-compliance will be reported to the DON or Designee. Any noted non-compliant employees will be re-educated or disciplined, if indicated, by the DON or Designee per the Personnel Policy Handbook.	
F 272	483 20(b)(1) COMPREHENSIVE	F 272		4-20-2015

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F 272 SS=D	Continued From page 6 <b>ASSESSMENTS</b>  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	<ol style="list-style-type: none"> <li>Resident #1's Posey Roll Guards were discontinued on 3/17/2015.</li> <li>All current physician orders have been reviewed to identify all residents with Posey Roll Guards ordered as part of their plan of care.</li> <li>A Pre-Restraint assessment is being completed on all residents with current orders for Posey Roll Guards. The Hand Assist Device Assessment form was revised on 4/9/2015 to include Posey Roll Guards to ensure assessment is completed to determine if the benefit of use out weighs the risk. The assessment form is now titled Hand Assist/Posey Roll Guard Assessment. The new protocol for Posey Roll Guard placement will require the nurse to perform a Pre-Restraint assessment and Hand Assist/Posey Roll Guard Assessment prior to implementation of a Posey Roll Guard. The assessment findings must indicate the benefits of use out weigh the risk. The assessments will be reviewed and updated by the RN Unit Manager with quarterly and annual MDS assessments to ensure the use is still indicated and beneficial to the resident. All licensed nurses will be in-serviced on 4/15/2015 by the DON on the proper protocol for assessment and use of Pose Roll Guards.</li> <li>The RN Unit Managers will forward all new physicians orders for Posey Roll Guards to the DON or Designee for review to ensure all assessments have been completed to maintain</li> </ol>	

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F 272	<p>Continued From page 7</p> <p>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 provide an initial assessment for the use of Posey Roll Guards, and to ensure ongoing assessments were completed for the use of Posey Roll Guards for one (1) resident, in the selected sample of nineteen (19) residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the facility's "Posey Roll Guards" policy/procedure, not dated, revealed Posey Roll Guards are used to help residents define the perimeter of the bed. Further review of the policy/procedure revealed each resident is to be assessed for the use of the Posey Roll Guards.</p> <p>Observation of Resident #1 during general tour, on 03/17/15 at 4:00 PM, revealed the resident was laying in bed on his/her back with a Posey Roll Guard in place to each side of the bed.</p> <p>Review of a facility falls summary for Resident #1 revealed he/she rolled out of the bed on 12/24/14, and Posey Roll Guards were added as an intervention at that time.</p> <p>Review of Resident #1's physician's orders, dated March 2015, revealed an order for the bilateral Posey Roll Guards on the bed to help define the perimeter of the bed; however, record review revealed no evidence of an assessment for the Posey Roll Guards.</p>	F 272	<p>compliance. The MDS Nurses will review the quarterly and annual assessments to ensure the RN Unit Manager has updated the assessment. Any non-compliance is to be reported to the DON or Designee for re-education or discipline, if indicated, per the Personnel Policy Handbook guidelines.</p>	4/20/2015
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F 272	Continued From page 8 Further review of the falls summary revealed two (2) additional falls, one (1) on 03/03/15 and one (1) on 03/17/15, since the implementation of the Posey Roll Guards. Record review revealed the Posey Roll Guards were discontinued after his/her fall on 03/17/15. Further review revealed there was no evidence of an investigation to determine if the Posey Roll Guards were related to the fall or were a contributing factor.  Interview with Registered Nurse (RN) #1 (Unit Manager of East Wing), on 03/18/15 at 11:07 AM, revealed the facility did not do an initial assessment or an ongoing assessment for the use of the Posey Roll Guards. RN #1 further stated there was no specific assessment for the Posey Roll Guards, and that they were normally added to the Side Rail Assessment. She stated her expectations were for assessments to be done on the use of the Posey Roll Guards, and further stated she did not think the Posey Roll Guards were a restraint. She stated she was unsure as to why the Posey Roll Guards were discontinued after the 03/17/15 fall, unless it was determined the Posey Roll Guards were not effective to prevent falls. She expected the falls investigation to be thorough and descriptive in regard to all falls.	F 272		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 281	1. Resident #1's physician was notified and orders received to change treatment to open to air on 3/19/2015. Nurses involved in failure to follow proper wound care were given verbal and written education regarding the fact that physician orders must be followed and orders can't be changed for treatments unless the physician is notified and orders received to do so.	

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F 281	<p>Continued From page 9</p> <p>and review of the facility's standards of practice, "Potter and Perry Manual of Basic Nursing Theory and Practice, Second Edition", it was determined the facility failed to follow the physician's orders for one (1) resident, in the selected sample of nineteen (19) residents (Resident #1). The staff failed to follow proper wound care orders for Resident #1.</p> <p>The findings include:</p> <p>Review of the facility's standards of practice, "Potter and Perry Manual of Basic Nursing Theory and Practice, Second Edition", revealed the nurse is obligated to follow the physician's orders unless he/she believes it is an error or would be detrimental to the client.</p> <p>Observation of Resident #1 during a skin assessment, on 03/18/15 at 2:25 PM, completed by Licensed Practical Nurse (LPN) #5 with assistance from State Registered Nurse Aide (SRNA) #10, revealed he/she had a scabbed area to the right outer ankle that did not have a dressing in place, and was left open to air. Review of Resident #1's record revealed the licensed staff failed to complete wound care treatments as ordered by the physician. The treatment listed for Resident #1, dated March 2015, revealed that eight (8) out of the last ten (10) days (03/08/15 - 03/17/15), the licensed staff initialed and signed the treatment sheets as left open to air (OTA); however, there was a physician's order for a treatment which had not been followed.</p> <p>Interview with LPN #5, on 03/19/15 at 9:00 AM, revealed she felt leaving the wound open to air was more appropriate, at that point, because the</p>	F 281	<ol style="list-style-type: none"> <li>2. Current physician orders are being reviewed to identify all residents who are currently receiving wound care that may be affected by the deficient practice.</li> <li>3. All TAR's and wound care orders are being reviewed and updated, if indicated, to ensure current physician orders are being followed. An in-service is scheduled on 4/15/2015 for all licensed nurses. Nurses will be educated by the Director of Nursing (DON) regarding providing proper wound care in accordance with physician orders. Education to include the importance of performing proper wound care per the physicians specified orders, contacting the physician every time there is a need for change in a treatment, the physician must be notified if the current ordered treatments aren't healing properly, prior treatment orders should be discontinued and the new physician's order written on both the physician's order sheet and on the Treatment Administration Record. Under no circumstance should a treatment be changed without orders from the physician. The RN Unit manager will forward a copy of all new treatment orders to the Wound Nurse for review.</li> <li>4. All new treatment orders will be reviewed by the RN Unit Manager to ensure the orders are in place on the TAR. The orders will be forwarded to the LPN Wound Nurse to be assessed weekly to ensure proper wound care is being provided as ordered by the physician and the physician is notified for further orders if the wound isn't healing</li> </ol>	

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F 281	Continued From page 10 wound was healing. She further stated she expected herself and others to follow the physician's orders.  Interview with Registered Nurse (RN) #1 (Unit Manager of East Wing), on 03/19/15 at 9:10 AM, revealed she expected the licensed staff to follow physician's orders and complete the treatments as ordered.  Interview with the Director of Nursing (DON), on 03/19/15 at 9:15 AM, revealed her expectations were for licensed staff to follow physician's orders and to complete their duties.	F 281	appropriately. Any non-compliance will be reported to the DON or Designee for re-education or discipline, if indicated, per the Personnel Policy Handbook.	4/20/2015
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy/procedure, it was determined the facility failed to ensure services provided by the facility were in accordance with the written plan of care for one (1) resident, in the selected sample of nineteen (19) residents (Resident #6). Resident #6 was care planned for non-skid socks or shoes; however, observation on 03/18/15 revealed the resident was in the floor without non-skid socks or shoes. In addition, Resident #6 was care planned for skin protectant/barrier cream post incontinency; however, observations on 03/18/15 and 03/19/15	F 282	<ol style="list-style-type: none"> <li>Care plan was updated on Resident #6 to specify non-skid socks or shoes at all times. Staff involved with the deficient practice was verbally in-serviced to follow the resident's plan of care and be sure and implement all interventions as stated on Nurse Aide Assignment Sheet per the Care Plan regarding application of non-skid socks and providing proper perineal care and application of barrier cream post each incontinent episode as care planned.</li> <li>All residents have the potential to be affected by the deficient practice.</li> <li>Licensed Nurses are reviewing all fall interventions and perineal care interventions on all residents care plans and nurse aide assignment sheets. Interventions will be reviewed, revised, and updated, if indicated, to reflect the current care needs of the resident. An in-service to be conducted by the DON is scheduled for 4/15/2015 for all</li> </ol>	

