

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

PRINTED: 07/24/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185171	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/10/2015
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NAME OF PROVIDER OR SUPPLIER  PARKVIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 544 LONE OAK RD. PADUCAH, KY 42003
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F 000	INITIAL COMMENTS  A Recertification/Abbreviated Survey (KY#23475) was conducted on 07/07/15 through 07/10/15 with deficiencies cited at the highest Scope and Severity of an "E". KY#23475 was substantiated with deficiencies cited.	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and / or executed solely because it is required by law the provision of Federal and State laws."	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to promote care for residents in a manner that maintains and enhances residents' dignity and respect for two (2) of thirty (30) sampled residents (Residents #13 and #15), and for three (3) unsampled residents (Residents A, D, and E). Observations revealed Unsampled Residents D and E were transported through the front lobby in a shower chair with parts of their bodies exposed to other residents, staff and visitors; staff were feeding Resident #15 and Unsampled Resident A while standing, and staff failed to wash Resident #13's face when there was a black substance on his/her lips and surrounding his/her mouth.  The findings include:  Review of the facility's policy titled, "Dignity", dated 2008, revealed all residents should be	F 241	1. Resident #13's face was cleaned of the black substance on 7/8/15 after brought to our attention. Resident's # 15 and A were fed their next meal appropriately with the staff sitting beside them at eye level. Resident's # D and E were completely covered for their baths after the inservice with the C.N.As by 8/9/15. 2. All residents deserve to have care delivered that promotes dignity and respect. Education provided to all staff by 8/9/15. 3. C.N.As were inserviced by the Executive Director on 7/24/15 to include caring for residents with individuality to promote dignity and respect. Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Exec Director* (X6) DATE: *8-21-15*

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 241	<p>Continued From page 1</p> <p>treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality. Treating residents with dignity and respect maintains and enhances each resident's self worth and improves his or her psychosocial well-being and quality of life. Assist residents' in daily care in a dignified manner (i.e. making sure residents are not exposed).</p> <p>Review of the facility's undated bathing policy titled, "Bathing a Resident", revealed multiple steps including Step #11: Assist the resident into the bath chair if needed. Make sure the wheels on the bath chair are locked and/or the chair is steady to prevent the resident from falling. Step #12: Cover the resident from the neck down with the bath blanket. Step #14: Transport the resident to the bath area. Put "Bath in Progress" sign on the outside of the door.</p> <p>1. Record review revealed the facility admitted Resident #13 on 11/12/09 with diagnoses which included Osteoarthritis and Osteoporosis. Review of the annual Minimum Data Set (MDS) assessment, dated 04/21/15, revealed the facility assess Resident 13's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of zero (0), which indicated the resident was not interviewable.</p> <p>Observation of Resident #13, on 07/08/15 at 11:02 AM and 12:00 PM, revealed the resident had a black colored substance on his/her lips and surrounding his/her mouth.</p> <p>Interview with Resident #13's son, who was at bedside, on 07/08/15 at 2:05 PM, revealed he came to visit Resident #13 and when he entered</p>	F 241	<p>All educations were completed by 8/9/15. This requirement was also added to our general orientation for new hires.</p> <p>4. Administration will interview 20 total residents per week to determine any concerns related to dignity and respect weekly for 4 weeks then 20 per month for an additional 2 months. Administration will observe 5 opportunities of an associate providing dignity and respect for non-interviewable residents (BIMS less than 8) on each hallway weekly for 4 weeks then 5 per month for an additional 2 months. The results of the interviews and observations will be brought to the QA committee (Executive Director, Asst. ED, DON, Director of Rehab, HK Supervisor, Director of HR, Business Office Manager, Maintenance Supervisor, Director of Medical Records, Social Services and ADON) to determine the need for further monitoring.</p> <p>5. Date completed:</p>	8/10/15

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F 241	<p>Continued From page 2</p> <p>his/her room, he observed a black substance on Resident #13's face, surrounding his/her mouth and on his/her lips. Resident #13's son stated it was disappointing to find his parent like this and that staff had told him it was probably medication.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 07/08/15 at 2:56 PM, revealed LPN #2 expected staff to perform hygiene care when a resident was soiled in any way and she would have expected Resident #13's face to have been cleaned during staff interactions with resident or during care being provided. LPN #2 stated she administered Resident 13's medication and Resident #13 received Ferrous Sulfate daily and had an order to have medications crushed. She stated this particular medication could have left the black residue appearance on his/her lips and mouth area due to resident's medications being crushed.</p> <p>2. Record review revealed the facility re-admitted Resident #15 on 12/23/11 with diagnoses which included Paralysis Agitans, Esophageal Reflux, Persistent Mental Disorder, Depressive Disorder, and Anxiety Disorder. Review of the quarterly MDS assessment, dated 05/27/15, revealed the facility assessed Resident #15's cognition as severely impaired with a BIMS score of zero (0), which indicated the resident was not interviewable.</p> <p>Observation of Resident #15, on 07/08/15 at 9:00 AM, revealed Certified Nurse Aide (CNA) #1 was standing over Resident #15 while feeding him/her the breakfast meal. The resident was sitting in a wheelchair at the time.</p> <p>Interview with CNA #1, on 07/08/15 at 2:55 PM,</p>	F 241			

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F 241	<p>Continued From page 3</p> <p>revealed it was inappropriate for staff to be standing up feeding a resident who was seated.</p> <p>3. Record review revealed the facility re-admitted Unsampld Resident A on 01/04/10 with diagnoses to include Acute, Ill-defined Cerebrovascular Disease, Anorexia, Late effects of Cerebrovascular Disease, and Osteoarthritis. Review of the quarterly MDS assessment, dated 07/02/15, revealed the facility was unable to assess Unsampld Resident A's cognition due to the resident being rarely/never understood, according to the coding of Section C0100. This indicated Unsampld Resident A was cognitively impaired.</p> <p>Observation of Unsampld Resident A, on 07/08/15 at 9:07 AM, revealed LPN #2 was standing over Unsampld Resident A while feeding breakfast to him/her. The resident was sitting in a wheelchair.</p> <p>Interview with LPN #2, on 07/08/15 at 2:56 PM, revealed she expected staff to sit down and feed the resident if they were going to be feeding the resident for the whole meal but it was ok for staff to stand up if the staff was in there for a short period of time trying to encourage the resident or cue the resident or get the resident back on task.</p> <p>Interview with CNA #2, on 07/08/15 at 3:05 PM, revealed she expected staff to sit while feeding a resident, not to stand up or over a resident while assisting to feed him/her.</p> <p>Interview with Unit Manager (UM) #1, on 07/08/15 at 3:10 PM, revealed she expected staff to sit down and get at eye level when providing assistance to residents with feeding/eating. She</p>	F 241		

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F 241	<p>Continued From page 4</p> <p>stated she expected staff who passed medications to be sure medication was swallowed by the residents, and if a resident had medication residue on his/her face, to be sure proper hygiene occurred.</p> <p>4. Record review revealed the facility admitted Unsampld Resident E on 06/06/13 with diagnoses which included Dysphagia, Anxiety, Essential Hypertension, Hemiplegia, Depressive Disorder, Old Cerebrovascular Accident with Left Hemiparesis, and Acute Upper Respiratory Infections. Review of the annual MDS assessment, dated 05/01/15, revealed the facility assessed Unsampld Resident E's cognition intact with a BIMS score of fourteen (14) which indicated the resident was interviewable. In addition, the resident required extensive assistance with activities of daily living.</p> <p>Observation on 07/10/15 at 9:55 AM revealed CNA #5 pushing Unsampld Resident E in a shower chair through the front lobby of the facility with a sheet only covering him from his/her shoulders to his/her knees and his lower legs exposed to staff, visitors and other residents in the lobby.</p> <p>Interview on 07/10/15 at 10:03 AM with Unsampld Resident E revealed he/she was given a shower in this manner every time he/she received a shower.</p> <p>Interview on 07/10/15 at 10:00 AM with CNA #5 revealed Unsampld Resident E was transported in this manner twice a week.</p> <p>Interview on 07/08/15 at 4:58 PM with LPN #11 revealed residents should be covered from head</p>	F 241		

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F 241	<p>Continued From page 5 to toe during shower transport.</p> <p>5. Record review revealed the facility admitted Unsampld Resident D on 05/23/08 with diagnoses which included Persistent Mental Disorder, Alzheimer's, Unspecified Non Psychotic Mental Disorder following Organic Brain Damage, and Depressive Disorder. Review of the quarterly MDS assessment, dated 05/07/15, revealed the facility assessed Unsampld Resident D's cognition as moderately impaired with a BIMs of 8 (eight) which indicated the resident was interviewable. The resident was assessed as needing extensive assistance of staff for dressing, grooming, hygiene, and bathing.</p> <p>Observation, on 07/08/15 at 3:32 PM, revealed CNA #9 pushing Resident D in a shower chair through the central lobby area of the facility from one unit to another unit where the resident resided. CNA #9 was transporting the resident at a fast pace and was talking with another staff member, ignoring the resident. The resident was dressed in a hospital gown and his/her legs were straight out in front of the resident with the majority of the resident's legs uncovered and exposed to visitors, staff, and residents that were in the lobby area. There was no sheet or bath blanket covering the resident.</p> <p>Interview was attempted with Unsampld Resident D, on 07/08/15 at 3:45 PM; however, the resident did not make eye contact or respond when spoken to.</p> <p>Interview with CNA #9, on 07/08/15 at 3:35 PM, revealed she always transports residents from one area of the facility through the lobby area in a shower chair and she places a sheet or bath</p>	F 241		

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F 241	Continued From page 6 blanket over the residents. CNA #9 stated she should have made sure the resident stayed covered and his/her body out of view of other residents, staff, and visitors in the lobby but had failed to do so.  Interview with LPN #10, on 07/10/15 at 9:30 AM, revealed CNAs transported residents in a shower chair to the shower room located on the 400 Hall from other units and the residents should be kept completely covered for dignity.  Interview with the Director of Nursing (DON), on 07/10/15 at 9:35 AM, revealed residents would be transported to the shower room from their units in the shower chair and should be provided privacy by covering the resident with a bath blanket or sheet. The DON stated the CNAs know to keep residents covered and Unsamped Resident D should have been kept covered for dignity.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who	F 278	1. An addendum was made to the MDS for resident # 29 to include a foley catheter by the MDS coordinator on 7/17/15. 2. An audit of all other residents with foley catheters was made by the MDS coordinators to ensure they had their catheters accurately coded on the MDS by 7/28/15. There were no others affected.	

