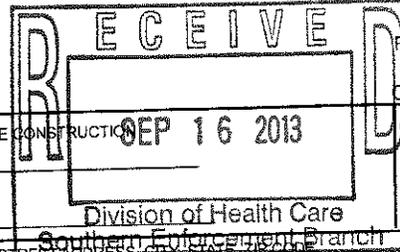


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 09/06/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP+4 203 BRUCE COURT DANVILLE, KY 40423	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to ensure individual needs were accommodated for one of eighteen sampled residents (Resident #8). Observation on 08/21/13 at 9:00 AM revealed Resident #8 was unable to reach the soap dispenser while seated in a wheelchair. The soap dispenser was located at the back of the sink in the resident's room.</p> <p>The findings include:</p> <p>A review of the facility's Resident Rights policy (10/12/11) revealed residents' needs were to be accommodated.</p> <p>Observation of Resident #8 after incontinence care on 08/22/13 at 9:00 AM revealed the resident was unable to reach the soap dispenser located at the back of the sink in the resident's</p>	F 246	<p>F246</p> <p>Specific measures were utilized to correct the violation identified by surveyors; starting by moving Resident #8's soap dispenser to ADA specifications 44 inches from the ground/floor. Allowing the resident to be able to use the dispenser more accessible while seated in a wheelchair 8/22/13.</p> <p>Under the direction of Administrator Marlin Sparks, the facility conducted & completed an audit to identify other residents having the potential to not be able to reach the soap dispenser while seated in wheelchair on 9-10-13. The audit was conducted by key employee Amy Sparks Co-Owner. Under the direction of Amy Sparks, staff moved soap dispensers starting on 9-10-13.</p> <p>After QA discussion facility decided to move remaining soap dispensers in remaining resident's rooms. On 9-11-13 all soap dispensers in entire facility patient rooms/areas were moved to accommodate residents while seated in wheelchairs using ADA guidelines of 44 inches.</p> <p>This systemic change will ensure the deficient practice will not recur. Facility</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Marlin Sparks
TITLE: Adm
(X6) DATE: 9-16-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 246	Continued From page 1 room to wash his/her hands. CNA #4 had to assist Resident #8 to obtain soap in order for the resident to wash his/her hands. Interview with CNA #4 on 08/22/13 at 9:00 AM revealed the soap dispensers should be moved closer so the residents could use them. CNA #4 said the maintenance staff had not been notified of the need for the soap dispenser to be moved. Interview with the Director of Nursing on 08/22/13 at 5:30 PM revealed the soap dispensers should be in a place that residents have access to them. The DON did not realize Resident #8 was unable to reach the soap dispenser while in the wheelchair.	F 246	round was conducted by Amy Sparks & Marlin Sparks to inspect all soap dispensers to ensure all were moved and in appropriate ADA placement this was completed on 9-11-13. Our facility plans to monitor soap dispensers by weekly QA checks. QA checks will ensure that resident's soap dispenser is in appropriate in placement, working efficiently, and has soap inside dispenser. This monitoring will be conducted by Amy Sparks Co-Owner, and or designee. All information will be reported back to Quality Assurance Committee each week for compliance. Additionally soap dispensers have also been added to monthly maintenance inspection checklist for each resident room. Maintenance checklist will be completed each month by a member of maintenance and or designee, and reported to the quality assurance committee. New Maintenance Inspection Checklist was updated on 8-23-13. Under the direction of Marlin Sparks, Administrator Chris Brown, Compliance Director educated Marty Bradshaw Maintenance Department on completing the checklist on 8/23/13. All corrective action completed on or before 9/13/13.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to ensure maintenance services to maintain a sanitary, orderly, and comfortable interior were provided. Observations on 08/21/13 at 1:00 PM revealed fourteen wheelchairs to have torn/cracked armrests, torn/cracked seats and/or backs, and torn footrests. Resident rooms 6, 40, and 43 were noted to have cracked, rough edges on the laminate of the sink. In addition, Resident #6 was observed on 08/20/13 and 08/21/13 to be wearing a soiled torso support vest.	F 253	F253 Dennis Oaks, Environmental Control Director immediately started the repair on 8-22-13 of wheelchairs that had been identified by surveyors to have	

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F 253	Continued From page 2 The findings include: 1. A review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy (10/12/11) revealed the facility will keep equipment utilized by the residents in good working condition. Observation of wheelchairs on 08/21/13 at 1:00 PM revealed 14 wheelchairs to have armrests, backs and seats, and footrests that were torn/cracked and in need of repair. Observation further revealed these wheelchairs were available and utilized by residents daily. Rooms 6, 40, and 43 were observed to have laminate on the sink that was cracked and rough and in need of repair. Interview with the Environmental Control Director (ECD) on 08/22/13 at 4:00 PM revealed wheelchairs were inspected when weekly room inspections were made. The ECD stated the room inspections were completed and turned in as part of the quality assurance program. The ECD further stated wheelchair and needed repairs could be turned in by staff in a book located at the nursing stations. The ECD stated no wheelchairs or sinks had been turned in by any staff as needing repairs. The ECD said no wheelchairs or sinks were identified during the weekly room inspections either. Interview with the Director of Nursing (DON) on 08/22/13 at 5:30 PM revealed staff could notify Maintenance of any needed repairs on work orders that were turned in at the nurses' station. The DON was not aware of any wheelchairs that had been turned in as needing repairs or of any resident sinks in need of repairs.	F 253	torn/cracked armrests, torn/cracked seats, and or backs, and torn footrests. Under the direction of Administrator Marlin Sparks, a wheelchair audit was ordered of every wheelchair in the entire facility on 9/10/13. Audit was led by Amy Sparks Co-owner. Each wheelchair was checked entirely for safety, cleanliness, tears, cracks, screws, working efficiently, having all equipment needed, arm rests, foot rest, etc. All wheelchairs that were identified in addition to the surveyors' recommendations were fixed and corrected, and parts ordered starting on 9/10/13 and finished 9/12/13. Amy Sparks, co-owner and or designee will be completing a wheel condition audit weekly to ensure wheelchairs are clean, working efficiently, that there are no tears, cracks, and arm rests, and foot rests are appropriate and in working condition. The wheelchair condition audit was implemented on 9/12/13 and includes chair number; date chair was checked and necessary repair. Each week all audit information will be reported to quality assurance committee. Counter tops in rooms #6, 40, and 43 were repaired of cracks, rough edges on the laminate area around the laminate of the sink. On 09/10/13. Under the direction of Marlin Sparks, Administrator a facility audit was conducted by co-owner Amy Sparks to identify other counter top area in addition to surveyor's that needed	