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F 282	<p>Continued From page 11 revealed barrier cream was not applied.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy/procedure, "Care Plans", undated, revealed all disciplines coordinate the care of each resident to maximize, maintain, or achieve the highest practicable level of well-being.</li> </ol> <p>Record review revealed the facility admitted Resident #6 on 06/26/14 with diagnoses which included Muscle Weakness, Diabetes Mellitus Type II, Dehydration, Anemia, Alzheimer's Disease, Dementia with Lewy body's, and a History of Falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/09/15, revealed the facility assessed Resident #6's cognition as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated the resident was not interviewable. In addition, the resident required extensive assistance with all activities of daily living.</p> <p>Record review revealed Resident #6 fell on 03/10/15 while attempting to toilet himself.</p> <p>Review of Resident #6's Comprehensive Care Plan for "Potential for injury from falls related to poor balance, unsteady gait and history of falls", last updated 03/11/15, revealed an intervention to include "non- skid socks or shoes".</p> <p>Review of Resident #6's Nurse's Assistant Assignments, dated 03/01/15, revealed assignments to include "non-skid socks or shoes".</p>	F 282	<p>nursing staff regarding the importance of implementing and performing the care planned fall interventions on each resident. On 4/15/2015 The LPN Staff Development Coordinator (SDC) will educate all SRNA's on providing proper perineal care and always implementing the care planned Nurse Aide Assignment interventions such as application of barrier cream post each incontinent episode.</p> <ol style="list-style-type: none"> <li>4. Random weekly visual checks will be conducted by the LPN SDC on ten residents for two months to ensure care planned interventions related to proper perineal care and fall interventions are being properly implemented and followed. The QAPI committee will perform ten random monthly audits thereafter to monitor for sustained compliance. Any non-compliance is to be reported to the DON or Designee for re-education and/or discipline, if indicated, per the Personnel Policy Handbook guidelines.</li> </ol>	4/20/2015	

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F 282	<p>Continued From page 12</p> <p>Observation, on 03/18/15 at 4:00 PM, revealed Resident #6's bed pad alarm was sounding and the resident was on the floor with two (2) staff members in the room. Further observation revealed the resident had one (1) bare foot and a regular sock on the other foot. In addition, Licensed Practical Nurse (LPN) #2 removed the regular sock and placed the non-skid socks on both feet.</p> <p>Interview, on 03/19/15 at 9:15 AM, with LPN #1, revealed she expected the staff to put non-skid socks on the resident whenever he was assisted to bed.</p> <p>Observation, on 03/19/15 at 2:30 PM, and on 03/19/15 at 3:05 PM, revealed Resident #6 was in bed with regular socks in place.</p> <p>Further observation revealed LPN #2 removed and replaced socks during the skin assessment. Interview, on 03/19/15 at 3:35 PM with LPN #2, revealed she believed non-skid socks or shoes were to be in place whenever Resident #6 was out of bed.</p> <p>Observation, on 03/20/15 at 9:40 AM revealed Resident #6 was in bed with non-skid socks in place.</p> <p>Interview, on 03/20/15 at 9:45 AM, with State Registered Nurse Aide (SRNA) #3, revealed Resident #6 should have non-skid socks on when in the bed. She stated she forgot to put his non-skid socks on when she put him to bed yesterday.</p> <p>Interview, on 03/20/15 at 10:30 AM with the Unit Manager (UM) of the West Wing, revealed she</p>	F 282		

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F 282	<p>Continued From page 13</p> <p>expected staff to carry out interventions on the care plans and if an intervention was not working, the staff were to let her know and it would be discussed during morning meetings. Further review revealed she believed an intervention for "non-skid socks or shoes" meant the resident should have non-skid socks or shoes when out of bed. The UM stated the care plan should specify when a resident should have non-skid socks while in bed.</p> <p>Interview, on 03/20/15 at 11:20 AM, with the Director of Nursing (DON), revealed she expected an intervention for non-skid socks or shoes to be in place for fall prevention, especially during transfers. Further review revealed she expected the resident to wear his/her shoes when out of the bed and non-skid socks when in the bed. She stated the interventions should be more specific.</p> <p>2. Review of the facility's policy/procedure, "Perineal Care", undated, revealed documentation to include gently wash, rinse, and dry the perineal area, wiping from the clean urethral area toward the dirty rectal area to avoid contaminating the urethral area with the germs from the rectal area.</p> <p>Review of the facility's standards of practice, "Basic Nursing Theory and Practice" Second Edition, revealed documentation to include cleansing of male genital area prior to wiping the anal area to prevent contamination of fecal material that can cause urinary tract infections.</p> <p>Review of Resident #6's urinalysis report, dated 03/15/15, revealed yellow, turbid with a small amount of blood and large amount of leukocyte</p>	F 282			

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F 282	<p>Continued From page 14</p> <p>esterase, indicating the resident had a urinary tract infection (UTI). He was prescribed an antibiotic, Cephalexin 500 milligrams (mg) by mouth (po) every eight (8) hours for ten (10) days for a UTI.</p> <p>Review of Resident #6's Comprehensive Care Plan for "Potential for alteration in skin integrity r/t incontinence/impaired mobility/dementia-skin desensitized to pain and pressure", updated 02/19/15, revealed an intervention to include "special skin care-skin protectant/barrier cream to peri and groin areas post incontinency".</p> <p>Review of Resident #6's Nurse's Assistant Assignments, dated 03/01/15, revealed assignments to include "special skin care-skin protectant/barrier cream to peri and groin areas post incontinency".</p> <p>Review of Resident #6's Nursing Skin Assessment, dated 03/19/15, revealed blanchable redness in the right buttock fold that was not present on the prior assessment, dated 03/15/15.</p> <p>Observation of incontinent care, on 03/18/15 at 1:30 PM, by SRNA #2 and SRNA #3, revealed SRNA #2 placed peri-wash onto a disposable Chux and wiped Resident #6's buttocks, then washed the resident's penile and scrotal area. No protectant/barrier cream was applied.</p> <p>Interview, on 03/20/15 at 2:00 PM, with SRNA #3, revealed, during perineal care on 03/18/15 at 1:30 PM, she observed SRNA #2 washed Resident #6's buttocks prior to washing his penile and scrotal area. She stated SRNA #2 did not retract the foreskin and left the soapy peri-wash solution</p>	F 282		

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F 282	Continued From page 15 on Resident #6's skin.  Observation of incontinent care, on 03/19/15 at 3:05 PM, revealed SRNA #4 placed peri-wash onto a disposable Chux and wiped Resident #6's perineal and scrotal area, dried the area, then rolled the resident to his right side and washed and dried his buttocks. No protectant/barrier cream applied.  Interview, on 03/20/15 at 2:30 PM, with SRNA #4 revealed the resident was care planned to have barrier cream applied with each episode of perineal care. SRNA #4 stated she was nervous and did not apply the cream.  Interview, on 03/20/15 at 10:30 AM with the UM of the West Wing, revealed the staff should apply cream to Resident #6 with each incontinent episode, and that the facility kept small packets of barrier cream for staff to use after each episode. Interview, on 03/20/15 at 11:20 AM, with the DON, revealed care plans should reflect residents' needs and she expected the staff to follow the interventions.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	1. The nurses involved with Resident #9's return admission were in-serviced regarding the proper protocol related to skin assessment upon admission or re-admission into the facility. Skin assessments should be completed within an hour of admission. 2. All new or re-admissions have the potential to be affected by the deficient practice.	

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F 309	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide services that maintain the highest practicable physical, mental, and psychosocial well being for one (1) resident, in the selected sample of nineteen (19) residents (Resident #9), related to bruising upon readmission to the facility.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure, "Nursing Procedure Admission Licensed Nurse", (no date), revealed the purpose is to begin assessment for formulation of the plan of care. Further review revealed to screen the resident and perform a thorough total body check, complete the admission assessment form, and check the resident prior to leaving duty.</p> <p>Record review revealed the facility readmitted Resident #9 from the local hospital, on 12/14/14 at 1:40 PM, with diagnosis to include Pneumonia, Senile Dementia, Depressive Disorder, Acquired Hypothyroidism, Congestive Heart Failure, and Esophagitis. Review of the quarterly Minimum Data Set (MDS), dated 02/09/15, revealed the facility assessed the resident as severely cognitively impaired.</p> <p>Review of Resident #9's Nursing Admission History Assessment Form, dated 12/10/14 (no time of assessment), revealed a skin review of systems identified the right and left arm with bruising, right arm and thumb were green in color, purple bruising on upper arms, the left arm and top of hand with greenish/purple bruising, the left</p>	F 309	<p>3. All new or re-admissions into the facility will have a full head to toe skin assessment completed by a licensed nurse within an hour of entering the facility. Assessment will be timed and be documented. Any noted bruising or abnormalities should be reported to the resident's physician and responsible party. The admitting nurse will also report abnormalities to the RN Unit Manager. The RN Unit Manager will report the abnormality to the Administrator or DON if indicated for further investigation. An in-service to be conducted by the Don is scheduled for 4/15/2015 for all licensed nurses regarding proper protocol for performing, documenting, and reporting abnormal findings from the completed skin assessments, as well as the need for them to be completed within an hour of admission or re-admission into the facility. Education will also include instruction to always perform a head to toe assessment on a resident prior to being discharged or sent out for treatment and to document the results.</p> <p>4. The DON or Designee will review all new admissions skin assessments to ensure the assessment is completed in a timely manner and all parties have been notified, if indicated. Any employee found in non-compliance will be re-educated and/or disciplined per guidelines of the Personnel Policy Handbook.</p>	4/20/2015

