

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

PRINTED: 08/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2014
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NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Paducah Center Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</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 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 for three (3) residents, in the selected sample of fifteen (15) residents (Residents #3, #5, and #7). The facility staff failed to ensure privacy was provided during care/treatment for Residents #3 and #5. Additionally, the staff excluded Resident #7 from conversation during provision of care.</p> <p>The findings include: Review of the facility's "Considerate and Respectful" policy/procedure, revised 09/01/13,</p>	F 241		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: J. Lopez TITLE: Administrator (X6) DATE: 9/10/14

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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NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH THIRD STREET PADUCAH, KY 42001	
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F 241	Continued From page 1 revealed employees should maintain resident privacy, focus on residents as individuals when talking to them and address residents as individuals when providing care and services. 1. Record review revealed the facility admitted Resident #3 on 11/06/13 with diagnoses which included Essential Hypertension, Generalized Muscle Weakness, Abnormality of Gait, Dementia, unspecified without Behavioral Disturbance, Hypopotassemia, Esophageal Reflux, and Psychosis. Review of the Significant Change-Minimum Data-Set (MDS) Assessment, dated 07/09/14, revealed the facility assessed Resident #3's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of "3", indicating the resident was not interviewable. Observation of a skin prep application, on 08/12/14 at 3:35 PM, revealed Licensed Practical Nurse (LPN) #3 did not close the door nor the privacy curtain prior to providing treatment to Resident #3. Interview with LPN #3, on 08/14/14 at 4:46 PM, revealed he/she should have closed the door, and completely closed the privacy curtain. Interview with the Nurse Practice Educator, on 08/15/14 at 10:43 AM, revealed she expected the staff to close the door and completely close the privacy curtain prior to providing a resident's treatment. 2. Record review revealed the facility admitted Resident #7 on 08/20/13 with diagnoses which included Essential Hypertension, Muscle Weakness, Urinary Tract Infection, Diabetes Type	F 241	Resident #3's dignity and respect was maintained by LPN #3 on 8/12/2014 which was observed by the Director of Nursing. The privacy curtain was pulled securely around resident #3 and the door was shut completely when care was provided on 8/12/2014. Resident #7's dignity and respect was maintained by CNA #6 and LPN #1 on 8/15/2014 by ensuring focus is on the resident and not excluding him/her in conversation when providing incontinence care which was observed by the Director of Nursing. Resident #5's dignity and respect was maintained by RN #1 and LPN #3 on 8/13/2014 by ensuring the privacy curtain was pulled securely around the resident which was observed by the Director of Nursing. Current residents including non-interview able residents were observed by the Director of Nursing on 8/15/2014 to ensure that privacy curtains were pulled during care, doors were shut during care and to ensure staff did not exclude residents in conversation during care. The Social Services Director interviewed Resident #3, 5 and 7 and/or their responsible party and remainder of interview able residents regarding any concerns of dignity and respect beginning on 8/15/2014 through 9/4/2014. Resident	09/09/2014

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F 241	Continued From page 2 II, Alzheimer's Disease, Peripheral Vascular Disease, Chronic Kidney Disease, Unspecified Psychosis, Dysphagia, Hyperlipidemia, Anxiety State, Depressive Disorder, Cellulitis, and Abscess-Unspecified-Site.-Review of the Quarterly MDS Assessment, dated 07/09/14, revealed the facility assessed Resident #7's cognition as severely impaired with a BIMS score of "3", indicating the resident was not Interviewable. Observation, on 08/15/14 at 9:40 AM, revealed Certified Nurse Aide (CNA) #6 and LPN #1 were engaged in a conversation, and excluded Resident #7 from the conversation while providing Incontinent care for him/her. Interview with CNA #3, on 08/15/14 at 11:00 AM, and LPN #1, on 08/15/14 at 10:20 AM, revealed the focus should be on the resident when providing care. 3. Record review revealed the facility admitted Resident #5 to the facility on 06/09/14 with diagnosis to include Muscle Weakness, Presenile Dementia, Blindness, and Macular Degeneration. Review of the MDS, dated 06/16/14, revealed Resident #5's BIMS score was "14", indicating the resident was cognitively intact. Observation, on 08/13/14 at 1:20 PM, during a skin assessment revealed Registered Nurse (RN) #1 and LPN #1 did not pull the privacy curtain at the doorway. During the skin assessment, Resident #5's buttocks was exposed when the door was opened by another staff member. Interview with RN #1, on 08/13/14 at 1:35 PM, revealed the privacy curtain should have been	F 241	#5 and responsible party's of Resident #3 and #7 voiced no concern related to dignity and/or respect. No further issues were identified by the interview able residents and/or responsible parties. Licensed nurses, nurse aides, rehab staff and recreation staff was reeducated on 8/21/2014 through 9/8/2014 by the Nurse Practice Educator regarding providing care in a manner to enhance or maintain a resident's dignity and respect to include keeping the privacy curtains completely pulled during care and keeping focus on the resident during care and not having conversations that excludes resident participation. The Director of Nursing, Assistant Director of Nursing and Nurse Practice Educator will observe five residents a week on all three shifts to include weekends of residents receiving ADL care related to dignity and respect for four weeks then three residents a week on all three shifts for one month, then two residents for a month on all three shifts to ensure privacy and dignity. Corrective action will be provided with the involved employee at the time of occurrence.	