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F 253	<p>Continued From page 3</p> <p>2. Review of the facility policy entitled "Cleaning and Disinfection of Resident-Care Items and Equipment" (dated 10/12/11) revealed resident care equipment, including reusable items and durable medical equipment, would be cleaned and disinfected. However, the policy did not address cleaning of the torso support vest used for residents.</p> <p>Resident #6 was observed on 08/20/13 at 11:55 AM, to be sitting in a wheelchair in the facility lobby with a torso support vest in place. The support vest was observed to be soiled/stained with a dried orange substance on the front of the vest. Resident #6 was observed again on 08/20/13, at 1:45 PM, 5:15 PM, and 6:15 PM, to continue with the soiled support vest in place. Resident #6 was observed on 08/21/13, at 8:40 AM, 9:20 AM, 10:15 AM, and 12:45 PM, to be up in the wheelchair with the soiled support vest in place.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #1 on 08/21/13, at 12:55 PM, revealed she was assigned to provide care to Resident #6 on 08/21/13. The CNA stated the CNAs were responsible to check the support vest daily for soiling/stains and to replace the vest when the vest was stained/soiled. CNA #1 stated she had not identified the stain on the resident's support vest on 08/21/13.</p> <p>Interview conducted with CNA #2 on 08/22/13, at 9:30 AM, revealed she had been assigned to Resident #6 on 08/20/13. CNA #2 stated the support vest was to be checked daily for any stains/soil and should be replaced when soiled. The CNA stated she had not paid attention to the</p>	F 253	<p>repair. The audit began on 9-11-13. Countertops were fixed, and repaired of any cracks, rough edges on the laminate of the sink beginning on 9-11-13 and finished on 9-13-13. An end audit was conducted by key employee Troy Sparks Co-Owner, and Amy Sparks Co-Owner to ensure accuracy and compliance was achieved on all counter tops that had been identified in the audit. Troy Sparks and Amy Sparks had no negative findings. They reported to Executive Director Jill Brown on 9-13-13 that all counter tops were repaired.</p> <p>Our facility plans to monitor counter tops by weekly QA checks. Checks will ensure that resident's counter tops are free from cracks and rough edges on the laminate of the sink. This monitoring will be conducted by Amy Sparks Co-Owner, and or designee. All information will be reported back to Quality Assurance Committee each week for compliance.</p> <p>Additionally counter tops have also been added to monthly maintenance inspection checklist for each resident room. Maintenance checklist will be completed each month by a member of maintenance and or designee, and reported to the quality assurance committee. New Maintenance Inspection Checklist was updated on 8-23-13. Under the direction of Marlin Sparks, Administrator Chris Brown, Compliance Director educated Marty Bradshaw Maintenance Department on completing the checklist on 8/23/13.</p>	

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F 253	Continued From page 4 stains on the resident's vest and had not replaced the vest with a clean one. Interview with the DON on 08/22/13, at 5:15 PM revealed direct care staff was responsible to replace the support vest when soiled. The DON stated she had adjusted the resident's vest on occasion on 08/20-21/13, but had not noticed the stain on the front of the resident's vest.	F 253	Resident #6 torso support was cleaned on 8/21/13 when Executive Director Jill Brown identified the stain when making rounds in the lobby. CNA#1 and CNA#2 were verbally counseled on posey support vest/cleaning and disinfection of resident-care items and equipment.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure one of nineteen sampled residents (Residents #6) who were unable to carry out activities of daily living (ADL) received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The facility failed to provide nail care for Resident #6. Observations on 08/20/13 and on 08/21/13 revealed Resident #6 had long jagged fingernails with a dark brown substance underneath the resident's fingernails. The findings include: Review of the facility Nail Care policy (no date) revealed all residents' nails would be kept clean on a daily basis and trimmed as necessary. The	F 312	A facility audit was conducted of all resident care items and equipment with no negative findings. The audit was conducted by Executive Director Jill Brown on 9-9-13. The policy for cleaning/disinfecting of lap buddies was implemented on 9/10/13. Please see attached. Employees were educated on 9-13-13 on cleaning of resident care items and equipment, and given information to the new changes to the facility policy. SRNA's were trained by RN, Rose Mackenzie, LPN's and RN's were trained by DON & RN Miranda Ruggles. Housekeeping & Laundry staff were trained by Amy Sparks, Co-owner. Each resident that has a lap buddy, foam belt, or torso support will be checked Q shift for cleanliness, condition and placement. Please see attached. The facility will monitor its progress weekly. A member of the nursing staff will continue to check QA tool labeled Dignity. Resident care item's has been added to the list please see attached. All information will be shared and reported to the quality assurance committee.	