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F 278	<p>Continued From page 7</p> <p>willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the Resident Assessment Instrument (RAI) 3.0 Manual, it was determined the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the status of one (1) of thirty (30) sampled residents (Resident #29) related to the failure to document the resident had a catheter.</p> <p>The findings include:</p> <p>Review of the RAI 3.0 Manual, dated May 2011, revealed when conducting an MDS Assessment staff were to speak with direct care staff from each shift who had cared for the resident to determine his/her needs. For Section H300 - if during the seven (7)-day look-back period the resident had an indwelling bladder catheter the Minimum Data Set (MDS) assessment should be coded as a nine (9).</p> <p>1. Closed record review revealed the facility admitted Resident #29 on 03/26/15 with</p>	F 278	<p>3. MDS coordinators were inserviced by the Executive Director by 8/1/15 to ensure foley catheters were accurately coded on the MDS if present during the proper time frames.</p> <p>4. MDS coordinators will monitor orders weekly for foley catheters to ensure they are accurately coded on the MDS for new admissions weekly times 4 weeks then at least 5 new admissions monthly for an additional 2 months.</p> <p>5. Completed by</p>	8/10/15

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F 278	<p>Continued From page 8</p> <p>diagnoses which included Chronic Kidney Disorder, Chronic indwelling Catheter, and Urinary Tract Infection.</p> <p>Review of the quarterly MDS assessment, dated 06/12/15, revealed the resident was coded as a three (3) for bladder indicating the resident was incontinent. Review of the seven (7) day look-back period from 06/04/15 to 06/12/15, revealed the resident had an indwelling catheter during this time frame and should have been coded a nine (9).</p> <p>Interview, on 07/08/15 at 4:10 PM, with Registered Nurse (RN) MDS Coordinator revealed the MDS for 6/12/15 should have reflected a coding on H0300 that the resident had an indwelling urinary catheter. She stated she expected if there was an order and the catheter was listed on the Medication Administration Record that it should be captured on the MDS.</p>	F 278		
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and</p>	F 279	<ol style="list-style-type: none"> <li>1. Resident #5 was re-assessed for his toileting needs and was properly careplanned and added to care guide upon completion by the Unit Manager on 7/27/15.</li> <li>2. Male residents who were assessed whose BIMS scores were between 8-15 and were physically able to use of a urinal were audited to ensure the urinal was offered and at the bedside and included on the careplan and careguide by the OT on 7/28/15.</li> </ol>	

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F 279	<p>Continued From page 9</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</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 use the results of assessments to develop a care plan for one (1) of thirty (30) sampled residents related for the use of a urinal for toileting needs (Resident #5).</p> <p>The finding include:</p> <p>Review of facility policy entitled, "RAI Process, Chapter #2 Assessment Process, last revised 03/15/07, revealed the purpose of a comprehensive assessment was to identify the resident's unique strengths, needs, preferences and potential for improvement. Family members and the resident, if able, should be involved to identify resident preferences and family expectations. Assessment information collected should be used to develop the care plan. Once staff know the resident, decisions should be made on how to best provide care to the resident. The resident and family input should be used to determine realistic expected outcomes for the care plan.</p> <p>Record review revealed the facility admitted Resident #5 on 04/27/15, with diagnoses which included Fracture of Intertrochanteric Section of Femur, Atrial-Fibrillation, Dyspepsia, Anemia and</p>	F 279	<p>3. Licensed Nurses were inserviced by the Executive Director to include identifying on the careplan the incontinence or toileting needs of the residents from the bowel and bladder assessment on 7/24/15. Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head. All educations were completed by 8/9/15. This was also added to our general orientation for Licensed Nurses.</p> <p>4. Licensed Nurses will audit new admission assessments for bowel and bladder to determine the toileting needs of the resident have been properly identified on the careplan and care guide weekly for 4 weeks then at least 5 new admissions per month for an additional 2 months. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by :</p>	8/10/15

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F 279	<p>Continued From page 10</p> <p>Acute Pharyngitis. Review of the admission Minimum Data Set assessment, dated 05/04/15, revealed the facility assessed Resident #5's cognition as moderately impaired with a Brief Interview of Mental Status (BIMs) score of eleven (11) which indicated the resident was interviewable. In addition the facility assessed the resident as continent of bladder and needing extensive assistance with activities of daily living.</p> <p>Review of Assessment for Bowel and Bladder Training, dated 04/27/15, revealed Resident #5 was a good candidate for individual training and was to proceed to urinary incontinence assessment and was continent of bowel and bladder requiring assist of one for toileting needs. Review of a Urinary Incontinence Assessment, dated 05/01/15, revealed Resident #5 was continent of bladder and required assistance for transfer in toileting and the following assistive devices to help facilitate toileting was checked: urinal, grab bars in bathroom, wheelchair, and bed rails.</p> <p>Review of the Comprehensive Care Plan, dated 05/05/15, revealed a goal for Resident #5's dignity to be maintained as evidenced by no verbal statements of embarrassment or fear of retribution through next review date. Review of Care Directive, with a print date of 07/07/15, revealed Resident #5 was one (1) assist with toileting; and his toileting program was for staff to prompt him/her to void; and to check and change. However, further review revealed there was no intervention on the care plan or Care Directive for a urinal to be available for the resident's use even though the Urinary Incontinence Assessment indicated the facility had assessed the resident as needing a urinal.</p>	F 279		

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F 279	<p>Continued From page 11</p> <p>Observation and interview with Resident #5, on 07/08/15 at 11:12 AM, revealed Resident #5 was asking his/her family member to get the urinal from the bathroom for his/her use. He/she stated the urinal should be kept at the bedside when in room for use.</p> <p>Interview with Resident #5's family member, on 07/08/15 at 11:10 AM, revealed the resident's urinal should be made available to Resident #5 by being kept at the bedside and not placed in the bathroom. He stated it needed to be accessible to the resident and it would do more harm for it to be in the bathroom because the resident could fall at night trying to go to the bathroom. He revealed staff had told him it had to be in the bathroom and in a bag, and he felt that was not convenient and safe for the resident.</p> <p>Interview on 07/09/15 at 2:15 PM with Licensed Practical Nurse (LPN) #7 and LPN #9 revealed they would want to be able to look at a care plan and know about a resident if they were not familiar with the resident.</p> <p>Interview on 07/10/15 at 8:40 AM and at 9:10 AM with LPN #4 revealed the urinal should be on the care plan because staff that was not providing care to Resident #5 all the time would not know he used a urinal and the resident does not get up to go to the bathroom all the time. LPN #4 further revealed that the urinal would help promote independence for the resident.</p> <p>Interview on 07/10/15 at 8:42 AM with MDS Nurse #1 revealed the urinal should be on the care plan and care guide for dignity reasons, and care plans were made for general used items at</p>	F 279		

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F 279	Continued From page 12 bedside.	F 279		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy and procedure and review of the Kentucky Board of Nursing (KBN) Advisory Opinion Statement (AOS) #14, it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of thirty (30) sampled residents (Resident #3). Staff failed to follow a physician's order related to not administering a Tuberculin (TB) skin test due to an allergy.</p> <p>The findings include:</p> <p>1. Review of the KBN AOS #14 Patient Care Orders, last revised 10/2010, revealed licensed nurses were responsible for administering medication and treatment as prescribed by the physician or advanced practice registered nurse.</p> <p>Review of the facility policy titled, "Allergies", not dated, revealed the purpose of the policy was to prevent anaphylaxis and to prevent all allergic reactions. Procedural steps included interviewing</p>	F 281	<p>1. The physician clarified that resident # 3 did not have an allergy to Tubercullin testing by 7/17/15. It was clarified on the careplan by the nurse on 7/27/15.</p> <p>2. All other residents were audited by the Nursing Administration to ensure all allergies were listed on the physician's order summary, the MAR , TAR and careplan by 7/19/15 and any issues were clarified at that time.</p> <p>3. Licensed Nurses were inserviced by the Executive Director to ensure services provided meet professional standards to include clarifying all allergies that relate to the residents on 7/24/15. Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head. All educations were competed by 8/9/15. This was also added to our general orientation for Licensed Nurses for new hires.</p>	

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F 281	<p>Continued From page 13</p> <p>the resident or family to determine allergies. Allergies should be recorded on resident care plan and on any other form(s) as appropriate.</p> <p>Record review revealed the facility admitted Resident #3 on 10/26/12 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Diastolic Heart Failure, Atrial Fibrillation and Malignant Neoplasm of the Prostate. Review of an Allergy List, dated 04/17/13, from another facility revealed the resident was allergic to tuberculin.</p> <p>Review of physician order sheet, dated July 2015, revealed an order with the original date of 04/01/14 stating "Do not administer PPD/2nd step PPD due to history of +PPD"; and no further orders related to TB; however, review of the TB Screening and Immunization Record, revealed staff administered a TB skin test on 02/11/13, 02/23/13, 1/14/14 and 01/19/15.</p> <p>Interview with the Registered Nurse Unit Manager, on 07/09/15 at 2:20 PM, revealed with any new admission, she would expect the staff to perform a thorough check of the chart documentation to ensure the allergy information was correctly listed. She stated the resident could have had serious adverse reactions with the administration of a medication the resident was allergic to. The staff should have identified the allergy if they had performed the five (5) medication rights.</p>	F 281	<p>4. Administrative Staff will audit new admissions weekly for four weeks then monthly times 2 additional months to determine allergies have been clarified on the physician's order sheets, the allergy sticker in the chart, MARS, TARS and careplans.</p> <p>5. Completed by :</p>	8/10/15
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in</p>	F 282	<p>1. Resident # 17 had his leg strap applied by 7/11/15. Resident #13 was gotten up for her next meal by the C.N.A per her careplan. Resident #13 was turned and repositioned every 2 hours as careplanned after notification.</p>	