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F 241	Continued From page 3 pulled around the entire bed in order to provide privacy for Resident #5 and to prevent the resident from being exposed during care. Interview with LPN #1, on 08/13/14 at 1:40 PM, revealed the privacy curtain should have been pulled around the entire bed while providing resident care in order to provide privacy. Interview with RN #2, on 08/15/14 at 9:25 AM, revealed she expected staff to provide privacy for all residents during care by closing the door, pulling the curtain around the entire bed, pulling the curtain between residents, and closing the blinds. Interview with the Assistant Director of Nursing (ADON), on 08/15/14 at 11:10 AM, revealed she expected the staff to pull the privacy curtain securely around the resident and close the door prior to providing treatment. She stated she expected the staff to focus on the residents, and include the residents in conversation when providing care. Interview with the Director of Nursing (DON), on 08/15/14 at 11:15 AM and 12:25 PM, revealed yearly training included dignity and respect. He expected the staff to focus on, as well as include the residents in conversation during provision of care. He also stated the staff should provide privacy for all residents during care by pulling the privacy curtain all the way around the residents at the doorway, as well as the curtain between residents.	E 241	The Social Services Director will interview five residents and/or responsible parties per week then three residents and/or responsible parties per week for sixty days for concerns of dignity and respect. Corrective action will be provided with the involved employee by the Director of Nurses and/or Social Services with follow up to the resident and/or responsible party. The Director of Nursing and Social Services Director will report findings to the monthly Performance Improvement committee for three months for review and further recommendations. The Performance Committee is attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members including the Social Services Director, Admissions Director, Payroll Coordinator and/or Dietary Manager for further recommendations.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			

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F 315	Continued From page 4 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	Resident #9's was given proper catheter care in a manner which prevented or reduced infections by CNA #8 and CNA #9 on 8/13/2013 that was observed by the Director of Nursing. Resident #9 catheter bag was repositioned appropriately on the wheelchair by the Director of Nursing and/or Assistant Director of Nursing on 8/15/2014 to keep the catheter collection bag from touching the floor.	9/9/14
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, the facility failed to provide catheter care in a manner which prevented or reduced urinary tract infections for two (2) residents, in the selected sample of fifteen (15) residents. (Residents #9 and #13). The findings include: Review of the facility's policy/procedure "Care of Indwelling Urinary Catheter", revised 01/02/14, revealed to perform catheter care twice a day and as needed (prn). Cleanse the proximal third of the catheter with soap and water, washing away from the insertion site and manipulating the catheter as little as possible, and rinse. Secure the catheter tubing to keep the drainage bag below the level of the resident's bladder and off the floor. Position catheter for straight drainage. 1. Record review revealed the facility admitted Resident #9 with diagnosis to include Alzheimer's, Psychosis, and Abscess of Buttock. Review of the Quarterly Minimum Data Set (MDS)		Resident #13 catheter collection bag was repositioned by the Director of Nursing and/or Assistant Director of Nursing on 8/15/2014 to prevent contact with the floor due to resident being in a low bed. Current residents with catheters in low beds and in wheelchairs were identified and observed by Director of Nursing on 8/15/2014 to observe that catheter collection bags are positioned appropriately when the resident is in bed or up in wheelchair to ensure the bag is not touching the floor with corrective action upon discovery. Those identified were immediately repositioned by the Director of Nursing on 8/15/2014 to ensure catheters were off the floor.	