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F 309	<p>Continued From page 17</p> <p>upper arm with purple bruising, the left hip edematous with bruising, groin area bruise, labia swollen discoloration noted documented by Licensed Practical Nurse (LPN) #4.</p> <p>Interview with Registered Nurse (RN) #1, on 03/20/15 at 11:25 AM, revealed her expectation is to be notified of any resident injury, bruising, or unusual occurrence immediately. Further interview revealed expectation of the admitting nurse to call her immediately regarding bruising and the nature. She stated, "I should have notified the Administrator, who does all investigations that may indicate abuse".</p> <p>Interview with LPN #5, on 03/20/15 at 2:40 PM, revealed she received Resident # 9 back in the facility, at 1:40 PM on 12/10/14. Further interview revealed she did not perform or document a skin assessment upon the resident's return to the facility.</p> <p>Interview with LPN #4, on 03/20/15 at 3:25 PM, revealed, on 12/10/14 at approximately 2:00 PM, she was informed of Resident #9's return to the facility and the need for a skin assessment. Further interview revealed, on 12/10/14 at 9:00 PM, she performed a skin assessment on Resident #9 and identified bruising. She stated that State Registered Nurse Aide (SRNA) #10 and #12 informed her of the resident's bruising, on 12/10/14 at approximately 3:00 PM, during the initial shift round.</p> <p>Interview with the Director of Nursing (DON), on 03/20/15 at 5:00 PM, revealed she expected the admitting nurse to perform an assessment on new or returning residents within an hour of entering the facility. Further interview revealed</p>	F 309			

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F 309	Continued From page 18 she expected skin assessments on new or returning residents to be performed earlier than 9:00 PM.  Interview with the Administrator, on 03/20/15 at 3:30 PM, revealed he received a call from LPN #4 on 12/10/14 at 9:31 PM informing him of bruising identified on Resident #9. Further interview revealed the Administrator expected residents to be assessed upon admission and/or return from a hospital stay.	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  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 residents' environment remained free from accident hazards as is possible for two (2) residents, in the selected sample of nineteen (19) residents (Residents #1 and #6). In addition, hazardous chemicals and items were stored in the shower room.  The findings include:  1. Review of the facility's policy/procedure,	F 323	1. Resident #1's Posey Roll Guards were discontinued on 3/17/2015. Fall interventions of a low bed, fall mat next to bed, place left side of bed against the wall, and monitor blood pressure every shift for seven days were also added to plan of care.  Care plan was reviewed and updated on Resident #6 to specify non-skid socks or shoes at all times. Staff involved with the deficient practice was verbally in-serviced to follow the resident's plan of care and be sure and implement all interventions as stated on Nurse Aide Assignment Sheet per the Care Plan regarding application of non-skid socks.  The metal carts and supplies were removed from both East Wing and West Wing shower rooms. Locking cabinets were placed in both shower rooms. Staff on duty at the time were verbally in-serviced to never leave any supplies out of the unlocked cabinet when not in use and the supply cabinet must be locked at all times when not in use. Education also included: Never share residents personal items such as make up or brushes; No aerosol items are to be utilized; Sharps containers must be	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/20/2015
NAME OF PROVIDER OR SUPPLIER  CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029	
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F 323	<p>Continued From page 19</p> <p>"Resident Falls Policy and Procedure", not dated, it was the policy of this facility that when a resident is found on the floor, the facility is obligated to investigate and try to determine how he or she got there, and to put into place an intervention to prevent this from happening again, unless there is evidence to suggest otherwise. The policy further stated the point of accurately capturing occurrences of falls on the assessment is to identify and communicate resident problems and potential problems, so that staff will consider and implement interventions to prevent falls and injuries from falls.</p> <p>Review of a falls summary, not dated, revealed Resident #1 fell on 12/24/14 at 3:15 AM after being restless and rolling out of bed. The resident was dressed and brought to a common area. A new intervention of adding Posey Roll Guards was added after the fall. Fall number two (2) listed on the falls summary, revealed on 03/03/15 at 4:25 AM, he/she was unaware of personal safety and an intervention of educating staff to get him/her up from the bed if awake on the last bed check. Fall number three (3) listed on the fall summary revealed he/she was restless in the bed before the fall and a new intervention was to put a fall mat next to the bed, discontinue the Posey Roll Guards, change the bed that is lower, along with putting the left side of the bed against the wall, and monitor his/her blood pressure every shift times seven (7) days.</p> <p>Review of the Fall Investigation Form, dated 03/03/15 at 4:25 AM, revealed he/she was found on the floor beside the bed and he/she was unable to state what happened along with being unaware of personal safety awareness. The investigation form further noted that an</p>	F 323	<p>closed and discarded when ¾ full, replaced, and always stored in the locked cabinet. The DON verbally instructed the supply manager to order mouthwash, anti-perspirant, and hand sanitizer that's alcohol free to replace all alcohol based products.</p> <p>2. All residents have the potential to be affected by the deficient practice.</p> <p>3. A Pre-Restraint assessment is being completed on all residents with current orders for Posey Roll Guards. The Hand Assist Device Assessment form was revised on 4/9/2015 to include Posey Roll Guards to ensure assessment is completed to determine if the benefit of use outweighs the risk. The assessment form is now titled Hand Assist/Posey Roll Guard Assessment. The new protocol for Posey Roll Guard placement will require the nurse to perform a Pre-Restraint assessment and Hand Assist/Posey Roll Guard Assessment prior to implementation of a Posey Roll Guard. The assessment findings must indicate the benefit of use outweighs the risk. The assessments will be reviewed and updated by the RN Unit Manager with quarterly and annual Minimum Data Set (MDS) assessments to ensure posey roll guard use is still appropriate. All licensed nurses will be in-serviced on 4/15/2015 by the DON on the proper protocol for assessment and use of Posey Roll Guards.</p>	

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F 323	<p>Continued From page 20</p> <p>intervention had been added to educate the staff to get him/her up if awake on the last bed check.</p> <p>Review of the Fall Investigation Form, dated 03/17/15 at 5:30 PM, revealed he/she was found on the floor and was unable to explain what happened due to being incoherent. The form mentioned that prior to the fall, he/she had been lying in bed before dinner and seemed to be a little agitated, kicking his/her blankets off, moaning. The medication nurse had given him/her some medication, and the Posey Roll was in place along with a call light in place.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, revealed Resident #1 was found on the floor and he/she was unable to explain what happened due to having Dementia and was incoherent. When asked if the Posey Roll Guards were a contributing factor in the fall on 03/17/15, she stated the Posey Roll Guards were discontinued after the fall and new interventions such as a low bed with a mat on the floor beside the bed had been added. She further stated the Posey Roll Guards had not prevented falls so they changed or updated the interventions.</p> <p>2. Review of the facility's policy/procedure, "Resident Falls Policy and Procedure", undated, revealed documentation to include interventions after the resident has been carefully assessed, interventions will be implemented that are individualized according to the resident's needs. Interventions can include adjust environmental risk factors, check the resident's footwear, keep pathways clear of clutter, lock brakes on beds/wheelchairs before transferring a resident and make sure the toilet seat is low/high enough.</p>	F 323	<p>Licensed Nurses are assessing all residents, reviewing, and revising, and updating care plans and nurse aide assignment sheets fall interventions, if indicated, to reflect the current care needs of the resident. An in-service to be conducted by the DON is scheduled for 4/15/2015 for all nursing staff regarding the importance of implementing and performing the care planned fall interventions on each resident. Nurses will be instructed to try and determine the root cause of the fall and place an effective intervention in place immediately.</p> <p>The metal carts were replaced with locking cabinets in both shower rooms. A mandatory in-service to be conducted by the DON is scheduled for 4-15-2015 for all nursing, housekeeping, maintenance, and supply management staff. Education to include: All products with labels that state "Keep out of the reach of children. If ingested call the Poison Control Center should never be left in an unlocked area: No aerosol items are to be utilized; All products must be kept in the locked cabinets in the shower rooms when not in use; Keep supplies you are using during showers in your vision the entire utilization time; Never share residents personal items such as make up or brushes; No aerosol items are to be utilized; Sharps containers must be closed and discarded in the appropriate biohazard box when ¾ full; Sharp containers must be stored in the locked cabinets at all times; No products should be left out of the locked cabinet in the shower room when not in use.</p>	
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F 323	<p>Continued From page 21</p> <p>Record review revealed Resident #6 was admitted to the facility on 06/26/14 with diagnoses which included Muscle Weakness, Diabetes Mellitus Type II, Dehydration, Anemia, Alzheimer's Disease, Dementia with Lewy body's and a History of Falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/09/15, revealed the facility assessed Resident #6's cognition as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated the resident was not interviewable. In addition, the resident required extensive assistance with all activities of daily living.</p> <p>Record review revealed Resident #6 fell on 03/10/15 while attempting to toilet himself.</p> <p>Review of Resident #6's Comprehensive Care Plan for "Potential for injury from falls related to poor balance, unsteady gait and history of falls", last updated 03/11/15, revealed an intervention to include "non-skid socks or shoes".</p> <p>Review of Resident #6's Nurse's Assistant Assignments, dated 03/01/15, revealed assignments to include "non-skid socks or shoes".</p> <p>Observation, on 03/18/15 at 4:00 PM, revealed Resident #6's bed pad alarm was sounding and the resident was on the floor with two (2) staff members in the room. Further observation revealed the resident had one (1) bare foot and a regular sock on the other foot. In addition, LPN #2 removed the regular sock and placed non-skid socks on both feet.</p> <p>Interview, on 03/19/15 at 9:15 AM with LPN #1,</p>	F 323	<p>4. The RN Unit Managers will forward all new physicians orders for Posey Roll Guards to the DON or Designee for review to ensure all assessments have been completed to maintain compliance. The MDS Nurses will review the quarterly and annual assessments to ensure the RN Unit Manager has updated the assessment.</p> <p>Random weekly visual checks will be conducted by the LPN SDC on 10 residents for 2 months to ensure care planned interventions related to proper fall interventions are being properly implemented and followed. The QAPI committee will perform 10 random monthly audits thereafter to monitor for sustained compliance.</p> <p>Maintenance and Housekeeping Staff will visually check the shower rooms daily to ensure compliance is maintained.</p> <p>Any noted non-compliance is to be reported to the DON or Designee for re-education and/or discipline, if indicated, per the Personnel Policy Handbook guidelines.</p>	4/20/2015	