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F 282	<p>Continued From page 14</p> <p>accordance with each resident's written plan of care.</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 implement care plan interventions for two (2) of thirty (30) sampled residents (Residents #13 and #17). Staff failed to secure a leg strap for a catheter for Resident #17 and failed to ensure Resident #13 was up for meals and turned and positioned every two (2) hours.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure titled, "Assessment Process", last revised 03/15/07, revealed each health-care discipline is responsible for the implementation of the action steps in the care plan.</p> <p>1. Review of the facility's policy/procedure, titled "Daily Catheter Care", not dated, revealed the catheter should be loosely taped to the resident's inner thigh to keep it from being pulled from the bladder or a catheter strap may be used with frail skin.</p> <p>Record review revealed the facility admitted Resident #17 on 03/28/14 with diagnoses which included Urinary Retention. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/13/15, revealed the facility assessed Resident #17's cognition as intact with a Brief Interview for Mental Status (BIM's) score of fifteen (15), which indicated the resident was</p>	F 282	<p>2. An audit was completed by the Unit Managers of all residents with foley catheters to ensure they each had a leg strap applied by 7/24/15. Any issues were addressed at that time. All residents were reassessed for the need to be turned and repositioned every two hours and audit of their careplan and careguide to ensure those interventions were there by Unit Managers and the OT by 8/9/15. All residents were observed or audited who desired to be up or as tolerated for meals by the Unit Managers by 8/9/15 to ensure the facility was following the care plan interventions.</p> <p>3. The Executive Director inserviced all C.NAs and Licensed Nurses on need to follow each residents care plan to include those with instructions on when to get residents up for meals, anyone with a foley catheter should have a leg strap and the need to turn and reposition residents (who are dependent) every two hours on 7/24/15. Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head. All educations were completed by 8/9/15. This information was also included in our general orientation for new Nurses and C.N.As.</p>		

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F 282	<p>Continued From page 15 interviewable.</p> <p>Review of Comprehensive Care Plan, dated 05/27/15, revealed to have a leg strap to secure catheter tubing at all times.</p> <p>Review of the Treatment Administration Record (TAR) for the month of July 2015, revealed to ensure leg strap was in place every shift and as needed (PRN). Further review of the TAR, revealed the last time it was initialed by nursing staff that it was in place was on the 7:00 PM to 7:00 AM shift on 07/07/15.</p> <p>Observations of catheter care for Resident #17 provided by Certified Nurse Aide (CNA) #4, on 07/08/15 at 2:30 PM, revealed there was no catheter leg strap in place.</p> <p>Interview with Resident #17 on 07/08/15 at 3:30 PM, revealed sometimes the leg strap was on and sometimes it was not on. The resident stated the leg strap helped to prevent the tubing being pulled.</p> <p>Interview with CNA #4, on 07/08/15 at 2:30 PM, revealed she was unsure why Resident #17 did not have a leg strap securing the catheter tubing. She stated the leg strap should be in place to prevent friction and pulling the catheter tubing from the genital area. She revealed it was the nurses responsibility to ensure the leg strap was in place.</p> <p>Interview with Registered Nurse (RN) #2, on 07/08/15 at 2:40 PM, revealed Resident #17 should of had a leg strap to secure his/her catheter tubing to prevent friction and pulling of the tubing from the genital area. She stated the</p>	F 282	<p>4. Administration will audit the following to ensure the care plan interventions are being followed: 10 catheters per week to ensure a leg strap is being utilized, 20 residents who desire to be up for meals, 10 residents who are dependent and require staff to turn and reposition them weekly for 4 weeks and then the same number monthly in total for an additional 2 months of each audit.. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by :</p>	8/10/15	

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F 282	<p>Continued From page 16</p> <p>resident was care planned for the leg strap and it was the nurses responsibility to ensure the leg strap was on the resident, because it was on the TAR. She further stated, "the nurse has to sign off at the beginning of every shift the leg strap is in place".</p> <p>Interview with the Director of Nursing (DON), on 07/09/15 at 3:20 PM, revealed she would expect the leg strap to be in place on Resident #17 to prevent friction on the genital area, and the nurses were responsible to ensure the strap was in place when they sign off on the TAR.</p> <p>2. Record review revealed the facility admitted Resident #13 on 11/12/09 with diagnoses which included Osteoarthritis and Osteoporosis. Review of the annual MDS assessment, dated 04/21/15, revealed the facility assessed Resident #13's cognition as severely impaired with a BIMS score of zero (0) which indicated the resident was not interviewable. Further review revealed Resident #13 was totally dependent upon staff for all transfers.</p> <p>Review of the Comprehensive Care Plan for Nutrition and Skin Breakdown, dated 04/29/15, revealed an intervention dated 06/18/15 for staff to feed Resident #13 and the resident was to be up for lunch and breakfast; and, an intervention to turn and reposition Resident #13 every two (2) hours while in bed and chair.</p> <p>Observation, on 07/08/15 at 9:21 AM, revealed Resident #13 was being fed breakfast by staff while Resident #13 was still in bed.</p> <p>Observations of Resident #13, on 07/08/15 at 9:11 AM, 11:02 AM, and 2:05 PM, revealed</p>	F 282		

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F 282	<p>Continued From page 17</p> <p>Resident #13 was laying down in bed on his/her left side.</p> <p>Interview with Unit Manager (UM) #1, on 07/08/15 at 03:09 PM, revealed she expected staff to follow the care plans for each resident.</p> <p>Further interview with the DON, on 07/09/15 at 3:20 PM, revealed she expected staff to follow the resident care plans.</p>	F 282		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable for one (1) of thirty (30) sampled resident (Resident #13). Observations revealed Resident #13 was not turned and repositioned during a five (5) hour time frame.</p> <p>The findings include:</p>	F 314	<ol style="list-style-type: none"> <li>1. Resident #13 was turned and repositioned appropriately after notification and the nurse received education 7/13/15 to ensure nursing assistants are following the care plan including turning and repositioning dependent residents.</li> <li>2. A skin assessment was completed by Licensed Nurses on all other residents by 7/26/15 and any issues were addressed at that time to include the careplan intervention of turning and repositioning.</li> <li>3. Education was provided by the Executive Director on 7/24/15 to Licensed Nurses and C.N.As to ensure residents do not develop pressure sores unless the individual's clinical condition demonstrates they are unavoidable and how turning and repositioning is essential to assist with this.</li> </ol>	

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F 314	<p>Continued From page 18</p> <p>Record review revealed the facility admitted Resident #13 on 11/12/09 with diagnoses which included Osteoarthritis and Osteoporosis.</p> <p>Review of the annual Minimum Data Set (MDS) assessment, dated 04/21/15, revealed the facility assessed Resident #13's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of zero (0), which indicated the resident was not interviewable.</p> <p>Review of Resident #13's Comprehensive Care Plan for "skin breakdown, dated 04/29/15, revealed an intervention to turn and reposition Resident #13 every two (2) hours while in bed and chair.</p> <p>Review of Resident #13's July 2015 Physician's Orders, revealed to turn and reposition Resident #13 every two (2) hours and as needed (PRN) when in bed every shift.</p> <p>Review of the July 2015 Treatment Administration Record revealed the nurse had initialed that the resident had been turned and repositioned every two (2) hours on 07/08/15 from 9:00-2:00 PM; however, observations of Resident #13 on 07/08/15 at 9:11 AM, 9:21 AM, 11:02 AM, and 2:05 PM revealed Resident #13 remained on his/her left side in bed.</p> <p>Review of a Weekly Skin Assessments, revealed Resident #13 was identified as having new areas of skin impairments on 07/03/15 to include dry skin, bruises, rash and two (2) stage two (2) pressure ulcers to the coccyx area which measured one (1) centimeter (CM) by two (2) cm. and one (1) cm by one (1) centimeter.</p>	F 314	<p>Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head by 8/9/15. This information is also included in our general orientation for Licensed Nurses and C.N.As.</p> <p>4. Unit Managers will audit 5 dependent residents weekly on each hall for 4 weeks then monthly times 2 months to ensure nursing assistants are turning and repositioning residents every two hours and prn to prevent skin breakdown. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	8/10/15

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F 314	Continued From page 19 Review of a Nursing Progress Note, dated 07/04/15 at 4:04 AM, revealed Resident #13 had two (2) pressure ulcers to the coccyx and a new order was written to apply extra protective cream to the coccyx every shift until healed.  Interview with Licensed Practical Nurse (LPN) #2, on 07/09/15 at 2:40 PM, revealed she expected turning and repositioning to be done every two (2) hours for Resident #13 as per physician's orders and care plan approaches to help prevent the development of pressure sores. She stated the nurses monitor this and have to initial the Treatment Administration Records (TAR) stating that they have monitored to be sure the resident was turned and repositioned as ordered and care planned.  Interview with Director of Nursing (DON), on 07/19/15 at 10:45 AM, revealed she expected the certified nurse aides to be sure residents are turned and repositioned and licensed staff to be sure that the turning and reposition of residents was being done.	F 314			
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 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.	F 315	1. Resident #17 had his leg strap applied on 7/10/15 by the Licensed Nurse. Resident #5 had a bowel and bladder assessment completed by the Unit Manager on 7/27/15 and his careplan and careguide were updated upon it's completion to reflect a urinal at bedside. Resident #5 went to Assisted Living on 7/28/15. Resident #13 received proper pericare after the C.N.A was educated on 7/27/15 to include gathering supplies first, changing gloves and proper pericare procedures by the Unit manager.		