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F 316	Continued From page 5 assessment, dated 07/25/14, revealed the facility assessed the resident with severe cognitive impairment and required total assistance with all activities of daily living. He/she had an indwelling urinary catheter related to a surgical wound. Observation, on 08/13/14 at 2:55 PM, revealed Resident #9, who had been incontinent of bowel, was provided incontinent care by two (2) Certified Nurse Aides (CNAs), #8 and #9. CNA #8 and #9 did not clean the indwelling urinary catheter tubing during care. Further observation, on 08/16/14 at 11:45 AM, revealed Resident #9 was sitting in a wheelchair with his/her indwelling urinary catheter collection bag touching the floor. Interview with CNA #9, on 08/13/14 at 3:05 PM, revealed she normally does catheter care while doing incontinent care, especially when the resident has had a bowel movement. She also stated she normally cleans the resident from the top of the tubing to the bottom. She stated "I don't know why I didn't, it is what it is, you saw it". Interview with CNA #8, on 08/13/14 at 3:15 PM, revealed catheter care should have been done, but wasn't. She revealed she had no explanation why it wasn't done. 2. Record review revealed the facility admitted Resident #13 on 08/10/14 with diagnoses to include Congestive Heart Failure, Cancer, and Chronic Renal Insufficiency. Review of the Physician's orders, dated 08/10/14, included "Foley catheter 16 FR with 10 ml balloon to bedside drainage". Observation, on 08/14/14 at 2:15 PM, revealed Resident #13 lying in bed with his/her eyes	F 316	Resident #9 and #13 were evaluated and monitored for signs and symptoms for infection by the Director of Nursing and/or LPN-Charge Nurse with no issues noted on 8/15/2014. Licensed nurses, nurse aides, Administrative Departments including the Administrator, Activities, Admissions, Coordinator, Dietary Manager, Medical Records, Maintenance Supervisor and Rehab Services were provided reeducation by the Nurse Practice Educator on 8/21/2014 through 9/8/2014 regarding catheter collection bags are not to touch the floor when the resident is either sitting up in a wheelchair or in a low bed. Nursing staff were provided reeducation on procedure for appropriate catheter care 8/21-9/8/14 by Nurse Practice Educator with return observations. Corrective action was provided at time of observation if indicated with the employee.	

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F 315	Continued From page 6 closed. Pale yellow urine was observed in the tubing draining in a bedside drainage bag which was lying directly on the floor. Further observation, on 08/15/14 at 8:00 AM, revealed Resident #13 was in bed with his/her urinary catheter drainage bag lying directly on the floor. Observation and interview with the Director of Nursing (DON), on 08/14/14 at 8:30 AM, verified the drainage bag was lying directly on the floor. The DON stated a resident's drainage bag should not be in contact with the floor.	F 315	The Director of Nursing, Assistant Director of Nursing, Unit Manager and Nurse Practice Educator will observe residents with a catheters when up in a wheelchair or in a low bed on all shifts to include weekends weekly for one month, every two weeks for one month, then monthly for one month to ensure that no catheter collection bags are not observed touching the floor. Catheter care observations will be conducted by		
F 323 SS=D	483.26(h) FREE-OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's investigation, it was determined the facility failed to ensure one (1) resident, in the selected sample of fifteen (15) residents (Resident #8), received adequate supervision and assistance to prevent elopement on 07/23/14. The findings include: Record review revealed the facility admitted Resident #8 on 11/08/10 with diagnoses to	F 323	the Nurse Practice Educator, Unit Managers, and Director of Nurses with CNAS providing care across all shifts including weekends weekly times one month, every two weeks times one month. Identified problems will be corrected immediately by the Director of Nursing, Assistant Director of Nursing, Unit Manager and Nurse Practice Educator. The Director of Nursing and/or Assistant Director of Nursing will report results to the Performance Improvement Committee monthly for three months for review and recommendations. The Performance Committee is attended by		