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F 312	<p>Continued From page 5</p> <p>policy noted all nails would be trimmed by the nursing assistants except for the diabetic residents and these would be trimmed by the licensed nurse.</p> <p>Review of the medical record revealed the facility admitted Resident #6 on 12/17/08 with diagnoses that included Closed Femur Fracture, Anemia, Hyperlipidemia, Bell's Palsy, and Degenerative Lumbar Disc Disease. Review of the quarterly assessment dated 08/09/13 revealed the facility assessed Resident #6 to be cognitively impaired and not interviewable. The resident was also assessed to require total staff assistance with personal hygiene and bathing needs. Review of the comprehensive care plan with a revision date of 08/20/13, revealed the facility addressed a self-care deficit problem for Resident #6. Interventions included shampoo and nail care on bath days and as needed.</p> <p>Resident #6 was observed on 08/20/13, at 12:20 PM, 1:45 PM, 3:10 PM, 3:50 PM, and 5:15 PM, to have long jagged fingernails with a dark brown substance underneath the resident's fingernails. The resident was again observed on 08/21/13, at 8:40 AM, 9:20 AM, 10:15 AM, and 12:45 PM, with long dirty fingernails. Additional observation conducted on 08/22/13, at 9:30 AM, revealed the resident's fingernails were still long with the dark brown substance present underneath the resident's fingernails.</p> <p>Interview with Certified Nurse Aide (CNA) #1 on 08/21/13, at 12:55 PM, revealed she had been assigned to Resident #6 on 08/21/13. CNA #1 stated she checked the resident's fingernails during the morning on 08/21/13 and did not identify a problem with the resident's fingernails.</p>	F 312	<p>All corrective action completed on or before 9/13/13.</p> <p>F312</p> <p>Resident #6 had nail care performed on 8-23-13. Nails were cleaned underneath with an orange stick; nails were trimmed with nail clippers and filed with emery board. SRNA's # 1, 2 & 6 were counseled and educated on proper nail care on 9/10/13. Additionally charge nurses witnessed nail care provided by SRNA's #1, 2, & 6 and found after training the SRNA were capable of carrying out tasks completely and accurately.</p> <p>An audit was conducted on identify other residents that needed nail care on 9/9/13. Jill Brown Executive Director instructed each charge nurse to check each resident and have staff provide nail care if necessary. On 9/10/13 Jill Brown, Executive Director and Marlin Sparks Administrator checked to ensure all residents had proper clean nail care. Mr. Sparks and Ms. Brown had no negative findings on 9/10/13.</p> <p>Policy was updated on "Care of Fingernails/Toenails" on 9/9/13. Staff was educated on nail care of fingernails and toenails and advised of the new policy on 9/13/13. SRNA's were trained by RN, Rose Mackenzie, LPN's and RN's were trained by DON & RN Miranda Ruggles. Please see attached. Nurses were educated that nail care needed to be documented on skin</p>	

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F 312	Continued From page 6 CNA #1 stated she did see the fingernail length and dark brown substance under the resident's nails when assisting with a skin assessment on 08/21/13 at 10:55 AM, but had not cleaned/trimmed the resident's fingernails. CNA #1 stated the resident's fingernails should have been trimmed and cleaned. Interview conducted with CNA #2 on 08/22/13, at 9:30 AM, revealed she had cared for Resident #6 on 08/20/13. CNA #2 stated the nurse aides were responsible to check the resident's fingernails daily and to trim/clean the nails as needed. CNA #2 stated she did not check the resident's fingernails on 08/20/13 and did not provide nail care for the resident. The CNA stated she had not provided nail care for Resident #6 because she had not checked the resident's fingernails on 08/20/13. Interview conducted with the Director of Nursing (DON) on 08/22/13, at 5:15 PM, revealed the nurse aides were responsible to check the residents' fingernails daily and to clean the residents' nails at least daily. The DON stated she conducted daily resident rounds to observe for resident care needs and occasionally identified long nails and would direct staff to trim/clean the resident's nails.	F 312	observation assessments that are completed each week for every resident. The facility will monitor progress weekly by continuing to check residents nail condition. Rose McKenzie and or designee will be checking nursing documentation of nail care documentation & observation on the weekly skin assessment. All information will be submitted to the quality assurance committee. **Although Surveyors and Facility didn't identify problems with oral care; facility trained and educated on oral care on 9/13/13. Education was presented by Peggy Lindsey PHDCCC-SLP. Facility policy was updated on 9/10/13. Additionally, facility will monitor weekly by checking condition of oral cavity documented on skin observation assessment. All information will be communicated to the quality assurance committee. Please see attached. Facility wanted to satisfy all requirements in F312, including personal and oral hygiene. ** All corrective action completed on or before 9/13/13.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	F315 Resident's #2, 8 & 11 were given proper perineal care on 8/21/13 after surveyor observation revealed deficient practice. Resident #3 was given proper perineal care and Foley catheter holder was positioned on 8/21/13 after surveyor observation revealed deficient practice.	