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F 315	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy/procedure, it was determine the facility failed to ensure three (3) of thirty (30) sampled residents (Resident #5, Residents #13 and Resident #17) were provided appropriate care and services to prevent an infection and to restore as much normal bladder function as possible. Staff failed to ensure a leg strap was in place to anchor the urinary catheter tubing for Resident #17 and provide proper pericare for Resident #13. In addition, the facility failed to ensure a urinal was at bedside to restore as much normal bladder function as possible for Resident #5.</p> <p>The findings include:</p> <p>Review of the facility's policy/procedure titled, "Daily Catheter Care", not dated, revealed to make sure catheter tubing and drainage bag were kept off the floor.</p> <p>1. Record review revealed the facility admitted Resident #17 on 03/28/14 with diagnoses which include Urinary Retention.</p> <p>Review of the Physicians orders, dated 05/27/15, and review of the Comprehensive Care Plan, dated 05/27/15, revealed to use leg strap to secure catheter tubing at all times.</p> <p>Review of the July 2015 Treatment Administration Record (TAR) revealed to ensure leg strap was in place every shift and as needed (PRN). Further review of the TAR, revealed the last time nursing staff had initialed the TAR was on the 7:00 PM to</p>	F 315	<p>2. An audit was completed by the Unit Managers of all residents with foley catheters to ensure they each had a leg strap applied by 7/24/15. Any issues were addressed at that time. An audit of all bowel and bladder assessments of residents were reviewed to ensure needs to facilitate toileting were addressed and incontinent residents to ensure proper pericare was performed was completed by Unit Mangers by 8/7/15.</p> <p>3. Licensed Nurses and C.N.As were inserviced by the Executive Director on 7/24/15 to ensure any resident with a foley catheter also has a leg strap for prevention of infection, the proper procedure for pericare to include the use of gloves and avoiding negative consequences of incontinence and bladder retraining and providing a urinal at bedside to male residents whose urinary assessments indicated the need and /or his request. Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head by 8/9/15.</p>	

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F 315	<p>Continued From page 21 7:00 AM shift on 07/07/15.</p> <p>Observation on 07/08/15 at 2:30 PM, during catheter care revealed Resident #17's leg strap was not in place.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 07/08/15 at 2:30 PM, revealed she was unsure why Resident #17 did not have a leg strap securing the catheter tubing. She stated the leg strap should be in place to prevent friction and pulling the catheter on the residents bladder and genital area. She further revealed, it was the nurses responsibility to ensure the leg strap was in place.</p> <p>Interview with Registered Nurse (RN) #2, on 07/08/15 at 2:40 PM, revealed Resident #17 should have a leg strap to secure his/her catheter tubing to prevent friction and pulling of the tubing on the genital area. She stated there was a care plan in place to ensure the leg strap was in place, and it was the nurses responsibility to ensure the leg strap was on the resident, because the nurse at the beginning of each shift has to initial on the TAR that the strap was in place.</p> <p>Interview with the Director of Nursing (DON), on 07/09/15 at 3:20 PM, revealed she expected the leg strap to be in place for Resident #17 to prevent friction on the genital area. She stated the nurses were responsible for ensuring the strap was in place at all times and they were required to check and initial the strap was in place on the TAR.</p> <p>2. Review of facility policy entitled, "RAI Process, Chapter #2 Assessment Process, last revised 03/15/07, revealed the purpose of a</p>	F 315	<p>This information was also added to our general orientation for Licensed Nurses and C.N.As in general orientation for new hires.</p> <p>4. Unit Managers will audit all new admissions bowel and bladder assessment to ensure interventions are in place that include observations that urinals at bedside for all male residents deemed necessary to restore normal bladder function, observations that staff are providing proper pericare and observations that staff are providing leg straps to residents with catheters to prevent infections and restore as much bladder function as possible. Audits to be completed weekly for 4 weeks then monthly for 2 additional months by Unit Managers. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	8/10/15

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F 315	<p>Continued From page 22</p> <p>comprehensive assessment was to identify the resident's unique strengths, needs, preferences and potential for improvement. Family members and the resident, if able, should be involved to identify resident preferences and family expectations. Assessment information collected should be used to develop the care plan. Once staff know the resident, decisions should be made on how to best provide care to the resident. The resident and family input should be used to determine realistic expected outcomes for the care plan.</p> <p>Review of facility policy date of September 2010 and entitled, "RAI Process, Chapter #3 MDS Items (H), Section H: Bladder and Bowel revealed, an individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence. Prompted voiding includes regular monitoring with encouragement to report continence status. Steps in Assessment: look for documentation in the medical record showing the there was implementation of an individualized resident specific toileting program that was based on an assessment of the residents unique voiding pattern. For many residents, incontinence can be resolved or minimized by eliminating environmental physical barriers to accessing commodes, bedpans, urinals, bladder retraining, prompted voiding, or scheduled toileting.</p> <p>Record review revealed the facility admitted Resident #5 on 04/27/15, with diagnoses which included Fracture of Intertrochanteric Section of Femur, Atrial-Fibrillation, Dyspepsia, Anemia and Acute Pharyngitis. Review of the admission MDS assessment, dated 05/04/15, revealed the facility</p>	F 315		

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F 315	<p>Continued From page 23</p> <p>assessed Resident #5's cognition as moderately impaired with a BIMS score of eleven (11) which indicated the resident was interviewable. In addition, the facility assessed the resident as continent of bladder and needing extensive assistance with activities of daily living.</p> <p>Review of Assessment for Bowel and Bladder Training with date of 04/27/15, and a Urinary Incontinence Assessment, dated 05/01/15, revealed Resident #5 was a good candidate for individual training and required assistance for transfer in toileting and required a urinal, grab bars in the bathroom, a wheelchair and bed rails to help facilitate toileting.</p> <p>Review of the Comprehensive Care Plan, dated 05/05/15, and Care Directive, with a print date of 07/07/15, revealed Resident #5 was one (1) assist with toileting; and his toileting program was for staff to prompt him/her to void and to check and change. However, further review revealed there was no intervention to address the assessed need to have a urinal at bedside to facilitate toileting.</p> <p>Observation and interview with Resident #5, on 07/08/15 at 11:12 AM, revealed Resident #5 was asking his/her family member to get the urinal from the bathroom for his/her use. He/she stated the urinal should be kept at the bedside when in room for use.</p> <p>Interview with Resident #5's family member, on 07/08/15 at 11:10 AM, revealed the resident's urinal should be made available to Resident #5 by being kept at the bedside and not placed in the bathroom. He stated it needed to be accessible to the resident and it would do more harm for it to</p>	F 315		

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F 315	<p>Continued From page 24</p> <p>be in the bathroom because the resident could fall at night trying to go to the bathroom. He revealed staff had told him it had to be in the bathroom and in a bag, and he felt that was not convenient and safe for the resident.</p> <p>Interview on 07/10/15 at 8:40 AM and at 9:10 AM with LPN #4 revealed the urinal should be on the care plan because staff that was not providing care to Resident #5 all the time would not know he used a urinal and the resident does not get up to go to the bathroom all the time. LPN #4 stated the urinal would help promote independence for the resident.</p> <p>Interviews on 07/10/15 with MDS Nurse #1 at 8:42 AM, and the Assistant Director of Nursing (ADON) at 9:40 AM revealed the urinal should be on the care plan and the urinal should be kept at bedside at bedside.</p> <p>3. Record review revealed the facility admitted Resident #13 on 11/12/09 with diagnoses which included Osteoarthritis and Osteoporosis. Review of the annual MDS assessment, dated 04/21/15, revealed the facility assessed Resident #13's cognition as severely impaired with a BIMS score of zero (0), which indicated the resident was not interviewable.</p> <p>Observation of CNA #1 providing pericare for Resident #13, on 07/08/15 at 12:00 PM, revealed CNA #1 did not put on clean gloves after he positioned the resident for pericare and prior to starting pericare. In addition, CNA #1 had to stop pericare to gather additional supplies and when he returned he did not change gloves prior to starting pericare again.</p>	F 315		
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F 315	Continued From page 25 Interview with Unit Manager (UM) #1, on 07/08/15 at 03:09 PM, revealed she expected staff to put on clean gloves prior to starting pericare and at anytime thereafter if staff needed to, to prevent cross contamination. UM #1 stated she expected staff to have supplies ready prior to starting pericare so staff would not have to stop and get supplies then resume pericare.	F 315		
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 and policy review it was determined the facility failed to ensure the residents' environment remains as free of accident hazards as is possible on six (6) of ten (10) resident wings (Wings 3, 4, 6, 7, 8, and 9/10). The facility failed to ensure biohazard waste was stored behind a locked door on Wings 6, 7, 8, and 9/10, medications were secured in a locked treatment cart on Wings 6 and 4, finger nail polish remover was stored locked on Wing 9/10, and a housekeeping cart containing bleach and chemicals was locked when staff not present	F 323	1. The Housekeeping cart was locked upon notification to the housekeeper and education was provided to this associate on 7/23/15. The Biohazard waste was removed from 9/10 and 6,7,8 by 7/11/15. Then a lock was installed on the 9/10 and 6,7,8 soiled utility rooms by the Maintenance Dept on 7/31/15. The fingernail polish remover was removed from the biohazard room by 7/11/15 by the Unit Manager. The insulin and prescription bottles were put in the treatment cart back under lock and key by 7/13/15 by the Unit Manager. 2. All other housekeeping carts were audited by the Housekeeping supervisor on 7/22/15 to ensure they were locked. All other treatment carts were audited by the Unit Managers by 7/24/15 to ensure insulin and prescription medications were under lock.	