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F 323	Continued From page 7 Include Dementia with Behavioral Disturbances, Alzheimer's Disease, Cognitive Deficits due to Cerebrovascular Disease, and Adult Failure to Thrive. Review of the Annual Minimum Data Set (MDS), dated 06/16/14, revealed Resident #8 had a Brief Interview Mental Status (BIMS) of three (3), indicating the resident was not interviewable. Review of the facility's investigation revealed Resident #8 eloped on 07/23/14 at approximately 8:00 PM. Further review revealed the resident exited the facility through the secured East door of the Solana Unit. Additionally, Certified Nurse Aide (CNA) #1 heard the door alarm sounding, responded, and observed Resident #8 near the East door of the Solana Unit; however, CNA #1 did not look outside the building perimeter or grounds. Interview with CNA #1, on 08/13/14 at 4:10 PM, revealed the last eyewitness account of Resident #8, prior to elopement on 07/23/14, was at 6:30 P.M. Further interview revealed CNA #1 was caring for another resident because his/her sensor alarm activated. She stated "I then heard a door alarm going off, so I went to check on it. I saw Resident #8 standing at the exit door holding on to the door handle. I redirected Resident #8 away from the door, closed the door, and reset the alarm. I did not look outside the outside the building perimeter and grounds". Interview with CNA #2, on 08/13/14 at 3:20 PM, revealed, on 07/23/14 at 7:15 PM, she was in the facility courtyard monitoring a smoke break for the residents. Further interview revealed while assisting residents back inside the facility, she observed Resident #8 on the outside of the facility in the courtyard, 125 feet from the exit door of the	F 323	the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members including the Social Services Director, Admissions Director, Payroll Coordinator and/or Dietary Manager for further recommendations. Resident #8 was returned to the unit and a head to toe evaluation was completed by the LPN Charge Nurse on 7/23/2014. No skin issues were identified and resident was able to move extremities without difficulty. An Elopement Evaluation was completed and care plan was updated on 7/23/14 and 7/24/14 to include a wander guard for safety by the LPN Charge Nurse. Upon notification of the Elopement, charge nurses immediately completed a census check on 7/23/2014. All residents (67 of 67) were present inside the facility. This was initiated at 8:00 p.m. CST by the	9/9/14

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F 323	Continued From page 8 Solana Unit. CNA #2 revealed Resident #8 did not go outside with the other residents when they went out for a smoke break. Interview with Licensed Practical Nurse (LPN) #3, on 08/13/14 at 4:10 PM, revealed Resident #8 had a wanderguard upon admission; however, the wanderguard was removed because the resident was not considered an elopement risk. She revealed she last saw Resident #8 on 07/23/14 at approximately 6:30 PM. She stated she was off the unit at 7:30 PM, and CNA #2 noticed Resident #8 outside the facility in the courtyard, and brought the resident back inside. Interview with CNA #4, on 08/13/14 at 2:55 PM, revealed an eyewitness account of Resident #8 packing his/her clothing and attempting to exit the East door of the Solana Unit. Further interview revealed the resident had exhibited these behaviors for the past year. Observation, on 08/13/14 at 8:30 AM, revealed the Maintenance Supervisor demonstrated the operation of the door on the East Solana Unit. The security code had to be entered before entry/exit. The alarm sounded until the security code was entered manually to disarm it. Interview with the Maintenance Supervisor, on 08/14/14 at 8:45 AM, revealed the door on the East Solana unit opened if the correct code was entered. He stated the wanderguard sensor deactivated the East door on the Solana Unit because the alarm continually was going off when residents with wanderguards went to the door. Further Interview revealed the door was only utilized for the Oxygen Therapy Provider, and staff does not use the door otherwise. He	F 323	licensed nurses on 7/23/2014. The Maintenance Director was notified and came to the facility on the evening of 7/23/2014 to validate that all doors and door alarms were functioning properly. It was noted by the Maintenance Supervisor on 7/23/2014 that all door alarms were functioning properly. The East door of Solana door mag lock was adjusted upon discovery. The Director of Nursing, Assistant Director of Nursing and Nurse Practice Educator responded to the facility and initiated elopement drills and education on 7/23/2014. Wander guard bracelets were checked by the Director of Nursing, Assistant Director of Nursing and/or the Nurse Practice Educator to ensure all bracelets were not outdated on 7/23/2014. No issues were identified by the Director of Nursing, Assistant Director of Nursing and/or Nurse Practice Educator on 7/23/2014.		

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F 323	Continued From page 9 revealed the Oxygen Therapy Provider accessed the East door on the Solana Unit on 7/23/14. He was contacted the evening of 07/23/14 at approximately 8:15 PM, and was informed a resident had exited the East door of the Solana Unit. The Maintenance Supervisor revealed upon checking the function of the door, he noted the door sensor alarm had malfunctioned. He further revealed all facility doors were checked daily for proper functioning. Interview with the Director of Nursing (DON), on 08/15/14 at 12:10 PM, revealed his expectations was if an alarm sounded, he expected the staff to check the alarm to see what caused the alarm to activate. Further interview revealed he expected the staff to look outside before securing the door and resetting the alarm. Interview with the Administrator, on 08/15/14 at 12:10 PM, revealed she was notified about the elopement on 07/23/14 between 7:30 PM and 8:00 PM. Further interview revealed, on 07/23/14 at 10:39 AM, the Administrator checked the East door of the Solana Unit during morning rounds with no concerns identified. She revealed Oxygen Therapy Providers were the only ones who accessed the East door of the Solana Unit. She also revealed she was unaware the wanderguard alarm sensor was not activated at the East door of the Solana Unit.	F 323	All staff were reeducated on 7/23/2014 through 7/25/2014 by the Director of Nursing, Assistant Director of Nursing, Nurse Practice Educator or Administrator regarding center policies on elopement prevention and management, expected employee response to door alarms. Each employee completed a post-test to validate learning. Reeducation regarding door function was initiated on 8/19/2014 through 9/3/2014 to all staff by the Nurse Practice Educator, Director of Nursing, and/or Assistant Director of Nursing. The Maintenance Director will check all doors Monday through Friday to ensure proper functioning including alarms and mag locks and document findings. In the absence of the Maintenance Director, the Administrator or a Licensed Nurse will check the doors to ensure proper functioning. On Saturdays and Sundays, the doors will be checked for proper functioning by the Ambassador staff (including: Payroll Coordinator,	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		