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F 315	<p>Continued From page 7</p> <p>who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide appropriate treatment and services to prevent urinary tract infections for four of eighteen sampled residents (Residents #2, #3, #8, and #11). Observations revealed after performing bowel incontinence care for Resident #2 staff proceeded to provide indwelling catheter care without changing gloves or cleansing hands. Observation of incontinence care for Residents #8 and #11 revealed staff failed to provide perineal care after soiled briefs were removed. Further, a review of the facility policy for indwelling urinary catheters revealed urinary catheters would be secured with a leg strap to reduce friction and movement at the insertion site. Observation of Catheter care for Resident #2 revealed the residents indwelling urinary catheter was not secured.</p> <p>The findings include:</p> <p>A review of the facility policy titled "Catheter Care," (dated 10/12/12) revealed staff would utilize standard precautions when handling or manipulating the drainage system and maintain clean technique.</p> <p>A review of the facility policy titled "Incontinence Care," (dated 10/12/12) revealed staff was to provide perineal care after brief changes.</p>	F 315	<p>SRNA's # 3, 4, 5, & 8 were counseled and educated on proper perineal/catheter care. Additionally charge nurses Steve Godbey LPN & Marilyn Cox LPN witnessed perineal, incontinence & catheter care provided by SRNA's #3, 4, 5 & 8 and found after training the SRNA were capable of carrying out tasks completely and accurately. Please see attached.</p> <p>An audit was conducted on identify other residents that needed perineal or catheter care on 9/10/13. Jill Brown Executive Director instructed charge nurses Chasity Wilson LPN, and Starr Brown LPN to check each resident and have staff licensed provide perineal and or catheter care if necessary providing any education if needed. No negative findings were reported to Executive Director, Jill Brown.</p> <p>Facility policy on perineal care & catheter care was updated on 9/10/13. Staff was educated and trained on perineal care, incontinence care & catheter care. SRNA's were trained by RN, Rose Mackenzie, LPN's and RN's were trained by DON & RN Miranda Ruggles.</p> <p>New QA tool will monitor Foley catheter leg bank Q shift for proper fit and placement. When leg band are changed if soiled prn. Integrity changes of skin under leg bands Q shift. Please see attached.</p> <p>QA tools have been revised to include monitoring of weekly licensed staff's performance of perineal during</p>		

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F 315	<p>Continued From page 8</p> <p>A review of the facility's Catheter Changing policy (dated 10/12/11) revealed urinary catheters would be secured with a leg strap to reduce friction and movement at the insertion site.</p> <p>1. A review of Resident #2's medical record revealed the facility admitted the resident on 02/06/12, with diagnoses including Left Renal Cyst, Urinary Retention, and Hypertension. A review of Resident #2's Quarterly Minimum Data Set assessment dated 08/04/13 revealed the facility had assessed the resident to be always incontinent of bowel and utilized an indwelling catheter for bladder drainage.</p> <p>On 08/21/13 at 2:18 PM, an observation revealed Certified Nursing Assistant (CNA) #5 cleaned fecal matter from Resident #2's buttock area. CNA #5 while wearing the same gloves obtained a clean cloth and performed indwelling catheter care for Resident #2 without changing gloves or cleansing her hands.</p> <p>CNA #5 stated in interview on 08/22/13 at 9:42 AM that she should have changed gloves and washed her hands after providing incontinence care to Resident #2 and prior to initiating indwelling catheter care.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 08/22/13 at 9:58 AM revealed she was responsible to assist CNAs performing indwelling catheter care as needed and observe care being performed on a routine basis. However, LPN #3 stated she had not identified any concerns related to hand hygiene. The LPN stated changing gloves and cleansing hands would be required between incontinence and indwelling catheter</p>	F 315	<p>observation. Also new SRNA's are observed by qualified nursing staff performing perineal and catheter care during their initial orientation. The Nursing Services QA tool has been revised to include monitoring of SRNA performance of perineal care on-going. Please see attached. All information will be reported back to the quality assurance committee.</p> <p>All corrective action completed on or before 9/13/13.</p> <p>F364</p> <p>On 8/20/13 all fourteen residents that received an order for pureed consistency diets were given new supper trays.</p> <p>The facility recognizing current 14 residents have an order for pureed diet had the potential to be affected, immediately took action. On 8/26/13 new thermometers were ordered and put into service use on 8/28/13. Meeting with Dietary Manager and Dietitian Brittany Terrell identified methods related to flavor, appearance and proper temperature. Food temperature will be tested in 30 minutes intervals through -out serving line.</p> <p>On 9/10/13 an additional QA tool was implemented to ensure each meal everyday was being checked for food palatability for pureed ordered diets. Facility will continue to use QA tool to monitor temps of all food and drink. Please see attached. All</p>		