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F 323	<p>Continued From page 22</p> <p>revealed she expected the staff to put non-skid socks on whenever Resident #6 was assisted to bed.</p> <p>Observation, on 03/19/15 at 2:30 PM, and at 3:05 PM, revealed Resident #6 was in bed with regular socks in place.</p> <p>Further observation revealed LPN #2 removed and replaced socks during the skin assessment. Interview, on 03/19/15 at 3:35 PM with LPN #2, revealed she believed non-skid socks or shoes were to be in place whenever Resident #6 was out of bed.</p> <p>Observation, on 03/20/15 at 9:40 AM revealed Resident #6 was in bed with non-skid socks in place.</p> <p>Interview, on 03/20/15 at 9:45 AM, with State Registered Nurse Aide (SRNA) #3, revealed Resident #6 should have non-skid socks on when in the bed. She stated she forgot to put Resident #6's non-skid socks on when she put him to bed yesterday.</p> <p>Interview, on 03/20/15 at 10:30 AM with the Unit Manager (UM) of the West Wing, revealed she expected the staff to carry out interventions on the care plans and if an intervention was not working, the staff were to let her know and it would be discussed during morning meetings. Further interview revealed she believed an intervention for "non-skid socks or shoes" meant the resident should have non-skid socks or shoes when out of the bed. The UM stated the care plan should specify when a resident should have non-skid socks on while in the bed.</p>	F 323		
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F 323	<p>Continued From page 23</p> <p>Interview, on 03/20/15 at 11:20 AM with the Director of Nursing (DON), revealed care plans should reflect the residents' needs and she expected the staff to follow the interventions. She expected an intervention for non-skid socks or shoes to be in place for fall prevention, especially during transfers. Further review revealed she expected the resident to wear his/her shoes when out of bed and non-skid socks when in the bed. She stated interventions should be specific.</p> <p>3. Observation, with the Maintenance Supervisor and the Housekeeping Supervisor, on 03/18/15 at 3:30 PM, revealed shopping cart-like containers in both shower rooms on the East and West Wings. Included in the contents of the carts were products with labels that stated "Keep out of the reach of children, and if ingested, call the Poison Control Center." Items included in the carts were medicated shampoos, antiperspirants, mouthwashes, a spray bottle of Lysol, a large can of aerosol hair spray and a sharps container full of used razors. Interview with the Maintenance Director revealed there were no showers in progress on either wing.</p> <p>Interview with SRNA #9, on 03/18/15 at 4:05 PM, revealed this could be a problem for confused residents.</p> <p>Interview with the Maintenance Director, on 03/18/15 at 4:00 PM, revealed he spoke with the staff about the issue and the carts were to be taken to the near-by, locked storage room, in between showers and were not intended to stay in the shower rooms. The flammable hair spray was not allowed in the building and chemicals were to be in a locked area.</p>	F 323			

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F 323	Continued From page 24 Interview with the DON, on 03/20/15 at 9:55 AM, revealed the metal carts were not supposed to be left in the shower room and should be locked up. There should be no aerosol hairspray in the facility, the Lysol should not be locked in the storage cabinet and the carts should be secured in a locked area.  Interview with the Administrator, on 03/18/15 at 4:05 PM, revealed he was unaware the carts remained in the shower room and stated the carts were not to be in the shower area after the resident's shower. He stated the staff were aware of this and would expect them to follow his expectations. In addition, there were rounds made to assess for these things and he expected this to be addressed.	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible, and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and the facility's policy/procedure, it was determined the facility failed to ensure residents	F 325	1. Resident #7 is receiving weekly weights and ordered dietary supplements on her tray as well as being assisted to eat when needed. The physician was notified regarding weight loss greater than 5% in 30 days. New orders were received to change diet to a mechanical soft and to increase Megace dosage. The resident is included in a weight loss Performance Improvement Plan (PIP) through the Quality Assurance And Performance Improvement (QAPI) Committee. The RN Unit Manager was verbally educated by the DON that she must notify the physician if a resident has greater than a 5 percent weight loss in one month as well as any noted dietary recommendations.  2. All residents have the potential to be affected by the deficient practice.		

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F 325	<p>Continued From page 25</p> <p>maintain acceptable parameters of nutritional standards of body weight for one (1) residents (#7) in the selected sample of 19. Resident #7 had a 7.13 % weight loss in one month.</p> <p>Findings include:</p> <p>Review of the facility's policy, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol from Dietary Services Policy and Procedure Manual 2005 MED-PASS, Inc. (Revised December 2011), revealed the nursing staff will monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time. The threshold for significant unplanned and undesired weight loss will be based on the following criteria (where percentage of body weight loss = (usual weight - actual weight) / (usual weight) x 100): 5 % weight loss is significant; greater than 5 % is severe in a one month period.</p> <p>Review of the Nutrition at Risk Policy and Procedure revealed residents with a weight change of 5% in one month, 10% in six months or a rate change that is a concern for the committee will be weighed weekly.</p> <p>Resident #7 was admitted to the facility on 01/27/15 with diagnoses to include Adult Failure to Thrive, Dysphagia, Anemia, Atrial Fibrillation and Hypertension.</p> <p>Review of the Initial Minimum Data Set (MDS) dated 02/03/15 revealed Resident #7 was assessed to have a Brief Inventory of Mental Status (BIMS) score of 10 indicating moderate cognitive impairment.</p>	F 325	<p>3. An in-service is scheduled on 4/15/2015 for all nursing staff, dietary manager, and the Registered Dietician (RD). Education will be conducted by the Director of Nursing (DON) regarding proper physician notification related to weight loss and dietary recommendations. Emphasis will be placed on the importance of ensuring the ordered high calorie supplements are on the residents tray and offered to the resident. The State Registered Nurse Aide's (SRNA) should always offer the supplement to the resident and report to the Charge Nurse anytime a resident doesn't consume the supplement then another staff member shall approach the resident and offer the supplement. All resident's weight and dietary recommendation records for the last month will be reviewed to ensure the physician has been notified of any noted dietary recommendations or weight loss greater than 5 percent in one month and visually observe all residents that have current orders for high calorie supplements during a meal to ensure they are being provided to the resident.</p> <p>4. The Dietician will monitor weight reports monthly for weight loss greater than 5 percent in one month and report results to the DON or Designee. All dietary recommendations will also be reported to the DON to perform audits to ensure the physician has been notified and any orders have been implemented to maintain compliance. The QAPI committee will audit 5 residents per week for one month then 5 per month for one quarter during meal times to ensure ordered high calorie supplements are being provided to the resident. Any non-compliance is to be reported to the DON or</p>		

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F 325	<p>Continued From page 26</p> <p>Review of Resident #7's care plan, dated 02/12/15, revealed to monitor his/her weight weekly, and notify the physician of weight loss as indicated. Further review of the monthly vital signs and weights record revealed the resident weighed 88.3 pounds (lbs) upon admission on January 27, 2015. In February 2015 (no specific date), his/her weight was recorded at 88 lbs, and on March 18, 2015, his/her weight was recorded at 82 lbs., with a 6.3 lb weight loss (7.13%) in thirty (30) days.</p> <p>Review of the physician's order dated 01/27/15 revealed monitor appetite three times per day and to offer substitutes if less than 75% of meal consumed.</p> <p>Interview with the Dietary Manager, on 03/19/15 at 1:10 PM, revealed the facility's policy/procedure for residents assessed nutritionally at risk was to increase calorie supplements.</p> <p>Observation on 3/18/15 at 12:05 PM revealed the resident was sitting up in a wheelchair across from the nurse's station with lunch tray placed on an over the bed table. The resident was observed dozing during the meal and there was no staff intervention/assistance to encourage the resident to eat. Further observation revealed magic cup was not available on the resident's lunch tray.</p> <p>Observation on 03/19/15 at 8:00 AM revealed Resident #7 was sitting up in a wheelchair across from the nurse's station with breakfast tray placed on the over the bed table. The resident was observed to only consume a few sips of cranberry</p>	F 325	<p>Designee. Any employee found to be in non-compliance will be re-educated and/or disciplined per the personnel policy handbook guidelines if indicated by the DON or Designee.</p>	4/20/2015	