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NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 10 of disease and infection.	E 441	Dietary manager, Social Service Director, Central Supply Clerk, Admissions Director, Business office Manager, Activities, MDS Coordinators, Central Supply Clerk, Medical Records and or Nurse Practice Educator) or a Licensed Nurse for proper functioning and document findings.	
	(a) Infection Control Program The facility must establish an Infection Control Program under which it: (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.		Elopement drills will be completed on all shifts to include the weekends by Nurse Practice Educator monthly for three months to audit training compliance. Reeducation will be provided by the Maintenance Director and/or Nurse Practice Educator upon discovery with the employee. Results of elopement drills will be presented to the Performance Improvement Committee for three months for review and recommendations. The Performance Committee is attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members including the Social Services Director, Admissions Director, Payroll Coordinator and/or Dietary Manager for further recommendations.	
	(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	This REQUIREMENT is not met as evidenced by: Thomas, Vonda Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure proper			

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NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001		
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F 441	Continued From page 11 Incontinent care and appropriate hand washing and gloving technique during the performance of perineal (incontinence) care for three (3) residents. In the selected sample of fifteen (15) residents (Residents #3, #5, and #7). The findings include: Review of the facility's "Hand Hygiene" policy/procedure, revised 10/01/2013, revealed employees should wash hands with soap and water after removing gloves, before and after direct patient care, immediately after contact with blood, body fluids, or other potentially infectious materials and when hands are visibly soiled or contaminated. 1. Record review revealed the facility admitted Resident #3 on 11/06/13 with diagnoses which included Essential Hypertension, Generalized Muscle Weakness, Abnormality of Gait, Dementia, unspecified without Behavioral Disturbance, Hypopotassemia, Esophageal Reflux, and Psychosis. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 07/09/14, revealed the facility assessed Resident #3's cognition as severely Impaired with a Brief Interview Mental Status (BIMS) score of "3", indicating the resident was not interviewable. Observation of a skin prep application, on 08/12/14 at 3:35 PM, revealed Licensed Practical Nurse (LPN) #3 washed her hands and donned gloves, touched treatment cart keys and placed the keys in her pocket. Further observation revealed she opened and applied skin prep to Resident #3's heel, removed the gloves, replaced the resident's sock and Prevalon boot, bagged a soiled towel, touched the resident and the	F 441	Resident #3 was provided care from LPN #3 on 8/12/2014 in a manner that ensured proper hand washing to prevent the spread of infection that was observed by the Director of Nursing. Resident #3 was provided care from C.N.A. #7 on 8/13/2014 by ensuring proper incontinent care was given to avoid the spread of infection that was observed by the Director of Nursing. Resident #7 was provided care from CNA #6 on 8/15/2014 in a manner that ensured proper incontinent care was given, removing soiled gloves, washing hands, and donning new gloves to ensure that infection control policies are being followed that was observed by the Director of Nursing. Resident #5 was provided care by RN #1 and LPN #1 on 8/13/2014 in a manner that ensured soiled gloves were removed, RN #1 and LPN #5 hands were washed and new gloves were donned to ensure that infection control policies are being followed that was observed by the Director of Nursing. Skin assessments were observed on all residents between 8/15/2014 and 8/21/2014 by the Director of Nursing, Nurse Practice Educator and/or Assistant Director of Nursing which resulted in 100% competency of staff observed. No other issues identified. Pericare was observed on 34 of 34 residents by the Director of Nursing, Nurse Practice	9/9/14	