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F 315	<p>Continued From page 9 care.</p> <p>Interview with the Director of Nursing (DON) on 08/22/13 at 10:04 AM, revealed CNAs are expected to provide indwelling catheter care per facility policy, including changing gloves and cleansing hands between providing incontinence and indwelling catheter care. The DON stated the nurses are responsible for observing CNAs provide indwelling catheter care and report any identified concerns to her. Subsequently, the DON stated training would be provided to the CNAs as needed.</p> <p>2. Observation of incontinence care on 08/21/13 at 9:00 AM revealed Resident #8 was taken to the bathroom and a soiled wet brief was removed. Resident #8 was allowed to sit on the commode and finish a bowel movement. CNAs #3 and #4 wiped Resident #8 with toilet paper after the resident finished having a bowel movement. CNAs #3 and #4 failed to provide perineal care to Resident #8 prior to applying a new brief.</p> <p>3. Observation of incontinence care for Resident #11 on 08/21/13 at 8:45 AM revealed Resident #11 was taken to the bathroom and a wet brief was removed. Resident #11 was placed upon the commode and the resident finished urinating. CNA #3 and CNA #4 failed to provide perineal care prior to applying a new brief.</p> <p>Interview with CNA #3 and CNA #4 on 08/21/13 at 3:10 PM revealed the CNAs said perineal care should have been provided to Resident #8 and Resident #11 prior to applying a new brief on Residents #8 and #11. CNA #3 and CNA #4 said they had been taught to provide perineal care to</p>	F 315	<p>information will be submitted to Quality Assurance Committee weekly and monthly.</p> <p>Dining Room assignments were updated on 9/12/13 to help with efficiency and accuracy ensuring resident receive trays timely with proper temperature and food is palatable.</p> <p>On 9/13/13 Dietary Staff were educated on proper temperature control, holding hot foods, cooking temperatures, tray temperature, keeping food out of the danger zone, proper food serving, appearance and taste of food, tasting all foods before serving to residents, staff communication with nursing. Dietitian Brittany Terrell educated Sarah Cassino DM. Sarah educated dietary staff.</p> <p>All corrective action completed on or before 9/13/13.</p> <p>F428</p> <p>Gradual Dose Reduction and medication regimen review was conducted for resident's #6, 7 & 15 on 9/9/13.</p> <p>Joyce Andros RN, ADON and Kourtney Shewmaker PharmD, Consultant Pharmacist identified other residents that also needed Gradual Dose Reduction on 9/9/13 thru documentation review of all residents. Pharmacist Consultant Pharmacist Shewmaker was in facility and prepared regimen review and suggestion for physicians on 9/9/13.</p>	

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F 315	<p>Continued From page 10</p> <p>residents. CNA #3 and CNA #4 said they were in a hurry and did not provide the perineal care.</p> <p>Interview with the Charge Nurse from B Hall on 08/22/13 at 4:15 PM revealed incontinence care was observed occasionally by the charge nurse upon rounds. The charge nurse stated that if any problems were identified during incontinence care the problem was addressed immediately. The charge nurse stated perineal care should have been performed on Resident #8 and Resident #11, and did not know why the CNAs did not provide the perineal care.</p> <p>Interview with the Director of Nursing (DON) on 08/22/13 at 5:30 PM revealed perineal care should be provided after every incontinence episode with any resident that was wearing a brief. The DON stated during rounds observations of staff performing incontinence care were made. If any problems were identified the problem was addressed immediately.</p> <p>4. A review of the medical record for Resident #3 revealed the facility admitted the resident on 01/25/13 with diagnoses including Urinary Retention, Acute Kidney Injury, Hypertension, and Renal Failure. A review of Resident #3's Quarterly Minimum Data Set assessment dated 07/17/13 revealed the facility had assessed the resident to be always incontinent of bowel and utilized an indwelling catheter for bladder drainage.</p> <p>A review of physician's orders for Resident #3 dated 08/01/13 revealed an order for the resident to have an indwelling urinary catheter to bedside drainage.</p>	F 315	<p>On 9/5/13 Executive Director, Jill Brown had a meeting with Pharmacist and Owner of the Medicine Shoppe (the facilities pharmacy) under the direction of Administrator Marlin Sparks. In the meeting Ms. Brown educated Ms. Coyle on F428 and the importance of GRD and medication regimen review. Ms. Coyle was going to educate Ms. Shewmaker.</p> <p>RN, ADON Joyce Andros will check monthly for compliance and report all findings to quality assurance committee.</p> <p>All corrective action completed on or before 9/13/13.</p> <p>F441</p> <p>On 8/22/13 Resident #2 was given proper incontinence care following the facility policy and procedures after surveyor identified CNA #5 in deficient practice. On 8/22/13 Resident #4 was given proper incontinence care following the facility policy and procedures after surveyor identified CNA #6 in deficient practice.</p> <p>An audit was conducted on 9/10/13 to identify other residents that could be affected by infection control care. Jill Brown Executive Director instructed each charge nurse Chasity Wilson, LPN and Starr Brown, LPN to witness staff providing direct care to residents. Specifically perineal care, catheter care, incontinence care but not limited to and educate staff if necessary. No negative findings were reported.</p>		