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F 325	Continued From page 27 juice. Further observation revealed the breakfast tray was removed by a SRNA #5 and no substitute was offered.	F 325		
F 369 SS=D	Interview with the Registered Dietician, on 03/19/15 at 10:15 AM, revealed the nutrition at Risk (NAR) was implemented for Resident #7 on 02/24/15 including magic cup supplement with lunch daily. Further interview revealed residents who are NAR would be weighed weekly. Resident #7 did not receive weekly weights. 483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS  The facility must provide special eating equipment and utensils for residents who need them.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review it was determined the facility failed to ensure special eating utensils were provided for one (1) resident of nineteen (19) sampled residents (Resident #9) in regards to a divided plate.  Findings include:  Record review revealed the facility admitted Resident #9 on 05/31/12 with diagnosis to include: esophagitis, heart failure, non alzheimer's dementia, anxiety, depression. Review of the Dietary Assessment, dated 02/15/15, revealed a divided plate would be utilized with meals to increase his/her independence with self-feeding. Review of	F 369	<ol style="list-style-type: none"> <li>1. Resident #9 is receiving their food in the divided plate with meals as ordered.</li> <li>2. Physician orders will be reviewed to identify all residents that have orders for special eating equipment or utensils to ensure they are being provided the assistive devices.</li> <li>3. The Registered Dietician or Dietary Manager will observe all residents with orders for assistive equipment for eating during a meal to ensure they are receiving the ordered eating equipment. Dietary cards will be reviewed to ensure the assistive equipment is listed on them. The care plan will be reviewed, revised, and updated, if indicated. An in-service for all nursing staff and dietary staff will be conducted by the DON on 4/15/15. Nursing staff will be educated to always read the dietary card and notify dietary if special equipment is missing. Dietary is responsible for getting the special eating equipment to the nursing staff. Dietary staff is to read</li> </ol>	

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F 369	<p>Continued From page 28</p> <p>Physician Orders, dated 02/15/15, revealed a telephone order for divided plate with meals. Review of Nursing Assistant assignments, dated 03/01/15, revealed divided plate with meals added to assignment on 02/15/15.</p> <p>Observation of the lunch meal, on 3/18/15 at 11:05 AM, revealed Resident #9 eating lunch in her room. Further observation revealed the resident consuming a mechanical soft diet as verified per review of physicians orders dated 2/15/15. Review of the dietary card on resident's dining tray revealed divided plate with meals however, divided plate was not utilized.</p> <p>Interview with SRNA #5, on 03/18/15 at 11:05 AM, revealed she served Resident #9 lunch tray. Further interview revealed she read dietary card and failed to notice "DIVIDED PLATE WITH ALL MEALS" added to the dietary card. SRNA #5 stated, "I should let dietary know the resident did not have divided plate".</p> <p>Interview with Dietician, on 03/19/15 at 10:15 AM, revealed Resident #9 was assessed for use of divided plate on 02/15/15 to encourage to feed self. Further interview revealed use of divided plate was important especially since divided plate enhanced residents' motivation to feed self.</p> <p>Interview with the Dietary Manager, on 03/19/15 at 1:10 PM, revealed it is dietary's responsibility to ensure resident's assessed for special eating utensils/equipment to have them at mealtime. Further interview revealed if utensils/equipment not available on resident tray he would expect staff serving resident tray to notify dietary and utensils would be provided.</p>	F 369	<p>the residents dietary card during preparation of the meal and set the tray up as ordered by the physician.</p> <p>4. The Registered Dietician or Dietary Manager will audit the prepared trays of ten residents with assistive devices ordered per week for one month followed by ten audits per month for one quarter to ensure residents are provided the proper equipment ordered for eating. Any noted non-compliance will be reported to the DON or Designee for re-education and/or discipline per the Personnel Policy Handbook guidelines.</p>	4/20/15	

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F 369	Continued From page 29  Interview with RN #1, on 03/20/15 at 11:25 AM, revealed expectation is for staff serving meals to review residents dietary card and ensure meal, utensils/equipment provided as indicated on diet card.  Interview with DON, on 03/20/15 at 5:00 PM, revealed expectation of all staff to review residents diet card prior to serving resident dietary tray and ensure resident receives meals, utensils/equipment as ordered.	F 369		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure that food was served at the appropriate temperatures. A test tray served on the East Wing on 03/19/15 had temperatures less than 120 degrees Fahrenheit (F) at the point of service.  The census of the facility was 91 residents, with	F 371	1. New heat plates and covers without steam holes are now being utilized for dining on the wings. Dietary is also only preparing ten trays at a time and sending them to the unit to shorten the amount of time involved from preparation to serving time. Temperature checks have been in compliance and no complaints of cold food have been received with the changes that have been made. 2. All residents have the potential to be affected by the deficient practice. 3. All meals served on the wings are now prepared and placed in new heat plates and solid covers without steam holes. Dietary is preparing ten trays at a time and sending them to the wing to shorten the amount of time involved from preparation to serving time. Food temperatures are being monitored on the units daily. 4. Dietary staff will audit food temperatures of one tray per food cart sent to the wings daily for one	

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F 371	<p>Continued From page 30</p> <p>two (2) of those residents being tube feeders and not utilizing the dining facilities.</p> <p>The findings include:</p> <p>Review of the "Temperatures for Food Safety" and "Food Temperatures" policy/procedure, updated April 2014, revealed temperatures were to be recorded at the beginning of the service line and at the end of the service line. If temperatures did not meet acceptable serving temperatures, the food was to be reheated or chilled to the proper temperatures. The palatability of foods determines the appropriate temperatures at bedside or tableside food. Generally, hot foods are palatable between 110-120 degrees F. Resident surveys will determine their acceptability.</p> <p>Interviews during the Resident Council Meeting, on 03/18/15 at 9:30 AM, revealed one (1) out of four (4) residents complained of cold food served on the East Wing.</p> <p>Observations of a test tray on the East Wing, during the noon meal service on 03/19/15, revealed the cart arrived on the unit at 11:15 AM. Four (4) servers arrived at 11:16 AM and twenty (20) trays were served at 11:25 AM. Temperatures taken at 11:26 AM revealed pureed potatoes at 118 degrees F and pureed cabbage at 108 degrees F. Further observations revealed the plate covers had a dime-sized hole at the top of the domed covers.</p> <p>Interview with the Dietary Manager, on 03/19/15 at 11:45 AM, revealed the test tray should have a temperature of at least 120 degrees F, and he thought this may be due to the time it took to get</p>	F 371	<p>month followed by weekly audits for one quarter to ensure compliance is maintained. Any non-compliance is to be reported to the DON or Designee.</p>	4/20/15

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F 371	Continued From page 31 all the trays off the cart. The plate covers have "always had a steam hole" at the top of the cover and he had periodically tested the trays before with no concerns.	F 371			
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens	F 441	<ol style="list-style-type: none"> <li>1. Resident #6 is receiving proper perineal care. Nurse aides involved in failure to provide proper care and application of the barrier cream post incontinent episodes have been educated on proper technique and importance of implementing and following the resident's plan of care by the LPN Staff Development Coordinator (SDC).</li> <li>2. All residents have the potential to be affected by the deficient practice.</li> <li>3. Licensed Nurses are reviewing all perineal care interventions on all residents care plans and nurse aide assignment sheets. Interventions will be reviewed, revised, and updated, if indicated, to reflect the current care needs of the resident. An in-service to be conducted by the DON is scheduled for 4/15/2015 for all nursing staff regarding the importance of implementing and performing the care planned interventions on each resident. On 4/15/2015 The LPN Staff Development Coordinator (SDC) will educate all SRNA's on providing proper perineal care and always implementing the care planned Nurse Aide Assignment interventions such as application of barrier cream post each incontinent episode.</li> <li>4. Random weekly visual checks will be conducted by the LPN SDC on 10 residents for two months to ensure</li> </ol>		

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F 441	<p>Continued From page 32</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) resident, in the selected sample of nineteen (19) residents (Resident #6). Observation, on 03/18/15, revealed State Registered Nurse Aides (SRNAs) failed to provide proper incontinent care.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure, "Perineal Care", undated, revealed documentation to include "gently wash, rinse, and dry the perineal area, wiping from a clean urethral area toward the dirty rectal area to avoid contaminating urethral area with germs from rectal area".</p> <p>Review of the facility's standards of practice, "Basic Nursing Theory and Practice" Second Edition, revealed documentation to include cleansing of male genital area prior to wiping the anal area to prevent contamination of fecal material that can cause urinary tract infections.</p> <p>Record review revealed the facility admitted Resident #6 on 06/26/14 with diagnoses which</p>	F 441	<p>care planned interventions related to proper perineal care are being properly implemented and followed. The QAPI committee will perform ten random monthly audits for one quarter thereafter to monitor for sustained compliance. Any non-compliance is to be reported to the DON or Designee for re-education and/or discipline, if indicated, per the Personnel Policy Handbook guidelines.</p>	4/20/2015