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F 441	Continued From page 12 wheelchair, and then transferred Resident #3 down the hallway to the activity room without washing her hands. Interview, on 08/14/14 at 4:45 PM, with LPN #3 revealed she should have removed her gloves and washed her hands following skin prep application, and prior to touching the resident, sock, boot and wheelchair. Observation of Incontinent care, on 08/13/14 at 14:20 PM, revealed Certified Nurse Aide (CNA) #7 removed Resident #3's soiled incontinent brief, provided perineal care, and repositioned Resident #3 to the left lateral position, and wiped from back to front to remove stool. Further observation revealed CNA #7 applied a clean incontinent brief, touched the linens, and the call light prior to removing her gloves or washing her hands. Interview, on 08/13/14 at 4:20 PM, with CNA #7 revealed she should have wiped front to back when removing stool, changed gloves, and washed her hands prior to placing a clean incontinent brief and before touching the resident, linens, and the call light. 2. Record review revealed the facility admitted Resident #7 on 08/20/13 with diagnoses which included Essential Hypertension, Muscle Weakness, Urinary Tract Infection, Diabetes Type II, Alzheimer's Disease, Peripheral Vascular Disease, Chronic Kidney Disease, Unspecified Psychosis, Dysphagia, Hyperlipidemia, Anxiety State, Depressive Disorder, Cellulitis, and Abscess Unspecified Site. Review of the Quarterly MDS Assessment, dated 07/09/14, revealed the facility assessed Resident #7's	F 441	Educator and/or Assistant Director of Nursing between 8/15/2014 and 8/21/2014 with no other issues identified. Treatment and dressing changes were observed with 12 of 12 staff members competent between 8/15/2014 and 8/21/2014. No issues identified. Licensed staff and nurses aides (CNAS) staff was reeducated and competency testing provided by the Nurse Practice Educator on hand hygiene including glove usage, proper handling of linens to include storage and incontinent care on 8/19/2014 through 9/8/2014. Licensed nurses as assigned by Nurse Practice Educator will observe CNAS providing direct care for hand washing, glove usage and handling of linens to prevent the spread of infections three times a week on all three shifts for four weeks then three times a month for two months on all three shifts. The Director of Nursing, Assistant Director of Nursing and/or the Nurse Practice Educator will observe Licensed nurses providing skin assessments and treatments for hand washing, glove usage and handling of linens to prevent the spread of		

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F 441	Continued From page 13 cognition as severely impaired with a BIMS score of "3", indicating the resident was not interviewable.	F 441	infections three times a week on all three shifts for four weeks then three times a month for two months on all three shifts.		
	Observation of incontinent care, on 08/15/14 at 9:50 AM, revealed CNA #6 removed Resident #7's soiled incontinent brief, cleansed the perineal and rectal area, removed soiled gloves, and donned clean gloves without washing her hands. Further observation revealed CNA #6 applied a clean incontinent brief, touched the resident, linens, alarm control, and bedside table without removing her gloves or washing her hands.		The Director of Nursing and/or the Assistant Director of Nursing will report results to the Performance Improvement Committee for three months for review and further recommendations. The Performance Committee is attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary Team Members including the Social Services Director, Admission Director, Payroll Coordinator and/or Dietary Manager for further recommendations.		
	Interview, on 08/15/14 at 10:10 AM, with CNA #6 revealed she should have washed her hands when gloves were changed, and should have removed her gloves and washed her hands prior to touching the resident, linens, alarm control, and bedside table.				
	Interview, on 08/15/14 at 11:10 AM, with the Assistant Director of Nursing (ADON) revealed her expectation was for staff to wash his/her hands and don gloves before providing incontinent care, after touching body fluids, and when visibly soiled or contaminated.				
	3. Record review revealed the facility admitted Resident #5 on 06/09/14 with diagnoses to include Muscle Weakness, Presenile Dementia, Blindness and Macular Degeneration. Review of the MDS Assessment, dated 06/16/14, revealed Resident #5's BIMS score was 14, indicating cognitively intact.				
	Observation, on 08/13/14 at 1:20 PM, during a skin assessment revealed Registered Nurse (RN) #1 and LPN #1 failed to change gloves after				