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F 315	<p>Continued From page 11</p> <p>Observation on 08/21/13 at 1:30 PM revealed CNA #7 providing urinary catheter care for Resident #3. Observation during urinary catheter care revealed Resident #3 had some redness of the penis, with a small amount of bleeding from the foreskin. Observations also revealed the catheter tubing was not secured.</p> <p>An interview conducted with CNA #7 on 08/21/13 at 2:25 PM revealed she had been employed by the facility for one month. CNA #7 stated she had no orientation on catheter care but was in-serviced on peri-care and catheter care two weeks ago. CNA #7 stated she had not seen anything to secure catheter tubing for residents during her employment at the facility. CNA #7 stated Resident #3's penis was always red and raw with some bleeding.</p> <p>An interview conducted with CNA #8 on 08/21/13 at 2:50 PM revealed she had been employed by the facility for 17 years. CNA #8 revealed she was not instructed to secure catheter tubing with a leg strap. CNA #8 revealed she was in-serviced on catheter care and peri-care approximately one month ago. CNA #8 stated she has observed Resident #3 masturbating and contributed this to the cause of the red, raw penis.</p> <p>An interview conducted with the DON on 08/22/13 at 5:10 PM revealed she was aware of Resident #3's red, raw penis. The DON revealed she had gotten reports from staff that Resident #3 had been observed masturbating and contributed that to the reason for the red, raw penis. The DON revealed that the facility had leg straps for securing catheters but was not aware they were not utilized for all residents.</p>	F 315	<p>On 9/10/13 SRNA #5 was verbally educated and counseled on incontinence care, catheter care, and proper policy pertaining to infection control. On 9-10-13 SRNA #6 was verbal educated and counseled on perineal care, and proper policy pertaining to infection control. Additionally charge nurses Steve Godbey LPN & Marilyn Cox LPN witnessed direct care of SRNA's and reported SRNA's capable of duties. Also new SRNA's are observed by qualified nursing staff performing care during their initial orientation.</p> <p>On 9/13/13 SRNA's were trained by RN, Rose Mackenzie, LPN's and RN's were trained by DON & RN Miranda Ruggles employee reviewed and were educated on facility infection control.</p> <p>Facility plans to continually monitor each antibiotic and urinary tract infection. Currently each antibiotic that is ordered is tracked and trended by DON and or designee. Tracking is completed by highlighting resident's room on facility map. This is performed to help the facility identify the need for continued education of hand washing, infection control etc. and to, encourage fluids. Furthermore each urinary tract infection is captured on a current QA tool under nursing and will be continued to be used. All information will be completed weekly, and all results will be submitted to the quality assurance committee.</p>	

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F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure foods were palatable and at the proper temperature for residents on the A Hall of the facility for the evening meal on 08/20/13. A test tray conducted for a pureed tray on 08/20/13 revealed food items were not palatable and not at the appropriate temperature. Fourteen residents received ordered pureed consistency diets which dietary staff had added thickener to, altering the taste of the pureed foods.</p> <p>The findings include:</p> <p>Review of the Minimum Temperature at Point of Service policy (no date) revealed the minimum temperature of the food at point of service to the resident for casserole dishes and vegetables should be greater than 115-125 degrees and milk should be below 45 degrees when served to the resident.</p> <p>Observation of the evening meal on 08/20/13 revealed an open cart containing 14 trays was transported from the kitchen to the A Hall of the facility at 6:17 PM. The last tray was intercepted at 6:47 PM (30 minutes later) and food</p>	F 364	<p>All corrective action completed on or before 9/13/13.</p> <p>The facility was in substantial compliance on September 14, 2013.</p>	

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F 364	<p>Continued From page 13</p> <p>temperatures were obtained with facility staff. The temperature of the pureed beef pasta casserole was 104 degrees Fahrenheit, the pureed broccoli was 92 degrees Fahrenheit, and the nectar-thickened chocolate milk was 60 degrees Fahrenheit. The casserole was tepid to taste and was bland and very starchy tasting with limited seasoning. The broccoli was cold to taste with no seasoning and a "glue" taste was also noted; the chocolate milk tasted warm. The test temperatures of the tray were verified by the facility staff.</p> <p>Interview conducted during the group interview on 08/20/13, at 3:00 PM, revealed Resident B complained of occasional cold food items.</p> <p>Interview with the Dietary Manager (DM) on 08/22/13, at 10:10 AM, revealed she had been the DM for approximately one month. The DM stated she monitored tray delivery usually during the breakfast meal once per week. However, the DM stated she had not monitored the food temperatures or tray delivery during the evening meal. The DM stated dietary staff had added thickener to the casserole and broccoli during the evening meal on 08/20/13 and the thickener altered the taste of the pureed foods. The DM stated she had previously tasted the pureed foods and was aware the taste was altered by the thickener but had not addressed this problem to ensure foods were palatable for the residents. The DM stated the trays should be delivered to the residents within ten minutes. In addition, the DM stated she was not aware of any resident complaints related to cold food.</p> <p>Interview with the Director of Nursing (DON) on 08/22/13, at 5:15 PM, revealed she "sporadically"</p>	F 364			

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F 364	Continued From page 14 monitored tray delivery to ensure trays/meals were delivered in a timely manner. The DON stated trays should be delivered within 30 minutes after the cart is delivered from the kitchen area.	F 364			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the consultant pharmacist reported drug irregularities to the attending physician and the Director of Nursing in regard to recommendation for a Gradual Dose Reduction (GDR) for three of eighteen sampled residents (Residents #6, #7, and #15). Although Residents #6 and #15 routinely received antipsychotic medications, there was no evidence the pharmacist had reviewed the medication regimen for the use of the psychotropic medications or that the pharmacist had recommended a GDR for these medications. In addition, Resident #7 received Depakote without monitoring levels and the pharmacist failed to recommend monitoring of the Depakote levels.	F 428			