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F 441	<p>Continued From page 33</p> <p>included Muscle Weakness, Diabetes Mellitus Type II, Dehydration, Anemia, Alzheimer's Disease, Dementia with Lewy body's and a History of Falls. Review of the quarterly Minimum Data Set (MDS) assessment, dated 02/09/15, revealed the facility assessed Resident #6's cognition as cognitively impaired with a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated the resident was not interviewable. In addition, the resident required extensive assistance with all activities of daily living.</p> <p>Review of Resident #6's urinalysis report, dated 03/15/15, revealed yellow, turbid with small amount of blood and a large amount of leukocyte esterase, indicating the resident had a urinary tract infection (UTI) and was prescribed an antibiotic Cephalexin 500 milligrams (mg) by mouth (po) every eight (8) hours for ten (10) days for a UTI.</p> <p>Observation of incontinent care, on 03/18/15 at 1:30 PM, by SRNA #2 and SRNA #3, revealed SRNA #2 placed peri-wash onto a disposable Chux and wiped Resident #6's buttocks, then washed the resident's penile and scrotal area. No protectant/barrier cream was applied.</p> <p>Interview, on 03/20/15 at 2:00 PM, with SRNA #3, revealed during perineal care on 03/18/15 at 1:30 PM, she observed SRNA #2 wash Resident #6's buttocks prior to washing his penile and scrotal area. She stated SRNA #2 did not retract the foreskin and left the soapy peri-wash solution on Resident #6's skin.</p> <p>Interview, on 03/20/15 at 11:20 AM, with the Director of Nursing (DON), revealed she</p>	F 441			

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F 441	Continued From page 34 expected the staff to follow all policies.	F 441			

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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1972.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1972, and upgraded in 2010 with 16 smoke detectors and 3 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1972 and upgraded in 2011.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Natural Gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 03/19/15. The facility was found in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-five (95) beds with a census of ninety-one (91) on the day of the survey.</p> <p>The findings that follow demonstrate non-compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 4/29/15
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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 2</p> <p>located at the top of the smoke barrier at the West end of the Main Hall that were not sealed to resist the passage of smoke.</p> <p>Interview, on 03/19/15 at 8:06 AM, with the Maintenance Supervisor revealed he was not aware of the penetration.</p> <p>The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or</p>	K 025			

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K 025	Continued From page 3 by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2. Reference: NFPA 80 Standard for Fire Doors and Windows (1999 edition)	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, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, thirty (30) residents, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the	K 029	K029  1. The items identified as deficient practices have been addressed as follows: The hazardous amount of paper stored in the West Wing Supervisor's Office was removed 3/31/15 to an appropriate storage area. The Dry Storage Room door that was held open by a container had the container removed 3/29/15 and has been scheduled to have a magnet hold open device with a fire alarm/power failure release activation installed by 4/30/15.  2. All residents are identified as having potential to be affected by the deficient practice.  3. All staff will be in-serviced by the Administrator on appropriate hazardous waste storage and requirements for automatic door closure has been scheduled for 4/15/15.	

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K 029	<p>Continued From page 4 survey, the census was ninety-one (91).</p> <p>The findings include:</p> <p>Observation, on 03/19/15 at 10:45 AM, with the Maintenance Supervisor revealed a hazardous amount of paper storage located in the West Wing Supervisors Office. The door was not rated or equipped with a self-closing device to keep the door closed. Further observation revealed unrated windows in the wall.</p> <p>Interview, on 03/19/15 at 10:46 AM, with the Maintenance Supervisor revealed he was not aware the room would have to meet the requirements of protection from hazards.</p> <p>Observation, on 03/19/15 at 12:55 PM, with the Maintenance Supervisor revealed the door to the Dry Storage Room was held open with a five (5) gallon container of cooking oil. The door was equipped with a self-closing device.</p> <p>Interview, on 03/19/15 at 12:56 PM, with the Maintenance Supervisor revealed he was not aware the room would have to meet the requirements of protection from hazards. The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1</p>	K 029	<p>4. The QI Supervisor will assign staff to monthly monitor paper storage and will monthly report to the Administrator or Director of Nursing results. The Maintenance personnel will check all doors for appropriate self-closure with quarterly test and report the findings to the QI Supervisor. The QI Supervisor will report the findings to the Administrator or Director of Nursing quarterly.</p> <p>5. Corrective action to be completed 4/30/15.</p>	4/30/15

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NAME OF PROVIDER OR SUPPLIER  CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029	
(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)	(X4) COMPLETION DATE
K 029	Continued From page 5 Hazardous Areas. 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: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (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.  Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.	K 029		

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K 029	Continued From page 6 Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.  Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	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			

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K 038	Continued From page 7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure locks on doors in the path of egress were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91).  The findings include:  Observation, on 03/19/15 at 10:50 AM, with the Maintenance Supervisor revealed two (2) locks on the West Wing Supervisors Office door to the corridor.  Interview, on 03/19/15 at 10:51 AM, with the Maintenance Supervisor revealed he was not aware of the requirements for locks in the path of egress.  Observation, on 03/19/15 at 1:10 PM, with the Maintenance Supervisor revealed a lock was installed over four (4) feet above the finished floor located on the Human Resources Office door to the corridor.  Interview, on 03/19/15 at 1:11 PM, with the	K 038	K038  1. The items identified as deficient practices have been addressed as follows: The two locks on the West Wing Supervisor's Office door had one lock removed 3/23/15. The lock installed over four feet from the finished floor in the Human Resource Office door was removed 3/23/15. The lock installed over four feet from the finished floor on the Conference Room door to the corridor was removed 3/23/15. 2. All residents are identified as having potential to be affected by the same deficient practice. 3. The Maintenance staff was in-serviced by the Administrator on 3/23/15 on the NFPA standard related to door locks. 4. All door lock modifications, changes, and installations must have prior approval by the Administrator. The Administrator shall, with a member of the Maintenance staff, check all doors monthly for compliance. 5. Corrective action was completed 3/30/2015	3/30/2015	

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K 038	<p>Continued From page 8</p> <p>Maintenance Supervisor revealed he was not aware of the requirements for locks in the path of egress.</p> <p>Observation, on 03/19/15 at 2:02 PM, with the Maintenance Supervisor revealed a lock was installed over four (4) feet above the finished floor located on the Conference Room door to the corridor.</p> <p>Interview, on 03/19/15 at 2:03 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for locks in the path of egress.</p> <p>The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation.</p> <p>Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such</p>	K 038			

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K 038	<p>Continued From page 9</p> <p>device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished floor.</p> <p>Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.</p> <p>Reference: NFPA 101 (2000 edition) 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</p>	K 038			

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K 038	<p>Continued From page 10 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 having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(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</p>	K 038		
K 045 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit</p>	K 045		

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K 045	<p>Continued From page 11</p> <p>discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress lighting was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91).</p> <p>The findings include:</p> <p>1) Observation, on 03/19/15 at 1:04 PM, with the Maintenance Supervisor revealed a one (1) bulb fixture located outside the Dietary Storage Exit.</p> <p>Interview, on 03/19/15 at 1:05 PM, with the Maintenance Supervisor revealed he was not aware the exit discharge did not have proper egress lighting.</p> <p>2) Observation, on 03/19/15 at 1:32 PM, with the Maintenance Supervisor revealed the light bulbs had been removed from the light fixture located outside the Exit door by Room #109.</p> <p>Interview, on 03/19/15 at 1:33 PM, with the Maintenance Supervisor revealed he was not</p>	K 045	<p>K045</p> <ol style="list-style-type: none"> <li>1. A licensed electrician installed proper egress lighting outside the Dietary storage area on 3/30/15. The electrician also inspected and ordered necessary parts to repair the light fixture by Room 109. On 4/10/15 the light fixture outside Room 109 was repaired.</li> <li>2. All residents are identified as having potential to be affected by the same deficient practice.</li> <li>3. Any alteration to exterior illumination at exterior doors will require Administrator approval.</li> <li>4. Exterior illumination shall be inspected and tested monthly by Maintenance staff for proper operation. A test log will be maintained.</li> <li>5. Corrective action to be completed by 4/30/15.</li> </ol>	4/30/15
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K 045	<p>Continued From page 12 aware the light bulbs had been removed from the light fixture.</p> <p>The census of ninety-one (91) was verified by the Administrator on 03/19/15. The survey findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch</p>	K 045		

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K 045	<p>Continued From page 13</p> <p>controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3*</p> <p>The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor.</p> <p>Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light.</p> <p>Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels.</p> <p>7.8.1.4*</p> <p>Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p> <p>7.8.1.5</p> <p>The equipment or units installed to meet the requirements of Section 7.10 also shall be permitted to serve the function of illumination of means of egress, provided that all requirements of Section 7.8 for such illumination are met.</p> <p>7.8.2 Sources of Illumination.</p> <p>7.8.2.1*</p> <p>Illumination of means of egress shall be from a source considered reliable by the authority having jurisdiction.</p> <p>7.8.2.2</p> <p>Battery-operated electric lights and other types of portable lamps or lanterns shall not be used for primary illumination of means of egress.</p>	K 045		
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K 045	Continued From page 14 Battery-operated electric lights shall be permitted to be used as an emergency source to the extent permitted under Section 7.9.	K 045		
K 047 S8=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91).  The findings include:  Observation, on 03/19/15 at 1:02 PM, with the Maintenance Supervisor revealed the Kitchen did not have an exit sign installed to insure the path of egress was clearly recognizable.  Interview, on 03/19/15 at 1:03 PM, with the Maintenance Director revealed he was not aware of the requirements for exit signage.  The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were	K 047  K047	<ol style="list-style-type: none"> <li>1. A certified electrician installed a exit sign in the Kitchen to assure the path of egress is clearly recognizable.</li> <li>2. All residents have been identified as having potential to be affected by the same deficient practice.</li> <li>3. Maintenance staff will be in-serviced on 4/15/15 by the Administrator on NFPA standards for Exit and Directional signs.</li> <li>4. Maintenance personnel will conduct monthly observations of all exit areas for proper signage and proper working order.</li> <li>5. Corrective action was completed 4/16/2015</li> </ol>	4/16/2015