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NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH THIRD STREET PADUCAH, KY 42001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 14 coming in to contact with the resident's peri/buttock area. They proceeded to touch the resident multiple times throughout the resident's skin assessment, and proceeded to touch Resident #5's bed linens, pillow, heel boot, and call light before taking off their gloves. Interview with RN #1, on 08/13/14 at 1:35 PM, revealed during the skin audit, gloves should have been changed after the peri-area/buttocks area was observed before proceeding to another area of the resident to prevent the possible spread of infection throughout the room. Interview with LPN #1, on 08/13/14 at 1:40 PM, revealed during the skin assessment, when examining the peri-area/buttocks area, she should have changed her gloves in order to prevent the spread of infection. Interview with RN #2, on 08/15/14 at 9:25 AM, revealed she expected the staff to wear gloves while performing a skin assessment and change gloves when coming into contact with the peri/buttocks area, wash hands, and put on a clean pair of gloves to provide continued resident care. RN #2 further revealed wearing soiled gloves could cause the spread of infection. Interview with the Director of Nursing (DON), on 08/15/14 at 11:15 AM, revealed he expected the staff to change gloves during any contact with a resident's peri- or buttock area, wash hands, and put on a new pair of gloves before proceeding with resident care to prevent the spread of infection.	F 441			

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NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 801 NORTH THIRD STREET PADUCAH, KY 42001	
(X4) ID PREFIX TAG K 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01. PLAN APPROVAL: 1963. SURVEY UNDER: 2000 Existing. FACILITY TYPE: SNF/NF. TYPE OF STRUCTURE: One (1) story, Type III (211). SMOKE COMPARTMENTS: Four (4) smoke compartments. FIRE ALARM: Complete fire alarm system installed in 1963, and upgraded in 1995 with 19 smoke detectors and no heat detectors. SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1963 and upgraded in 2005. GENERATOR: Type II generator installed in 1963. Fuel source is Natural Gas. A standard Life Safety Code Survey was conducted on 08/12/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-four (74) beds with a census of sixty-nine (69) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal	ID PREFIX TAG K 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Paducah Center Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	(X5) COMPLETION DATE



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

J. Lopez Administrator 9/2/14

TITLE

(X5) DATE

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

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NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 1. Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000			
	Deficiencies were cited with the highest deficiency identified at "F" level.				
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-four (74) beds and at the time of the survey, the census was sixty-nine (69).	K 050	A fire drill was held on all shifts on 9/4/14 and documentation of drills was recorded and filed by Maintenance Director. Fire drills will be held by Maintenance Director and/or Administrator monthly, on various shifts and times and documentation showing employees participation. Drills will be recorded by the Maintenance Supervisor in the Life Safety binder. A back-up copy of documentation will be saved electronically in the TELS system. Reeducation was completed with the Maintenance Director and	9/13/2014	
	The findings include: Fire Drill review, on 08/12/14 at 12:10 PM with the Maintenance Supervisor, revealed the fire drills were not being conducted quarterly on all shifts.				

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K 050	Continued From page 2 There was no fire drill performed on 1st shift during the 1st quarter of 2014, no fire drill performed on 2nd shift during the 4th quarter of 2013, and no drill was performed on 3rd shift during the 2nd quarter of 2014 and the 4th quarter of 2013.	K 050	Administrator on 8/12/2014 by the Regional Property Manager to ensure all fire drill documentation is completed each time a fire drill has been conducted. An electronic calendar with assigned tasks will be generated by TELS that includes fire drills. A copy will be submitted to the Administrator to ensure fire drills are conducted timely.		
K 062 SS=F	Interview, on 08/12/14 at 12:11 PM with the Maintenance Supervisor, revealed he was unaware the fire drills were not being conducted on each shift as required. The census of sixty-nine (69) was verified by the Administrator on 08/12/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/12/14. Actual NFPA Standard: Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	The Maintenance Supervisor will conduct fire drills quarterly according to the assigned tasks calendar and report findings to the Administrator. Regional Property Manager will check quarterly results at time of monthly visits with corrective action if indicated. The Maintenance Director will bring a copy of the electronic calendar which includes assigned shifts and dates to perform drills to the monthly Performance Improvement Committee. Fire drill documentation will be documented and uploaded each time completed into TELS by the		
	This STANDARD is not met as evidenced by: Based on sprinkler record review, and interview it was determined the facility failed to maintain the sprinkler system in accordance with National Fire				

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K 062	Continued From page 3 Protection Association (NFPA) standards. The deficient practice has the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for seventy-four (74) beds and at the time of the survey, the census was sixty-nine (69). The findings include: Sprinkler record review, on 08/12/14 at 11:55 AM with the Maintenance Supervisor, revealed the facility failed to provide documentation for an obstruction investigation test performed since 4-16-09. Interview, on 08/12/14 at 11:56 AM with the Maintenance Supervisor, revealed he was unaware the test was not performed and he relies on the sprinkler company for him to comply with NFPA standards. The census of sixty-nine (69) was verified by the Administrator on 08/12/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/12/14. Actual NFPA Standard: Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection,	K 062	Maintenance Director, The Maintenance Director will report results to the monthly Performance Improvement Committee for three months attended by the Medical Director, Administrator, Director of Nursing, and the Interdisciplinary Team Members (including: Payroll Coordinator, Dietary manager, Social Service Director, Central Supply Clerk, and or Nurse Practice Educator) for further recommendations.	