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F 323	<p>Continued From page 26 on Wing 3.</p> <p>Review of the facility's wander list revealed there were twenty-eight (28) residents in the facility identified as wanderers.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, "General Housekeeping", not dated, revealed all hazardous/toxic substances will be kept in a locked area.</p> <p>Observation during the general tour of the facility, on 07/09/15 at 2:00 PM with the Director of Nursing and Maintenance, revealed a red bags containing biohazardous waste was stored in four (4) out of (5) storage rooms behind an unlocked door on Wings 6, 7, 8, and 9/10. Each door was labeled as a biohazardous storage room.</p> <p>Further observation during the tour revealed finger nail polish remover was stored in an unlocked storage room on Wing 9/10. Review of the hazard warning if swallowed revealed it could cause low blood pressure, nausea, pain in abdomen, vomiting, acting as if drunk, drowsiness, decreased level of consciousness, incoordination, difficulty breathing</p> <p>Interview with the Director of Nursing and Maintenance, on 07/02/15 at 8:33 AM, revealed they both stated the storage rooms should be locked to protect from residents.</p> <p>2. Further observation during the general tour of the facility on 07/09/15 with the Director of Nursing and Maintenance, a housekeeping cart</p>	F 323	<p>All storage areas for biohazard or where chemicals may be stored have been audited by the Maintenance Dept and all have been locked as of 7/31/15.</p> <p>3. Education was provided to all housekeepers and all other associates by the Executive Director or Housekeeping Supervisor by 8/9/15 about the need to keep the environment free of accident hazards and including keeping all housekeeping carts locked and biohazard doors requiring a lock and other chemicals such as fingernail polish remover and insulins and other medications not to be left unattended. Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head by 8/9/15. This information is also added to our general orientation for new hires.</p> <p>4. The Housekeeping supervisor will audit all biohazard rooms to ensure they have a lock on them monthly for 3 months. The Nursing Administration will audit all treatment carts and medication carts weekly times 4 weeks then monthly times 2 months to ensure insulins and prescription medication are under lock and key.</p>	

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F 323	<p>Continued From page 27</p> <p>was found unlocked and unattended on Wing 3. The housekeeper had walked away from the cart and failed to secure the cleaning products inside to include chemicals and bleach. The warning related to Chlorine Bleach include that it was a strong corrosive material; it will irritate the eyes, skin and the respiratory tract by merely inhaling the gasses. In addition, when bleach is mixed with other cleaners a poisonous gas is released that can cause bloody noses, neurological disorders, headaches and even death.</p> <p>Interview with Housekeeper #1, on 07/09/15 at 3:15 PM, revealed she was aware the cart was to be locked and stated she failed to secure it before walking away. She stated the hazards of a resident getting into the cart was a concern.</p> <p>Interview with the Director of Housekeeping, on 07/10/15 at 8:31 AM, revealed she expected the housekeeping carts to remain secured and locked when out of the site of the Housekeeper. She stated this could be a hazard to residents because there were chemicals stored in the carts.</p> <p>3. Observation of a treatment cart, left unattended on Wing 6 on 07/08/15 from 3:55 PM until 4:05 PM, revealed nine (9) unlocked, labeled prescription bottles, containing resident's insulins, on the top of the treatment cart.</p> <p>Interview with Registered Nurse (RN) #3 on 07/08/15 at 4:05 PM, revealed the RN stated the medications should have been kept in the locked drawers.</p> <p>4. Observation of a treatment cart, left unattended on Wing 4, on 07/08/15 from 4:39 PM until 4:45 PM, revealed six (6) unlocked, labeled</p>	F 323	<p>The Housekeeping Supervisor will audit each housekeeping cart weekly times 4 weeks then monthly times 2 months to ensure they are locked. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	8/10/15

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F 323	Continued From page 28 prescription bottles, each containing resident's insulins, on top of the treatment cart.  Interview with Registered Nurse (RN) #2, on 07/08/15 at 4:45 PM, revealed the RN stated the insulins should have been placed in the locked drawers.  Interview with the Director of Nursing (DON) on 07/09/15 at 3:12 PM, revealed the DON expected that all medications including insulins, should be kept in locked drawers on the carts.	F 323		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked,	F 431	1. A lock was installed on the 9/10 and 6,7,8 soiled utility rooms by the Maintenance Dept on 7/31/15. The insulins were removed from the top of the medication carts by 7/24/15 by the Unit Managers and stored in the locked compartment. The Nurse who signed out the meds early received an education concerning the need to maintain an accurate narcotic count on 7/8/15 by the Unit Manager. 2. All other storage areas with chemicals or hazards had locks applied by the Maintenance dept by 7/31/15. All narcotic sheets were audited by the Unit Managers by 7/13/15 to ensure an accurate count of narcotics.	

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F 431	<p>Continued From page 29</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</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 store all drugs and biologicals in locked compartments on two (2) medication carts and failed to ensure one (1) storage room was locked that contained Peroxide and Normal Saline. In addition, the facility failed to ensure their system of ensuring an accurate count of narcotics was effective for two (2) unsampled residents (Residents B and C). Observation revealed Peroxide and Normal Saline was stored in an unlocked storage room and Insulin was not locked in two (2) medication carts when staff not present. Further observation of a controlled substance medication count revealed Unsampled Resident B scheduled Lyrica 75 milligram (mg) and Unsampled Resident C's Oxycodone 10 mg. tablet count was inaccurate.</p> <p>The findings include:</p> <p>1. Review of facility policy title, "Controlled Drugs", last revised 02/2013, revealed a controlled drugs proof sheet should be accurately</p>	F 431	<p>3. All staff received education from the Executive Director on 7/24/15 to store all drugs and biological in a locked compartment. Licensed Nurses received education from the Executive Director on 7/24/15 to ensure our system of accurately counting narcotics and storing insulin in a locked compartment when staff not present. Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head by 8/9/15.</p> <p>4. The Housekeeping supervisor will audit all biohazard rooms to ensure they have a lock on them monthly for 3 months. The Nursing Administration will audit all treatment carts and medication carts weekly times 4 weeks then monthly times 2 months to ensure insulins and prescription medications are under lock and key. The Unit Managers will also audit the narcotic count sheets weekly times 4 weeks then monthly times 2 months to ensure an accurate narcotic count is being completed. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by</p>	8/10/15	

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F 431	<p>Continued From page 30</p> <p>maintained on all residents requiring controlled medications. Strict control of narcotics is always maintained. The narcotic proof of use sheet should be accurately maintained on residents requiring the medication, and each dose of the controlled medication given by the nurse should be dated with the signed off date, hour given, residents name, physician of the resident, amount of medication dispensed, the signature of the nurse, and the balance of medication after the given dose has been dispensed.</p> <p>Review of facility policy titled, "Policies for Medication Administration, Standard", last revised 04/02/13 revealed all medications should be administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis. The responsibility of the nursing professional consist of checking the Medication Administration Record (MARs) at the room of the resident, reading each order, reading the label three (3) times, preparing the medication for the resident, comparing the name of the resident to name on the MARs, explaining the procedure to the resident, administering the medication to the resident, and after the resident has swallowed the medication, then initial each medication in the correct box on the MARs after medication is given; PRN medication is charted with initials and time given.</p> <p>Record review revealed the facility admitted Unsampled Resident B on 06/10/15 with diagnoses which included Venous Peripheral Insufficiency, Other Chronic Pain, Osteoarthritis, and Cellulitis and Abscess of leg.</p> <p>Review of Controlled Drugs Proof Sheet for Unsampled Resident B on 07/07/15 at 9:55 AM</p>	F 431		
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F 431	<p>Continued From page 31</p> <p>revealed Lyrica 75 mg capsule, give one (1) capsule orally three (3) times a day; with the last dose dated as signed out on 07/07/15 at 2:00 PM and the count to be seventy-six; however, review of Unsampld Resident B's Lyrica 75 mg. capsule give one (1) capsule orally three (3) times a day bubble card revealed there were seventy-seven (77) capsules left in the card.</p> <p>2. Record review revealed the facility admitted Unsampld Resident C on 05/07/15 with diagnoses which included Closed fracture of Acetabulum, Mononeuritis of unspecified site, Closed Fracture of Three Ribs, Anxiety State, Spasm of Muscle, and Depressive Disorder.</p> <p>Review of the Controlled Drugs Proof Sheet for Unsampld Resident C on 07/07/15 at 10:00 AM revealed Oxycodone 10 mg IR tablet, give one (1) tablet orally every four (4) hours as needed for pain with the last dose dated as signed out on 07/07/15 at 11:00 AM and the count was seventy-six; however, review of the Oxycodone 10 mg IR tablet, give one (1) tablet orally every four (4) hours as needed for pain bubble card revealed there were seventy-seven (77) tablets left.</p> <p>Interview, on 07/07/15 at 10:20 AM with Licensed Practical Nurse (LPN) #6, revealed the narcotic count was off because she had signed Unsampld Resident B's Lyrica out for the 2 PM dose even though she it was not 2:00 PM because she knew she was going to give it at 2:00 PM. She stated she also had signed out Unsampld Resident C's Oxycodone 10 mg. ahead of time because she knew the resident would ask for it, but he/she had not asked for the medication. LPN #6 further stated she knew she</p>	F 431		

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F 431	<p>Continued From page 32</p> <p>should not sign out the medication until after the resident has swallowed the medication but she knew she was going to have several admissions.</p> <p>Interview, on 07/07/15 at 10:28 AM with Registered Nurse (RN) #4, revealed staff should not pull narcotics, and if a resident needs a pain pill then the staff will assess the resident and see what they have ordered for pain, and sign out when the medication is given. She stated "don't sign out ahead of time, is a big no-no".</p> <p>Interview, on 07/07/15 at 3:30 PM with Unit Manager (UM) #2, revealed staff should sign out medications after they have been given to and taken by the resident, and PRN medications should not be pulled or signed out before asking a resident if the medication was wanted.</p> <p>Interview, on 07/08/15 at 3:40 PM with Director of Nursing (DON), revealed staff should sign out the narcotics after they are given because the resident may refuse the medications and it is the policy of the facility. The DON stated staff should watch the resident swallow the medication then come back and chart that it has been taken by the resident.</p> <p>3. Review of the facility's policy titled, "A Guide To Medication Utilization", dated 2004, revealed it did not address medication and biologicals must be locked, however it stated that medications and pharmaceuticals must be under continuous supervision.</p> <p>Observation during the general tour of the facility with the Director of Nursing (DON) and Maintenance, on 07/09/15 at 2:00 PM, revealed eight (8) containers of "Argyle Tracheostomy</p>	F 431		