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K 047	<p>Continued From page 15 acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard: Reference: NFPA 101 (2000 edition)</p> <p>19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.</p> <p>7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the</p>	K 047		
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K 047	Continued From page 16 centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. 7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame. 7.10.1.6* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or	K 047		

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NAME OF PROVIDER OR SUPPLIER  CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029		
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K 047	Continued From page 17 other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. 7.10.1.7* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted. 7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.3* Sign Legend. Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters. 7.10.4* Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5 Illumination of Signs. 7.10.5.1* General.	K 047			

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K 047	<p>Continued From page 18</p> <p>Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode.</p> <p>7.10.5.2* Continuous Illumination.</p> <p>Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8.</p> <p>Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system.</p> <p>7.10.6 Externally Illuminated Signs.</p> <p>7.10.6.1* Size of Signs.</p> <p>Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height.</p> <p>Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high.</p> <p>Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5.</p> <p>7.10.6.2* Size and Location of Directional Indicator.</p> <p>The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be</p>	K 047		
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K 047	<p>Continued From page 19</p> <p>of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated. Exception: This requirement shall not apply to approved existing signs. Figure 7.10.6.2 Chevron-type indicator.</p> <p>7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5.</p> <p>7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5. Reference: NFPA 98 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other.</p>	K 047		
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K 047	Continued From page 20 Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system. NFPA 101 LIFE SAFETY CODE STANDARD	K 047	K052	
K 052 S6=D	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect two (2) of eight (8) smoke compartments, twenty (20) residents, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91).	K 052	<ol style="list-style-type: none"> <li>1. The artificial plant blocking the fire pull in the Main Lobby area was removed from the facility on 3/20/15. The strobe light outside Room 213 is scheduled for repair on 4/20/15.</li> <li>2. All residents have been identified as having potential to be affected by the deficient practice.</li> <li>3. All staff will be in-serviced on 4/15/15 by the Administrator on NFPA standards related to access to fire pulls. Maintenance staff will be in-serviced on 4/15/15 by the Administrator on proper maintenance of the fire alarm system.</li> <li>4. Maintenance personnel will conduct weekly inspections of all fire pulls for NFPA compliance. Strobe light checks will be conducted by Maintenance staff during monthly fire drill exercises.</li> <li>5. Corrective action will be completed on</li> </ol>	4/16/2015

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K 052	<p>Continued From page 21</p> <p>The findings include:</p> <p>1) Observation, on 03/19/15 at 1:50 PM, with the Maintenance Supervisor revealed an artificial tree blocking the manual fire pull located in the Main Lobby.</p> <p>Interview, on 03/19/15 at 1:51 PM, with the Maintenance Supervisor revealed he was not aware the tree was blocking the manual fire pull.</p> <p>2) Observation, on 03/19/15 at 2:05 PM, with the Maintenance Supervisor revealed the strobe light located by Room #213 failed during a test of the Fire Alarm System.</p> <p>Interview, on 03/19/15 at 2:06 PM, with the Maintenance Supervisor revealed he was not aware the strobe light was no longer operating.</p> <p>The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.</p>	K 052		
K 056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to</p>	K 056	<p><b>K055</b></p> <p>1. The light fixture blocking the sprinker in the West Wing Kitchenatta has been scheduled to be modified by a licensed electrician to meet NFPA 101 Life Safety Code Standards. Automatic sprinklers have been scheduled for installation in the airlocks outside Rooms 217, 204, 109, 120, &amp; 126.</p>	

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K 058	<p>Continued From page 22</p> <p>provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the sprinklers were installed, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect seven (7) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91). According to CMS S&amp;C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.</p> <p>The findings include:</p> <p>1) Observation, on 03/19/15 at 10:56 AM, with the Maintenance Supervisor revealed a sprinkler head located in the West Wing Kitchenette was obstructed from developing a full pattern by a light fixture installed within twelve (12) inches of the sprinkler head and extending down below the sprinkler deflector.</p> <p>Interview, on 03/19/15 at 10:56 AM, with the</p>	K 058	<p>2. The facility maintenance supervisor and the CMS environmental surveyor inspected all the area of the facility identifying areas not properly sprinkler protected and all sprinkler heads for obstruction. All residents have the potential to be affected by the same deficient practice.</p> <p>3. A Maintenance staff in-service was conducted by the Administrator on 3/23/15 on sprinkler head obstruction. The maintenance schedule for checking the fire alarm system has been changed to include a quarterly review by the Administrator to assure NFPA compliance for properly sprinklered areas.</p> <p>4. The QI Director will review quarterly the monthly maintenance logs for the fire alarm system including sprinklers. The sprinkler heads will be visually inspected by the QI Director and the Administrator each six months for any obstruction and for areas not properly sprinkler head protected.</p> <p>5. Completion date is 4/14/15.</p>	4/14/15

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K 056	<p>Continued From page 23</p> <p>Maintenance Supervisor revealed he was aware of the requirement; however he had not noticed the sprinkler head being obstructed in the Kitchenette.</p> <p>2) Observation, on 03/19/15 at 12:32 PM, with the Maintenance Supervisor revealed the Airlock located at the Exit Door by Room #217 did not have sprinkler protection installed.</p> <p>Interview, on 03/19/15 at 12:33 PM, with the Maintenance Supervisor revealed he was not aware the Air Locks did not have sprinkler protection.</p> <p>3) Observation, on 03/19/15 at 12:40 PM, with the Maintenance Supervisor revealed the Airlock located at the Exit Door by Room #207 did not have sprinkler protection installed.</p> <p>Interview, on 03/19/15 at 12:41 PM, with the Maintenance Supervisor revealed he was not aware the Air Locks did not have sprinkler protection.</p> <p>4) Observation, on 03/19/15 at 1:30 PM, with the Maintenance Supervisor revealed the Airlock located at the Exit Door by Room #109 did not have sprinkler protection installed.</p> <p>Interview, on 03/19/15 at 1:31 PM, with the Maintenance Supervisor revealed he was not aware the Air Locks did not have sprinkler protection.</p> <p>5) Observation, on 03/19/15 at 1:40 PM, with the Maintenance Supervisor revealed the Airlock located at the Exit Door by Room #120 did not have sprinkler protection installed.</p>	K 056		
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K 058	<p>Continued From page 24</p> <p>Interview, on 03/19/15 at 1:41 PM, with the Maintenance Supervisor revealed he was not aware the Air Locks did not have sprinkler protection.</p> <p>6) Observation, on 03/19/15 at 1:46 PM, with the Maintenance Supervisor revealed the Airlock located at the Exit Door by Room #128 did not have sprinkler protection installed.</p> <p>Interview, on 03/19/15 at 1:47 PM, with the Maintenance Supervisor revealed he was not aware the Air Locks did not have sprinkler protection.</p> <p>The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p>	K 058		

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K 058	<p>Continued From page 25</p> <p>19.3.5.2*</p> <p>Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria:</p> <p>(1) It shall be in accordance with Section 9.7.</p> <p>(2) It shall be electrically connected to the fire alarm system.</p> <p>(3) It shall be fully supervised.</p> <p>Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>Reference: NFPA 101 (2000 Edition) 9.7 AUTOMATIC SPRINKLERS AND OTHER EXTINGUISHING EQUIPMENT 9.7.1 Automatic Sprinklers. 9.7.1.1*</p> <p>Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Exception No. 1: NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted for use as specifically referenced in Chapters 24 through 33 of this Code.</p> <p>Exception No. 2: NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, shall be permitted for use as provided in Chapters 24, 26, 32, and 33 of this Code.</p>	K 058			

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K 056	Continued From page 26  Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)	K 056																										
	<table border="0"> <tr> <td colspan="2" style="text-align: center;">Maximum Allowable Distance</td> </tr> <tr> <td style="text-align: center;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td style="text-align: center;">of Deflector  Obstruction (in.) (B)</td> </tr> <tr> <td>Less than 1 ft</td> <td style="text-align: center;">0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td style="text-align: center;">2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td style="text-align: center;">3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td style="text-align: center;">5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td style="text-align: center;">7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td style="text-align: center;">9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td style="text-align: center;">12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td style="text-align: center;">14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td style="text-align: center;">16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td style="text-align: center;">18</td> </tr> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector  Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18			
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3 ft 6 in. to less than 4 ft	12																											
4 ft to less than 4 ft 6 in.	14																											
4 ft 6 in. to less than 5 ft	16 1/2																											
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K 064	NFPA 101 LIFE SAFETY CODE STANDARD	K 064																										