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K 062	Continued From page 4 testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.	K 062	A sprinkler inspection was scheduled for 9/12/2014 and was completed on 9/10/2014 by Lamar Mann from Century Fire Protection. Sprinkler systems will be inspected, tested and maintained to ensure compliance every five years by the contracted vendor. The original documentation will be kept in the Life Safety Binder and a backup copy of all inspections and tests will be saved electronically in the TELS system. An electronic calendar with assigned tasks will be generated by TELS to ensure sprinkler systems are inspected, tested and maintained. Reeducation was completed with the Maintenance Supervisor and Administrator on 8/12/2014 by the Regional Property Manager to ensure all inspections and tests are completed timely. Sprinkler tests and inspections will be conducted timely and documentation saved on the TELS system by the Maintenance Supervisor.	9/13/2014
	Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186312	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2014
NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 601 NORTH THIRD STREET PADUCAH, KY 42001	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 5 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves	K 062	The Maintenance Supervisor will bring a copy of the electronic calendar to the Performance Improvement Committee to include dates of when sprinkler system inspections and tests are due. The Maintenance Supervisor will report results to the Performance Improvement Committee monthly for three months attended by the Medical Director, Administrator, Director of Nursing and Interdisciplinary team members (including Payroll Coordinator, Dietary manager, Social Service Director, Central Supply Clerk, and or Nurse Practice Educator) for further recommendations.	

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NAME OF PROVIDER OR SUPPLIER PADUCAH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH THIRD STREET PADUCAH, KY 42001		
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K 062	Continued From page 6.	K 062			
	Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1				
	Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1				
	Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1				
	Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1				
	Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operatlon Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves				
	Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually				

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K 062	Continued From page 7	K 062	The employee smoking area was cleaned by maintenance director.	
	9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually		Cigarette butts and trash were disposed of appropriately on 8/13/14	
	9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2		A walk through on 8/13/2014 by the Administrator, Maintenance Director and Regional Property Manager discovered excessive cigarette butts near the entrance door by the employee smoking area and the north hallway door. No other areas were identified. The identified areas were cleaned on 8/13/2014 by the Admissions Director and the Business Office Manager.	9/13/2014
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	Reeducation for all staff and new hires was initiated on 8/21/2014 to include smoking only in designated smoking areas, using the proper dispensers for trash and cigarette butts by the Administrator. Audits/rounds will be conducted by the Administrator and/or Maintenance Director twice a week for a month then twice a month for two months to ensure cigarette butts are placed in the appropriate containers and trash is	
	This STANDARD is not met as evidenced by: Based on observation, smoking policy review,			

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K 066	Continued From page 8 and interview, it was determined the facility failed to ensure the use of approved smoking areas, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of four (4) smoke compartments, twenty (20) residents, staff and visitors. The facility has the capacity for seventy-four (74) beds and at the time of the survey, the census was sixty-nine (69). The findings include: Observation, on 08/12/14 at 2:24 PM with the Maintenance Supervisor, revealed the area at the maintenance shop exit was being used as a smoking area and over fifty (50) cigarette butts were on the ground surrounding the smoking area. Interview, on 08/12/14 at 2:25 PM with the Maintenance Supervisor, revealed he was unaware the cigarette butts were being placed on the ground. Observation, on 08/12/14 at 2:27 PM with the Maintenance Supervisor, revealed the metal container with a self-closing lid had trash placed inside the container. Interview, on 08/12/14 at 2:28 PM with the Maintenance Supervisor, revealed he was unaware trash was being placed inside the metal container. The census of sixty-nine (69) was verified by the Administrator on 08/12/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 08/12/14.	K 066	placed separate from cigarette butt. Maintenance staff will provide corrective action at the time of discovery including reeducation of the involved employees. The Maintenance Director and/or Administrator will report results to the Performance Improvement Committee monthly for three months attended by the Medical Director, Administrator, Director of Nursing, and the Interdisciplinary Team Members (including: Payroll Coordinator, Dietary manager, Social Service Director, Central Supply Clerk, and or Nurse Practice Educator) for further recommendations.		

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K 066	Continued From page 9	K 066			
	Actual NFPA Standard:				
	NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:				
	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.				
	(2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.				
	(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				