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F 431	Continued From page 33 Care Trays" being stored in an unlocked storage room each containing Peroxide and Normal Saline solution.  Interview with the Director of Nursing (DON), on 07/10/15 at 8:33 AM, revealed the Peroxide and Normal Saline should be stored in a locked area.  4 Observation of a treatment cart, left unattended on Wing Four (4), on 07/08/15 from 4:39 PM until 4:45 PM, revealed six (6) unlocked, labeled prescription bottles, each containing resident's insulins, on top of the treatment cart.  Interview with Registered Nurse (RN) #2 on 07/08/15 at 4:45 PM, revealed the RN stated the insulins should have been placed in the locked drawers.  5. Observation of a treatment cart, left unattended on Wing Six (6) on 07/08/15 from 3:55 PM until 4:05 PM, revealed nine (9) unlocked, labeled prescription bottles, containing resident's insulins, on the top of the treatment cart.  Interview with Registered Nurse (RN) #3 on 07/08/15 at 4:05 PM, revealed the RN stated the medications should have been kept in the locked drawers.  Interview with the DON, on 07/09/15 at 3:12 PM, revealed the DON expected that all medications including insulins, should be kept in locked drawers on the carts.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	<p>Continued From page 34</p> <p>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.</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</p> <p>(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>	F 441	<p>1. Residents #5, 13, and 17 were all reassessed by Licened Nurses to determine no ill effects of the failure to provide proper infection control by 7/30/15.</p> <p>2. All other residents with wounds, foley catheters and incontinence were reassessed to determine no further infections occurred as a result of the deficient practice by the Unit Mangers by 7/30/15.</p> <p>3. All staff were educated by the Executive Director, SDC or appropriate dept head concerning our infection control program to include proper wound care principles, transporting linens, keeping tubings off the floor, storing tubings when not in use in a plastic bag, keeping catheter bags off the floor, placing oxygen equipment in bags, sorting soiled linen, and pericare procedures related to infection control by 8/9/15.</p> <p>4. Adminstration will do 10 observations of each hall to observe for proper infection control practices which include: proper woundcare, transporting linens, keeping tubing off the floor, storing tubing in a plastic bag when not in use, sorting soiled linens and proper pericare weekly times 4</p>		

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F 441	<p>Continued From page 35</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 maintain an Infection Control Program to maintain a safe, sanitary and comfortable environment for three (3) of thirty (30) sampled residents (Residents #5, #13 and #17) related to improper wound care, improper pericarp and disposal of soiled linens and briefs, urinary catheter tubing dragging the floor, nasal cannula and c-pap on the floor, transporting of uncovered laundry to residential floors and no protective barriers in use while sorting laundry.</p> <p>The findings include:</p> <p>Review of facility policy with revision date of 05/01/12 and entitled, Hand Hygiene, revealed: the purpose is to decrease the risk of transmission of infection by appropriate hand hygiene. Policy statement reveals handwashing/hand hygiene is considered the most important single procedure for preventing nosocomial infections. Antiseptic control or kill microorganisms contaminating skin and other superficial tissues and are sometimes composed of the same chemicals that are use for disinfection of inanimate objects. Although antiseptics and other handwashing agents do not sterilize the skin, they can reduce microbial contamination depending on the type and the amount of contamination, the agent used, the presence of residual activity, and the handwashing technique followed.</p> <p>1. Review of facility policy titled, "Wound Care Procedure for Major Wounds", last revised</p>	F 441	<p>weeks then monthly for 2 additional months.</p> <p>5. Completed by</p>	8/10/15

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F 441	<p>Continued From page 36</p> <p>05/21/04, revealed the purpose was to provide guidelines for good technique in performing wound care. Care must be taken to prevent contamination of the supplies and surfaces used in wound care. Procedure: set up the supplies on a clean surface at the bedside (cover the surface with a clean impervious barrier before putting the supplies out). clean hands following hand hygiene guidelines, cut the tape with clean scissors, put gloves on, remove the soiled dressing and place in a bag at the bedside, remove gloves, discard bag, clean scissors with 60 seconds of contact with alcohol and place on a clean corner of setup, clean hands using hand hygiene guidelines, put on clean gloves, clean wound per physician order, clean wound from center outward, place soiled gauze used for cleaning in bag, remove gloves, put clean gloves on, apply a clean dressing as ordered.</p> <p>Record review revealed the facility admitted Resident #5 on 04/27/15 with diagnoses which included Fracture of Intertrochanteric Section of Femur, Atrial-Fibrillation, Dyspepsia, Anemia and Acute Pharyngitis.</p> <p>Review of Pressure Ulcer Status Record, dated 07/02/15, revealed Resident #5 had a 0.3 cm X 0.4 cm right buttock unstagable wound and a 1.3 cm X 0.5 cm left buttock unstagable wound.</p> <p>Observation on 07/07/15 at 3:50 PM with Registered Nurse (RN) #5 during wound care revealed RN #5 cleansed the wound to right buttock with saline gauze and then cleansing the left buttock with the same saline gauze. RN #5 then sprayed personal cleanser on a wash cloth and wiped the right buttock wound and then the left buttock wound with the wash cloth. RN #5</p>	F 441		

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F 441	<p>Continued From page 37</p> <p>proceeded to take scissors and cut a piece of Sorbact, (placed remaining Sorbact in plastic bag it came in), and put it in the wounds of the right and left buttocks with finger then placed Mepiplex over right buttock wound and left buttock wound. RN #5 failed to change her glove through this whole process.</p> <p>Interviews on 07/07/15 at 4:00 PM and on 07/08/15 at 3:05 PM with RN #5 revealed she had put the Sorbact in the bag for use during the next wound care but if she used the contaminated Sorbact to pack the wound it could possibly contaminate the wound. RN #5 stated it would have been better to throw away the Sorbact because the Sorbact was no longer sterile. RN #5 further stated she should have changed the saline gauze because of contamination to the wound because you don't want to introduce anything to a wound that was healing.</p> <p>Interview on 07/08/15 at 3:10 PM with Unit Manager (UM) #2 revealed she expected when staff provided wound care to clean from center out, discard the gauze and use a new one each time for each wound and if there were two (2) different wounds they should do two (2) different dressing changes. UM #2 stated when staff cuts the Sorbact the staff should change gloves and then place in the wound and if the Sorbact was touched with dirty gloves and contaminated it should be discarded.</p> <p>Interview, on 07/10/15 at 9:40 AM with Assistant Director of Nursing (ADON), revealed that staff should not do wound dressing with one gauze or cut the Sorbact with the same gloves on that was used to cleanse the wound and then save the Sorbact for the next dressing change.</p>	F 441		

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F 441	<p>Continued From page 38</p> <p>Interview, on 07/08/15 at 3:40 PM with Director of Nursing (DON), revealed each wound should be cleansed independently because of the possibility of cross contamination and she would expect staff to change gloves once they have cleaned the wound and the rest of the Sorbact should have been discarded.</p> <p>2. Review of the facility's policy/procedure titled, "Daily Catheter Care", not dated, revealed staff should make sure the catheter tubing and drainage bag are kept off the floor.</p> <p>Review of the facility's policy/procedure titled, "Respiratory Care Services Policy/Procedure", not dated, revealed staff should properly clean the mask each morning or after each use by wiping with a disinfectant, and properly store.</p> <p>Review of the facility policy/procedure titled, "Oxygen Therapy/Mask and Nasal Cannula", not dated, revealed staff should ensure when masks and cannulas are not in use, to store in plastic bag.</p> <p>Record review revealed the facility admitted Resident #17 on 03/28/14 with diagnoses which included Urinary Retention, Congestive Heart Failure, Chronic Airway Failure, and Chronic Obstructive Pulmonary Disease.</p> <p>Observations on 07/08/15 at 11:30 AM, 1:30 PM, 2:30 PM and 3:30 PM, revealed Resident #17's catheter tubing and urinary drainage bag were lying on the floor.</p> <p>Observation on 07/08/15 at 2:30 PM, revealed Resident #17's nasal oxygen tubing was lying in</p>	F 441		

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F 441	<p>Continued From page 39</p> <p>the seat of Resident #17 wheelchair not bagged..</p> <p>Observations on 07/08/15 at 8:25 AM, 10:10 AM, and 2:30 PM revealed Resident #17's Continuous Positive Airway Pressure (CPAP) mask was not bagged lying on the bedside table.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 07/13/15 at 2:30 PM, revealed the catheter tubing and urinary bag should not be touching the floor, and the oxygen tubing and CPAP mask should be bagged when not in use to prevent infection.</p> <p>Interview with RN #2, on 07/08/15 at 2:40 PM, revealed the urinary catheter bag and tubing should not touch the floor to prevent possible infection and the oxygen tubing and CPAP mask should be placed in a bag while not is use to prevent infection. Further interview revealed it was the nurses responsibility to check the CPAP mask every morning to make sure it was cleaned and bagged during the day to prevent the potential risk of infection.</p> <p>Interview with the DON, on 07/09/15 at 3:20 PM, revealed she would expect the oxygen tubing and CPAP mask to be bagged while not in use, and she would expect the urinary drainage bag and tubing to be attached to the bed/wheelchair in a manner that it would not be touching the floor to prevent the potential risk of infection. She stated she was not sure if the Oxygen policy was specific to the proper storage of tubing, but she would expect the oxygen tubing to be stored in a bag while not in use to prevent the potential of infection.</p> <p>3. Review of the facility's policy titled, "Laundry Services", not dated, revealed staff should wear</p>	F 441			