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F 428	Continued From page 15 The findings include: Review of the facility's Medication Regimen Review policy (dated 10/12/11) revealed the consultant pharmacist (RPh) would perform a medication regimen review for each resident in the facility to ensure medications were used appropriately and to prevent or minimize adverse consequences related to medication therapy to the extent possible. The policy further noted the RPh would provide a written, signed, and dated copy of the report listing the irregularities found and the recommendations for their solutions. 1. Review of the medical record for Resident #6 revealed the facility admitted the resident on 12/17/08 with diagnoses that included Mental Disorder, Agitation, Depression, Dementia, Anxiety, and Psychosis. Review of the August 2013 physician's orders revealed the physician had prescribed Zoloft (antidepressant) 25 mg to be administered daily, Remeron (antidepressant) 15 mg at bedtime, Ativan (antianxiety) 0.5 mg daily, and Depakote (mood stabilizer) 250 mg twice a day. Review of the quarterly comprehensive assessment dated 08/09/13, revealed the facility assessed Resident #6 to be cognitively impaired and not interviewable. The resident was assessed to exhibit indicators of delirium (inattentiveness and disorganized thinking). Mood indicators were assessed as little interest/pleasure in doing things, poor appetite, trouble concentrating on things, and being short-tempered or easily annoyed. Resident #6 was also assessed to have physical and verbal behaviors one to three days during the	F 428			

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F 428	<p>Continued From page 16</p> <p>assessment reference period and resistance to care one to three days during the assessment reference period.</p> <p>Further review of the medical record revealed the consultant pharmacist had conducted a monthly medication regimen review for Resident #6 from 07/11/12 through 08/15/13. However, there was no evidence the pharmacist had identified the use of the psychotropic/psychoactive medications for Resident #6 during this timeframe and no evidence the pharmacist had recommended a dosage reduction attempt for either of the medications administered routinely to the resident.</p> <p>Interview with the Facility Nurse Consultant on 08/21/13, at 1:20 PM, revealed she was responsible to review the medical record after the consultant pharmacist conducted the monthly medication regimen review. The nurse consultant stated she was also responsible to send any pharmacy recommendations to the physician for review. The nurse consultant further stated she relied on the pharmacist to conduct the review of all psychoactive medications and to make recommendations for GDR of these medications.</p> <p>Interview with the facility RPh on 08/22/13, at 11:05 AM, revealed she was responsible for conducting monthly medication regimen reviews for residents at the facility. The RPh stated she "focused" primarily on psychotropic medications and did not believe GDR was required for the antidepressant/antianxiety medications.</p> <p>2. Review of the medical record for Resident #15 revealed the facility admitted the resident on</p>	F 428			

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F 428	<p>Continued From page 17</p> <p>05/13/08 with diagnoses that included Insomnia, Dementia, and Bipolar Disorder. Review of the August 2013 physician's orders revealed Resident #15 was prescribed Zyprexa (Bipolar/Schizophrenia) 10 mg daily and Ativan (antianxiety) 1 mg twice a day routinely. In addition, Ativan 0.5 mg was also ordered to be administered twice a day as needed.</p> <p>Review of the significant change comprehensive assessment (MDS) dated 06/10/13, revealed the facility assessed Resident #15 to have no delirium, no behaviors, and a depression score of 3, which indicated minimal symptoms of depression. The resident was further assessed to have a Brief Interview for Mental Status (BIMS) score of 14 and no changes were identified in the resident's behavioral symptoms.</p> <p>Further review of the medical record revealed the consultant pharmacist had conducted a monthly medication regimen review for Resident #6 from 07/11/12 through 08/15/13 and no irregularities were identified. There was no evidence the pharmacist had identified the use of the psychotropic/psychoactive medications for Resident #6 during this timeframe and no evidence the pharmacist had recommended a dosage reduction attempt for either of the medications administered routinely to the resident.</p> <p>Interview with the facility RPh on 08/22/13, at 11:05 AM and 5:35 PM, revealed she was responsible for conducting monthly medication regimen review for residents at the facility. The RPH stated she had "focused" primarily on psychotropic medications and did not believe GDR was required for the antianxiety</p>	F 428			

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F 428	Continued From page 18 medications. The RPh further stated she had not made any recommendations for GDR attempts for any resident who had a psychiatric diagnosis. 3. Review of the medical record for Resident #7 revealed the facility admitted the resident on 03/19/12 with diagnoses that included Alzheimer's Dementia, Dementia with Delusions, Behavior Disturbances, and Bipolar Disorder. A review of the August 2013 physician's orders revealed Resident #7 was prescribed Depakote (mania) 250 mg daily at 3:00 PM. Further review of the medical record revealed Resident #7 had been on Depakote since 04/06/12 with no evidence that a Depakote level had been obtained. Review of the medical record revealed the consultant pharmacist had conducted a monthly medication regimen review for Resident #7 from 07/11/12 through 08/15/13 and no irregularities were identified. There was no evidence the pharmacist had identified that Resident #7 was taking Depakote. Interview with the facility RPh on 08/22/13, at 11:05 AM, revealed she was responsible for conducting monthly medication regimen reviews for residents at the facility. The RPh stated she did not remember if a Depakote level had been recommended for Resident #7.	F 428			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423		
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F 441	<p>Continued From page 19</p> <p>to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens 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 facility policy, the facility failed to ensure an infection control program, to prevent</p>	F 441			