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NAME OF PROVIDER OR SUPPLIER  CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029	
(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 064 SS=D	<p>Continued From page 27</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain fire extinguishers in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91).</p> <p>The findings include:</p> <p>Observation, on 03/19/15 at 1:08 PM, with the Maintenance Supervisor revealed storage totes were being stored under the fire extinguisher located in the New Dining Room.</p> <p>Interview, on 03/19/15 at 1:08 PM, with the Maintenance Supervisor revealed the facility had storage rooms available for the totes to have been properly stored.</p> <p>The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard:</p>	K 064	<p>K064</p> <ol style="list-style-type: none"> <li>1. The storage totes being stored under the fire extinguisher located in the New Dining Room were moved to a proper storage location on 3/20/15.</li> <li>2. The improper storage under the fire extinguisher in the New Dining Room was identified during the facility tour on 3/19/15. All residents have been identified as having potential to be affected by the deficient practice.</li> <li>3. All staff will be In-serviced on 4/15/15 by the Administrator on proper storage within the</li> </ol>	

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K 064	<p>Continued From page 28</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) 9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>Reference: NFPA 10 Standard for Portable Fire Extinguishers</p> <p>6.1.2 The procedure for inspection and maintenance of fire extinguishers varies considerably. Minimal knowledge is necessary to perform a monthly "quick check" or inspection in order to follow the inspection procedure as outlined in Section 6.2. A trained person who has undergone the instructions necessary to reliably perform maintenance and has the manufacturer's service manual shall service the fire extinguishers not more than 1 year apart, as outlined in Section 6.3.</p> <p>6.2 Inspection.</p> <p>6.2.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require.</p> <p>6.2.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items:</p> <p>(1) Location in designated place (2) No obstruction to access or visibility (3) Operating instructions on nameplate legible</p>	K 064	<p>facility as it relates to NFPA standards.</p> <p>4. Maintenance staff will conduct weekly inspections of all fire extinguishers for compliance.</p> <p>5. Corrective action was taken 3/19/15.</p>	4/15/15
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K 064	Continued From page 29 and facing outward (4)* Safety seals and tamper indicators not broken or missing (5) Fullness determined by weighing or " hefting " (6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (7) Pressure gauge reading or indicator in the operable range or position (8) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (9) HMIS label in place 6.2.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 6.2.2, immediate corrective action shall be taken. 6.2.3.1 Rechargeable Fire Extinguishers. When an inspection of any rechargeable fire extinguisher reveals a deficiency in any of the conditions listed in 6.2.2(3), (4), (5), (6), (7), and (8), it shall be subjected to applicable maintenance procedures. 6.2.3.2 Nonrechargeable Dry Chemical Fire Extinguisher. When an inspection of any nonrechargeable dry chemical fire extinguisher reveals a deficiency in any of the conditions listed in 6.2.2(3), (5), (6), and (7), it shall be removed from further use, discharged, and destroyed at the direction of the owner or returned to the manufacturer. 6.2.3.3 Nonrechargeable Halon Agent Fire Extinguisher. When an inspection of any nonrechargeable fire extinguisher containing a halon agent reveals a deficiency in any of the conditions listed in 6.2.2(3), (5), (6), and (7), it shall be removed from service, not discharged, and returned to the manufacturer. If the fire extinguisher is not returned to the manufacturer, it shall be returned to a fire equipment dealer or	K 064		

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K 064	Continued From page 30 distributor to permit recovery of the halon. 6.2.4 Inspection Recordkeeping. 6.2.4.1 Personnel making inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. 6.2.4.2 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded. 6.2.4.3 Records shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file or by an electronic method that provides a permanent record. 6.3* Maintenance. 6.3.1 Frequency. Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.	K 064			
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 98  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the manual hood suppression pull was readily available, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91).  The findings include:	K 069	<b>K069</b>  1. The facility fire system service provided, First Line, has scheduled the relocation of the manual hood suppression pull to the Kitchen egress path on 4/25/15. 2. All residents have been identified as having potential to be affected by the same deficient practice. 3. First Line personnel will in-service the Center's Maintenance staff on the Kitchen Hood Suppression System on 4/25/15. 4. Maintenance personnel will inspect the Kitchen Hood Suppression System montly to assure compliance with NFPA standards. 5. Corrective action will be completed 4/26/15.	4/26/15	

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K 089	<p>Continued From page 31</p> <p>Observation, on 03/19/15 at 1:00 PM, with the Maintenance Supervisor revealed the manual pull for the Kitchen Hood Suppression System was not located in the egress path.</p> <p>Interview, on 03/19/15 at 1:01 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for the location of the manual hood suppression pull.</p> <p>The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard:</p> <p>NFPA 96 (1998 edition)7-5.2 Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation shall activate the fire alarm signaling system.</p> <p>Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or</p>	K 089		

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K 069  K 072 SS=F	<p>Continued From page 32 releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system. NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficient practice has the potential to affect six (6) of eight (8) smoke compartments, ninety-five (95) residents, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91).</p> <p>The findings include:</p> <p>Observation, on 03/19/15 at 8:26 AM, with the Maintenance Supervisor revealed the storage of clean linen carts in the Laundry Hall exit corridor.</p> <p>Interview, on 03/19/15 at 8:27 AM, with the Maintenance Supervisor revealed the items were routinely stored in this location.</p> <p>Observation, on 03/19/15 at 12:28 PM, with the Maintenance Supervisor revealed the storage of clean linen carts in the exit corridor by room #218.</p>	K 069  K 072	<p><b>K072</b></p> <ol style="list-style-type: none"> <li>The clean linen carts stored in the Laundry Hall exit corridor were moved to an appropriate location on 3/20/15. The clean linen carts stored in the ext corridor by Rooms 218, 208, 110, 119, &amp; 127 were moved to appropriate locations on 3/20/15.</li> <li>All residents are identified as having potential to be affected by the deficient practice.</li> <li>All staff will be in-serviced by the Administrator on April 15,</li> </ol>	

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K 072	Continued From page 33  Interview, on 03/19/15 at 12:29 PM, with the Maintenance Supervisor revealed the items were routinely stored in this location.  Observation, on 03/19/15 at 12:38 PM, with the Maintenance Supervisor revealed the storage of clean linen carts in the exit corridor by room #208.  Interview, on 03/19/15 at 12:39 PM, with the Maintenance Supervisor revealed the items were routinely stored in this location.  Observation, on 03/19/15 at 1:30 PM, with the Maintenance Supervisor revealed the storage of clean linen carts in the exit corridor by room #110.  Interview, on 03/19/15 at 1:31 PM, with the Maintenance Supervisor revealed the items were routinely stored in this location.  Observation, on 03/19/15 at 1:42 PM, with the Maintenance Supervisor revealed the storage of clean linen carts in the exit corridor by room #119.  Interview, on 03/19/15 at 1:43 PM, with the Maintenance Supervisor revealed the items were routinely stored in this location.  Observation, on 03/19/15 at 1:48 PM, with the Maintenance Supervisor revealed the storage of clean linen carts in the exit corridor by room #127.  Interview, on 03/19/15 at 1:49 PM, with the Maintenance Supervisor revealed the items were routinely stored in this location.	K 072	2015 on corridor passage impediments.  4. The Administrator or his designee will daily survey all corridors for compliance.,  5. Corrective action will be completed by	4/16/2015	

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K 072	Continued From page 34 The census of ninety-one (91) was verified by the Administrator on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.  Actual NFPA Standard:  Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.  Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (98 cm) and below.	K 072		
K 076 SS=D	Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD  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	K 076		

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K 076	Continued From page 35  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage was in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of eight (8) smoke compartments, twenty (20) residents, staff and visitors. The facility has the capacity for ninety-five (95) beds and at the time of the survey, the census was ninety-one (91).  The findings include:  1) Observation, on 03/19/15 at 11:00 AM, with the Maintenance Supervisor revealed oxygen stored in the West Wing Medicine Room and Soiled Utility Room. Combustible material was stored within five (5) feet of the tanks and a light switch and plug were installed below five (5) feet from the floor.  Interview, on 03/19/15 at 11:01 AM, with the Maintenance Supervisor revealed he was not aware of the requirements for oxygen storage.  2) Observation, on 03/19/15 at 1:24 PM, with the Maintenance Supervisor revealed oxygen stored in the East Wing Medicine Room and Soiled Utility Room. Combustible material was stored within five (5) feet of the tanks and a light switch and plug were installed below five (5) feet from the floor.	K 076	K076  1. A certified electrician relocated the light switch and plug in both the West Wing Medicine Room and the East Wing Medicine Room to a distance above five feet above the finished floor on 3/31/15. The combustible material was relocated on 3/31/15. 2. All residents have been identified as having potential to be affected by the deficient practice. 3. All staff will be in-serviced on 4/15/15 by the Administrator on appropriate storage of combustible materials. Any alterations or installation of electrical plugs or switches will require approval of the Administrator before work begins. 4. Maintenance staff will conduct quarterly evaluations of all electrical plugs and switches for compliance and for proper storage of combustible materials. 5. Corrective action was taken on 3/31/15 and will be complete on	4/16/2015

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NAME OF PROVIDER OR SUPPLIER  CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029	
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K 076	<p>Continued From page 36</p> <p>Interview, on 03/19/15 at 1:25 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for oxygen storage.</p> <p>The census of ninety-one (91) was verified by the Administrator, on 03/19/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/19/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 8-3.1.11.2 Storage for nonflammable gases less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>)</p> <p>(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.</p> <p>(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(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</p> <p>(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.</p>	K 076		

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

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/19/2015
NAME OF PROVIDER OR SUPPLIER  CALVERT CITY CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 FIFTH AVE CALVERT CITY, KY 42029	
(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 078	Continued From page 37 (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.  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: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b>	K 078		