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F 441	<p>Continued From page 40</p> <p>gowns and gloves when sorting soiled linen and eye protection soul be used when there is a potential for splashing blood or other infectious materials in the eyes. In addition, clean laundry must be stored and transported in covered carts.</p> <p>Observation during the general tour of the facility, on 07/10/15 at 2:00 PM, revealed the laundry staff were not using gown or eye protection during sorting of the soiled laundry. Further observation revealed the Housekeeping Director was transporting clean linen to the wings in a cart without a cover.</p> <p>Interview, on 07/09/15 at 2:55 PM, with the Laundry Staff #1 and #2, revealed they do not wear any form of clothing barrier when sorting the soiled laundry.</p> <p>Interview, on 07/10/15 at 8:31 AM, with the Housekeeping Director, revealed she expected the staff to use gowns, gloves and eye protection when sorting soiled laundry. Additionally she stated she failed to cover the cart while transporting clean linen to the wings and this put the clean laundry at risk for contamination.</p> <p>4. Record review revealed the facility admitted Resident #13 on 11/12/09 with diagnoses which included Osteoarthritis and Osteoporosis.</p> <p>Observation of pericare care for Resident #13, revealed Certified Nursing Assistant (CNA) #1 placed a dirty wash cloth on the bed side table after cleaning Resident #13's genital area. CNA #1 also removed a soiled brief during pericare and placed on the foot of the bed not covered or contained. CNA #1 did not change his gloves prior to resuming pericare.</p>	F 441		

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F 441	Continued From page 41  Interview with CNA #1 on 07/08/15 at 12:00 PM, revealed him stating needed to change his gloves after handling a soiled brief and prior to resuming pericare. He also stated that he should of had bags available for disposing of soiled linen and dirty briefs appropriately and that it was not appropriate to place a soiled wash cloth on the bedside table and that it was also inappropriate to place a soiled brief at the foot of the bed without being contained in a bag.  Interview with Unit Manager (UM) #1, on 07/08/15 at 03:09 PM, revealed she expected staff to have bags available and ready prior to starting pericare so staff would be able to place soiled items into the bags for containment. She also expected staff to put on clean gloves prior to starting pericare and at anytime thereafter if staff needed to, to prevent cross contamination. UM #1 stated she expected staff to have supplies ready prior to starting pericare  Interview with DON, on 07/09/15 at 10:45 AM, revealed she expected staff to place clean gloves on prior to starting pericare and at any time during pericare as need. She also expected staff to dispose of soiled lines and briefs appropriately and it was not appropriate to place soiled linen on a bedside table or to place a soiled brief on the foot of a bed.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456	1. The Restorative refrigerator was removed by 7/11/15. The refrigerators for Wings 1/3 had a thermometer and a temperature log added to them by the Dietary Manager on 7/27/15.	

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F 456	<p>Continued From page 42</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 maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. Observation revealed three (3) refrigerators without temperature log entries. One (1) refrigerator was located in the Restorative Dining Room and two (2) refrigerators were in the medication room on Wings 1 and 3 nursing stations.</p> <p>The findings include:</p> <p>Review of the policy titled, "Cold Food Storage", not dated, revealed temperature should be checked and recorded at least twice daily.</p> <p>Observation during the general tour of the facility with the Director of Nursing (DON) and Maintenance, on 07/09/15 at 2:00 PM, revealed a refrigerator in the Restorative Dining Room was found to have no temperature log or thermometer in the refrigerator. This refrigerator was labeled for resident use only. Additionally, the medication rooms on Wing 1 and 3 contained medication refrigerators and review of the temperature log for these refrigerators revealed temperatures had not been recorded for seven (7) consecutive days.</p> <p>Interview on 07/10/15 at 8:33 AM, with the DON and Maintenance, both revealed the temperaturea were obtained by nursing and should be recorded appropriately. They both stated the were not aware of there being a refrigerator in the Restorative Dining Room. They revealed the temperatures needed to be</p>	F 456	<p>2. All other refrigerators in medication rooms, nourishment rooms and the kitchen were audited by the Dietary Manager on 7/27/15 to ensure they had a thermometer and a temperature log with no other issues noted.</p> <p>3. The dietary staff and Licensed staff were educated by the Executive Director, SDC or Dietary Manager by 8/9/15 about the need to maintain safe equipment to include refrigerators needing a thermometer and temperature logs. This was also added to our orientation for new hires of dietary associates and Licensed staff.</p> <p>4. The Dietary Manager will audit refrigerators in the med rooms, nourishment rooms and kitchen weekly times 3 weeks then monthly times 2 months. The results of those audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	8/10/15
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F 456  F 514 SS=D	<p>Continued From page 43</p> <p>monitored to to ensure items that required to be refrigerated were kept at the proper temperature.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure, it was determined the facility failed to maintain clinical records on each resident that were accurately documented for one (1) of thirty (30) sampled residents (Resident #3) related to an allergy.</p> <p>The findings include: Review of the facility policy titled, "Allergies", not dated, revealed the purpose of the policy is to prevent anaphylaxis and to prevent all allergic reactions. Procedural steps include interviewing the resident or family to determine allergies.</p>	F 456  F 514	<p>1. Residents #3 had an order clarified by the physician on 7/8/15 stating the resident was not allergic to the ppd skin test.</p> <p>2. 100% audit of all other resident's allergies was completed by the Licensed Nurses by 7/19/15.</p> <p>3. The Executive Director educated all Nursing personnel to clarify residents allergies on the physician's order sheets, the chart allergy sticker, TARS and MARs, and careplans on 7/24/15. Anyone who missed this meeting was inserviced by the Staff Development Coordinator or appropriate dept head. All educations were competed by 8/9/15. This information was also added to our general orientation for Licensed Nurses</p> <p>4. Unit Managers will audit all new admissions weekly for 4 weeks then at least 10 per month for 2 additional months. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	8/10/15
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F 514	<p>Continued From page 44</p> <p>Allergies should be recorded on resident care plan and on any other form(s) as appropriate.</p> <p>Record review revealed the facility admitted Resident #3 on 10/26/12 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Diastolic Heart Failure, Atrial Fibrillation and Malignant Neoplasm of the Prostate.</p> <p>Review of a Allergy List from an acute care facility, dated 04/17/13, and review of the resident's face sheet with an admission date of 10/26/12 revealed the resident was allergic to the tuberculin (TB) skin test. However, review of readmission orders, 04/17/13, revealed Resident #3 had no known allergies (NKA).</p> <p>Review of Physician Orders for July 2015 revealed allergies to be listed as lisinopril and TB skin test. Page eight (8) of the same orders has an order, initiated on 01/14/14, for "Do not administer PPD/2nd step PPD due to history of positive PPD". Review of July 2015 Medication Administration Record (MAR) and the Treatment Administration Record (TAR) revealed the resident has allergies to lisinopril and TB skin test. Further review revealed a Care Directive guide, dated 07/07/15, which stated Resident #3 was allergic to TB skin test.</p> <p>Interview with the Registered Nurse Unit Manager, on 07/09/15 at 2:20 PM, revealed with any new admission, she would expect the staff to perform a thorough check of the chart documentation to ensure the allergy information was correctly listed.</p> <p>Interview with the Director of Nursing (DON), on 07/10/15 at 9:25 AM, revealed she expected that</p>	F 514		
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F 514	Continued From page 45 allergies are listed with one hundred percent (100%) accuracy and that they be consistently documented throughout the chart.	F 514		

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1968.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222).</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1968 and upgraded March 2012, with 102 smoke detectors and 09 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1968.</p> <p>GENERATOR: Type II generator installed in 1996. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was initiated on 07/08/15 and concluded on 07/09/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for two-hundred twenty-eight (228) beds with a census of two-hundred two (202) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan or correction is prepared and /or executed solely because it is required by law the provision of Federal and State laws."</p> 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>AM M... Exec Director</i>	TITLE	(X6) DATE 8-21-15
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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 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 018 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b> Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of twelve (12)	K 018	1. Room 305 door was adjusted by Maintenance and properly closed by 7/27/15. 2. All resident doors were checked by Maintenance and the Assistant ED to ensure proper closure by 7/28/15. There were no other issues at that time. 3. Education was provided by the Executive Director to all staff on the importance of all resident doors latching properly on 7/24/15. Anyone who did not attend was inserviced by the SDC or other appropriate dept head by 8/9/15. This information was also added to our general orientation for new associates. 4. Maintenance will audit 8 resident rooms doors per hallway weekly for 4 weeks then 10 per month per hallway for an additional 2 months to determine proper closure. The results of the audits will be brought to the QA committee to determine the need for further monitoring. 5. Completed by:	9/01/15

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K 018	<p>Continued From page 2</p> <p>smoke compartments, two (2) residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred two (202).</p> <p>The findings include:</p> <p>Observation, on 07/09/15 at 10:21 AM, with the Maintenance Director and the Assistant Executive Director revealed the corridor door to resident room #305 would not latch when tested.</p> <p>Interview, on 07/09/15 at 10:22 AM, with the Maintenance Director and the Assistant Executive Director revealed they were unaware the door would not latch.</p> <p>The census of two-hundred two (202) was verified by the Executive Director on 07/09/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director and the Assistant Executive Director at the exit interview on 07/09/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding</p>	K 018		

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K 018	<p>Continued From page 3</p> <p>1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.</p>	K 018		
K 029 SS=D	<p>Reference: CMS: S&amp;C-07-18</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p>	K 029	<p>1. 14 cardboard boxes were removed from the Director of HR's office, and 7 boxes of paper were removed from the social services office by the Maintenance dept by 7/31/15. A door closure was added to the Dayroom/ Education training office by the Maintenance Dept by 8/9/15.</p>	