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F 441	<p>Continued From page 20</p> <p>the development and transmission of disease/infection, was maintained for two of eighteen sampled residents (Residents #2 and #4) and one unsampled resident. Staff was observed to place a soiled washcloth against a new open area on Resident #2's coccyx. Staff was also observed to place a clean washcloth on the contaminated draw sheet before providing incontinence care for Resident #4.</p> <p>The findings include:</p> <p>Review of the facility's General Guidelines for Incontinence Care policy (dated 10/12/11) revealed soiled linen is to be placed into a designated container. Further review of the General Guidelines revealed that clean equipment is to be placed on the bedside table or overbed table.</p> <p>1. Review of the medical record revealed the facility admitted Resident #2 on 02/06/12, with diagnoses including Bullous Pemphigoid, Left Renal Cyst, Urinary Retention, and Alzheimer's. Review of the Minimum Data Set (MDS) dated 08/04/13, revealed that Resident #2 had an indwelling catheter and was incontinent of bowel. Observation of incontinence care conducted on 08/21/13, at 2:18 PM, revealed a new open area was present on Resident #2's coccyx area. Certified Nursing Assistant (CNA) #5 was observed to place all equipment for incontinence care on the bedside table. This equipment included a plastic bag for the soiled linens. After CNA #5 provide incontinence care, she laid the soiled (with feces and urine) washcloths on the bed against the open area on Resident #2's coccyx.</p>	F 441		

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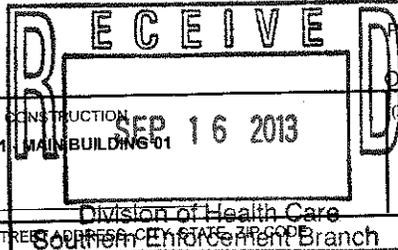
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2013
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F 441	<p>Continued From page 21</p> <p>Interview with CNA #5 on 08/22/13, at 9:42 AM revealed she should have put the dirty washcloths into a plastic bag. CNA #5 said she was unaware she had placed the soiled washcloth against the open area on Resident #2's coccyx.</p> <p>2. Review of the medical record revealed the facility admitted Resident #4 on 06/05/12, with diagnoses including History of Cardiovascular Accident, Left Sided Weakness, Seizures, and Hypertension. Review of the MDS dated 05/23/13, revealed Resident #4 was frequently incontinent of bladder and always incontinent of bowel. Observations conducted of incontinence care on 08/21/13, at 2:37 PM, revealed CNA #6 prepared all supplies for incontinence care and proceeded to lay the clean wet washcloths on the dirty draw sheet where Resident #4 had been lying. CNA #6 continued to provide incontinence care for Resident #4 using the clean washcloths that had been laid on the soiled draw sheet. After incontinence care, CNA #6 disposed of the soiled washcloths and dirty draw sheet in a plastic bag she had hanging on the edge of the bedside table.</p> <p>Interview with CNA #6 on 08/22/13, at 9:47 AM revealed she was trained to put all clean equipment on the bedside table or a washbasin on the bedside table could be used. The CNA said she couldn't remember where she had placed the clean washcloths and stated, "If I laid them on the resident's bed, they were contaminated, and I should have put them into the dirty linen and got clean ones."</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 08/22/13, at 9:58 AM revealed that she makes</p>	F 441		

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F 441	<p>Continued From page 22</p> <p>rounds daily, watching CNAs provide incontinence care and assisting when needed. CNAs are to put dirty washcloths into plastic dirty linen bags. LPN #3 said that clean washcloths should be placed on clean linen, like a dry towel on the bedside table. She stated that she hadn't observed any problems with disposing of soiled linens or the placement of clean linens. If there was a concern, nursing staff would report it to the Director of Nursing and retraining would be initiated.</p> <p>Interview with the Director of Nursing (DON) on 08/22/13, at 10:04 AM, revealed the facility had an in-service this past Friday, 08/16/13 on peri-care. The DON said that the facility had continual training on different areas of resident care and the DON was preparing another in-service on peri-care at this time. The DON also stated random observations were conducted of staff performance during incontinence care and no problems had been identified.</p>	F 441			

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1990 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: 1 story, Type III (200) SMOKE COMPARTMENTS: 6 FIRE ALARM: Complete automatic fire alarm system. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system. GENERATOR: Type II diesel generator. A life safety code survey was initiated and concluded on 08/20/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.	K 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA	K 052	K052 On 8/21/13 facility called fire sprinkler Alarm Company to notify the company of deficient programming to system doors. On 8/22/13 fire sprinkler Alarm Company was in facility and successfully reprogrammed fire alarm system and 4 doors. The new programming allows the doors NOT to be able to be held open while the fire alarm is silenced per NFPA standards. This reprogramming affected the entire facility and all facility fire/smoke barrier doors were corrected on 08/22/13. Fire Alarm Service Company will check quarterly during inspection that doors will not hold open when system is silenced per NFPA standards. All findings will be reported to the quality assurance committee. The facility was in substantial compliance on September 14, 2013.	

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

[Handwritten Signature]

[Handwritten Signature]

(X6) DATE
9-16-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 052	<p>Continued From page 1</p> <p>72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 90 beds with a census of 88 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 08/20/13, at 2:20 PM with the Director of Maintenance (DOM), a test of the facility fire alarm system revealed the fire/smoke barrier doors would close when the alarm was activated but could be reset while in the silent mode to the open position. The doors should not reset to the open position until the fire alarm is reset and showing normal conditions.</p> <p>An interview with the DOM on 08/20/13, at 2:20 PM revealed he was not aware the fire/smoke barrier doors should not be able to be reset while the fire alarm system is still showing fire</p>	K 052			

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K 052	Continued From page 2 conditions. The findings were revealed to the Administrator upon exit. Reference: NFPA 72 (1999 Edition). 3-9.6.3 All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with 3-9.2.	K 052			