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K 029	Continued From page 4 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 Association (NFPA) standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred two (202).  The findings include:  1. Observation, on 07/09/15 at 9:33 AM, with the Maintenance Director and the Assistant Executive Director revealed a hazardous amount of paper was being stored in the Dayroom/Education Training Office. The room was rated; however a self-closing device was not installed on the door.  Interview, on 07/09/15 at 9:34 AM, with the Maintenance Director and the Assistant Executive Director revealed they were not aware of the requirements for protection from hazards.  2. Observation, on 07/09/15 at 9:35 AM, with the Maintenance Director and the Assistant Executive Director revealed fourteen (14) cardboard boxes of paper were being stored in the Director of Human Resources Office. The room was rated;	K 029	2. All other offices were audited by 7/30/15 to ensure there was no excessive paper to warrant a self -closure by the Maintenance Dept. 3. The Executive Director inserviced all associates about the protection of Hazards including the amount of paper in offices to ensure self -closures are not warranted on doors on 7/24/15. Anyone who did not attend was inserviced by the SDC or other appropriate dept head by 8/9/15. 4. The Asst. ED will audit 10 offices per week times 4 weeks to determine the proper storage of paper and to ensure there is no need for self -closures to be placed. Then the Asst ED will audit 10 offices per month for an additional 2 months to determine the same. Results of the audits will be brought to the QA committee to determine the need for further monitoring. 5. Completed by:	9/01/15

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K 029	<p>Continued From page 5 however a self-closing device was not installed on the door.</p> <p>Interview, on 07/09/15 at 9:36 AM, with the Maintenance Director and the Assistant Executive Director revealed they were not aware of the requirements for protection from hazards.</p> <p>3. Observation, on 07/09/15 at 9:45 AM, with the Maintenance Director and the Assistant Executive Director revealed seven (7) cardboard boxes of paper were being stored in the Social Services Office. The room was rated; however a self-closing device was not installed on the door.</p> <p>Interview, on 07/09/15 at 9:46 AM, with the Maintenance Director and the Assistant Executive Director revealed they were not aware of the requirements for protection from hazards.</p> <p>The census of two-hundred two (202) was verified by the Executive Director on 07/09/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director and the Assistant Executive Director at the exit interview on 07/09/15.</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 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</p>	K 029		

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K 029	<p>Continued From page 6</p> <p>accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 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</li> <li>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</li> </ul> <p>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.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>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.</p>	K 029		

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K 029	Continued From page 7  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	1. The Dry Storage kitchen door was assessed by a vendor on 7/23/15 and bid to replace the door was obtained. The door has been ordered and the facility is awaiting it's installation by 9/1/15. Maintenance removed the key pad alarm system from the door next to the break room leading the dry storage hallway by 9/1/15. The wing 10 Exit door was adjusted by the Maintenance dept and egresses properly as of 7/28/15. Signage for door on Wing 10 was also added by the Maintenance dept to indicate it was equipped with delayed egress on 7/30/15.	

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K 038	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the path of egress was maintained free from obstructions or impediments for full instant use for fire or other emergencies in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of twelve (12) smoke compartments, forty-four (44) residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred two (202).</p> <p>The findings include:</p> <p>1. Observation, on 07/09/15 at 10:12 AM, with the Maintenance Director and the Assistant Executive Director revealed the delayed egress lock installed on the Dry Storage Kitchen Hall Exit door failed to operate when tested. Further observation revealed two (2) delays in the path of egress from the Dining Room to the Dry Storage Kitchen Hall Exit.</p> <p>Interview, on 07/09/15 at 10:13 AM with the Maintenance Director and the Assistant Executive Director revealed they were not aware the delayed egress door was not functioning as intended, or of the requirements for the number of delays located in the path of egress.</p> <p>2. Observation, on 07/09/15 at 10:45 AM, with the Maintenance Director and the Assistant Executive Director revealed the Wing 10 Exit door was equipped with a delayed egress lock; however the door did not have signage to indicate the door</p>	K 038	<p>2. All other doors were inspected by the Maintenance dept. during a fire alarm again on 7/31/15. All doors tested properly by closing with the alarm.</p> <p>3. The Executive Director inserviced all staff on the need not to obstruct paths of egress and the need for full instant use for fire and other emergencies on 7/24/15. Anyone who did not attend was inserviced by the SDC or other appropriate dept head by 8/9/15. This information was also added to our general orientation for new hires.</p> <p>4. The maintenance dept will audit all paths of egress during weekly fire alarm testing times 4 weeks then monthly times 2 additional months to ensure paths are not obstructed and doors fully open with fire alarms. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by : <input checked="" type="checkbox"/></p>	9/01/15

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K 038	<p>Continued From page 9 was equipped with delayed egress.</p> <p>Interview, on 07/09/15 at 10:46 AM with the Maintenance Director and the Assistant Executive Director revealed they were not aware the delayed egress door was not missing the delayed egress signage.</p> <p>The census of two-hundred two (202) was verified by the Executive Director on 07/09/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director and the Assistant Executive Director at the exit interview on 07/09/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 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>Reference: NFPA 101 (2000 Edition) 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</p>	K 038		

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K 038	<p>Continued From page 10 visible from any direction of exit access.</p> <p>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.</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 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>	K 038		

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K 038	Continued From page 11  (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.  (d) *On the door adjacent to the release device, 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  7.2.1.5 Locks, Latches, and Alarm Devices. 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Exception No. 1: This requirement shall not apply where otherwise provided in Chapters 18 through	K 038			

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K 038	Continued From page 12 23. Exception No. 2: Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (a) Permission to use this exception is provided in Chapters 12 through 42 for the specific occupancy. (b) On or adjacent to the door, there is a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high on a contrasting background that reads as follows: <b>THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED</b> (c) The locking device is of a type that is readily distinguishable as locked. (d) A key is immediately available to any occupant inside the building when it is locked. Exception No. 2 shall be permitted to be revoked by the authority having jurisdiction for cause. Exception No. 3: Where permitted in Chapters 12 through 42, key operation shall be permitted, provided that the key cannot be removed when the door is locked from the side from which egress is to be made.	K 038		
K 052 SS=D	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 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	1. The Dry storage door was repaired by maintenance on 7/29/15 and consistently opens during a fire alarm. 2. All other doors with a magnetic lock were inspected and opened during the activation of a fire alarm by 7/31/15. 3. The Executive Director inserviced all associates about the protection of Hazards including the amount of paper in offices to ensure self-closures warranted on doors on 7/24/15.	

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K 052	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on observation during the testing of the fire alarm 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 three (3) of twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred two (202).</p> <p>The findings include:</p> <p>1. Observation during the testing of the fire alarm, on 07/09/15 at 11:17 AM, with the Maintenance Director and the Assistant Executive Director revealed the magnetic lock located on the Dry Storage Hall Exit Door failed to release upon activation of the Fire Alarm.</p> <p>Interview, on 07/09/15 at 11:18 AM, with the Maintenance Director and the Assistant Executive Director revealed they were unaware the magnetic lock would not release with the activation of the fire alarm control panel.</p> <p>2. Observation during the testing of the fire alarm, on 07/09/15 at 11:17 AM, with the Maintenance Director and the Assistant Executive Director</p>	K 052	<p>Anyone who did not attend was inserviced by the SDC or other appropriate dept head by 8/9/15. This information was also added to our general orientation for new hires.</p> <p>4. Maintenance will audit all magnetic doors during weekly fire alarm tests for 4 weeks then monthly times 2 months to ensure they release during the fire alarm. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by:</p>	9/01/15

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K 052	<p>Continued From page 14 revealed the magnetic lock located on the Dry Storage Hall Exit Door failed to release upon activation of the Fire Alarm.</p> <p>Interview, on 07/09/15 at 11:18 AM, with the Maintenance Director and the Assistant Executive Director revealed they were unaware the magnetic lock would not release with the activation of the fire alarm control panel.</p> <p>The census of two-hundred two (202) was verified by the Executive Director on 07/09/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director and the Assistant Executive Director at the exit interview on 07/09/15.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition), 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 072 SS=D	<p>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:</p>	K 072	<ol style="list-style-type: none"> <li>1. The process for getting the food carts back to the kitchen has been changed to prevent blocking the path of egress and the staff were re-educated by 8/9/15 by the Executive Director, SDC, or Dietary Manager. Carts will be called for from the kitchen and stored in the hallway by the dish room and not in resident hallways.</li> <li>2. All residents benefit from all paths of egress being free of obstruction or impediments and to full instant use during a case of fire or emergency.</li> </ol>	

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K 072	<p>Continued From page 15</p> <p>Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility has the capacity for two-hundred twenty-eight (228) beds and at the time of the survey, the census was two-hundred two (202).</p> <p>The findings include:</p> <p>Observation, on 07/09/15 at 10:16 AM, with the Maintenance Director and the Assistant Executive Director revealed four (4) Dietary Food Carts being stored in the egress path of the Breezeway to Main Dining Room. The carts were observed being unattended from 9:08 AM until 10:16 AM. Further observation revealed one (1) of the four (4) carts was blocking the Exit Door.</p> <p>Interview, on 07/09/15 at 10:17 AM, with the Maintenance Director and the Assistant Executive Director revealed the carts were routinely stored in this location.</p> <p>The census of two-hundred two (202) was verified by the Executive Director on 07/09/15. The findings were acknowledged by the Executive Director and verified by the Maintenance Director and the Assistant Executive Director at the exit interview on 07/09/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously</p>	K 072	<p>3. All staff were inservice by 8/9/15 to ensure the importance of keeping paths of egress clear of obstruction or impediments during an emergency or fire by the Executive Director or other appropriate dept head.</p> <p>4. The maintenance dept will audit all paths of egress when carts are being returned to the kitchen during weekly fire alarm testing times 4 weeks then monthly times 2 additional months to ensure paths are not obstructed and doors fully open with fire alarms. The results of the audits will be brought to the QA committee to determine the need for further monitoring.</p> <p>5. Completed by :</p>	9/01/15

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K 072	<p>Continued From page 16 maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>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 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.</p> <p>Reference: S&amp;C-12-21-LSC</p>	K 072		