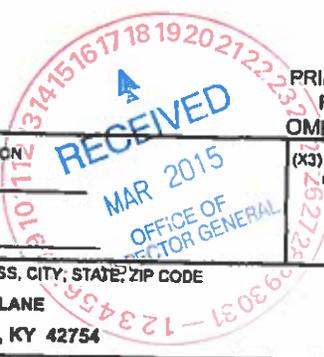


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/17/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  01/30/2015
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NAME OF PROVIDER OR SUPPLIER  SPRING VIEW HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754
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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		
F 281	<p>Amended</p> <p>A Recertification Survey was conducted on 01/27/15 through 01/30/15 with deficiencies cited at the highest Scope and Severity of a "D".</p> <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:</p> <p>Based on interview, record review, and review of the facility's Standards of Practice and Kentucky Board of Nursing KRS 314.021(2), it was determined the facility failed to ensure services provided met professional standards of quality for one (1) of fifteen (15) sampled residents (Resident #12), who was administered two (2) doses of an antibiotic that was listed as an allergy.</p> <p>The findings include:</p> <p>Review of the Kentucky Board of Nursing KRS 314.021(2), revised 10/2010, revealed nurses are held individually responsible and accountable for rendering safe, effective nursing care to residents and for judgements exercised and actions taken in the course of providing care.</p> <p>Review of the facility Standards of Practice "Eighth Edition Clinical Nursing Skills Basic to Advance Skills" revealed "upon admission, a comprehensive list of the client's home</p>	F 281	<p>Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p> <p>F 221: 483.20(k)(93)(i) Services Provided Meet Professional Standards</p> <p><u>Corrective Measures for Resident(s) Identified In The Deficiency:</u></p> <p>[1] Amoxicillin 500 mg, Keflex 250 mg Probiotic discontinued 1/27/2015 following physician notification by the licensed nurse of the allergy. Resident #12 was assessed by a licensed nurse on 1/27/2015 for any adverse effects with none noted.</p> <p>[2] Resident #12 started on Zyvox 600mg orally two times a day beginning on 1/27/15 by the licensed nurse for 14 days and Entapenem 1000 mg on 1/27/15 intravenously daily for 14 days.- by the licensed nurse.</p> <p>[3] Resident #12's comprehensive care plan was reviewed and revised as indicated by the Inter-disciplinary care plan team on 2/8/2015 as indicated.</p> <p>[4] Resident #12's chart was reviewed by the Regional Resource Nurse on 2/10/2015 to ensure the allergy sticker was on the chart with the correct listing of allergies placed on her profile.</p>	2/28/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE CHA	(X6) DATE 02/23/2015
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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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F 281	<p>Continued From page 1</p> <p>medications is obtained including the route, dose, and frequency of use. A list of allergies to foods, drugs, devices, and materials is also obtained."</p> <p>Record review revealed the facility admitted Resident #12 on 06/06/00 with diagnoses to include Dementia, Chronic Kidney Disease Stage III to IV, Anxiety, Hypertension, Leukocytosis, Depression, Hypothyroidism, Peripheral Vein Disease and Joint pain. Review of the Quarterly Minimum Data Set (MDS) assessment, completed on 11/28/14, revealed the facility assessed Resident #12 as moderately impaired with a Brief Interview for Mental Status (BIMS) score of nine (9).</p> <p>Review of the Physician's Orders, dated 01/27/15, revealed an order for Amoxicillin 500 milligrams (mg) three (3) times daily (TID) for fourteen (14) days. Further review revealed the telephone order was received from the primary medical physician and written by Registered Nurse (RN) #4.</p> <p>Review of the resident's chart revealed an allergy sticker on the binder with documentation to include his/her allergies. This list included Penicillins, NSAIDS, Diflucan, and Sulindac.</p> <p>Review of the Medication Administration Record (MAR), dated January 2015, revealed Resident #12 received two (2) doses of Amoxicillin at 2:00 PM and 8:00 PM on 01/27/15.</p> <p>Interview with the nurse who administered the medications on 01/27/15 revealed she removed the initial dose of Amoxicillin from the emergency drug kit and administered the medication to Resident #12. She stated an order for Diflucan</p>	F 281	<p><u>How Other Resident's Who May Be Affected By This Practice Were Identified</u></p> <p>[1] 100% chart audit of the clinical records by the Regional Resource Nurse on 2/10/2015 for allergies and placement of allergy identification labels on the clinical record.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-Occurrence:</u></p> <p>[1] Licensed nurses and the Medical Records Director were educated by the Director of Nursing and or Assistant Director of Nursing on 2/19-2/25/2015 on the clinical importance of identification of resident allergies and the placement of the allergy stickers with the listed allergies of each resident.</p> <p>[2] All new admissions and re-admission charts will be reviewed in the Abbreviated Quality Assurance meeting Monday-Friday by the Director of Nursing, Assistant Director of Nursing, or Unit Managers to ensure the allergies are identified, placed on the allergy label and placed on the clinical record. On the weekends the licensed nurse doing the admission or re-admission will verify the allergy sticker is in place and on the clinical record by the Check Off Sheet For Admissions.</p> <p>[3] Each resident will have their allergy list audited monthly by the Unit Managers to ensure the allergies are accurate and listed correctly on the allergy label and on the clinical record.</p> <p>[4] Any variances will be addressed</p>	2/28/15

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F 281	<p>Continued From page 2</p> <p>100 mg was ordered and was not given due to Resident #12 having an allergy to Diflucan. The nurse stated she failed to notice the Amoxicillin allergy. Further interview revealed she was unaware of any adverse reaction resulting from the administration of Amoxicillin to Resident #12.</p> <p>Review of the Physician's Orders, dated 01/27/15, revealed a wound culture and sensitivity report was received, and the physician was notified. An order was received to discontinue the Amoxicillin and Diflucan, and a new order for Zynox and Entapenem was received.</p> <p>Interview with the resident's next of kin, on 02/12/15 at 7:43 PM, revealed she was unsure of the type of reaction Resident #12 had when administered Amoxicillin in the past. She stated the allergy had been taken lifelong, and believed the resident had experienced a severe reaction.</p> <p>Interview with the Director of Nursing (DON), on 01/29/15 at 11:00 AM, revealed she expected the nurses to check the residents' allergies and call the ordering physician and make the physician aware of the allergy. The DON expected the medication aide or nurse to check residents' allergies prior to administering medications. She stated all allergies are listed on the bottom of the MAR. The DON stated the facility was unable to locate a specific policy/procedure and followed the guidelines recommended in the Eight Edition Clinical Nursing Skills Basic to Advanced Skills. She stated the physician should be notified and staff should check the resident more often for signs and symptoms related to the medication administered.</p>	F 281	<p>immediately by the Unit Manager.</p> <p><u>Monitoring Measures To Maintain On-going Compliance</u> [1] The Director of Nursing is will monitor the results of the monthly allergy audit and bring the results of the monthly allergy audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Social Services Director, Activity Director, Maintenance Director, and Unit Managers] q month x six months for review and development of action plan to ensure services provided meet the professional standards of quality.</p> <p>F 282 483.20(k)(#)(ii) Services by Qualified Persons Per Care Plan</p> <p><u>Corrective Measures For Resident's Identified In The Deficiency.</u> [1] On 2/9/2015, Resident #12 was placed on Nephro 240 cc with medication pass two times daily. [2] On 2/12/2015, the licensed nurse notified Resident #12's physician and received an order for Remeron to be changed to 7.5 mg daily at bedtime. [3] Resident #12 is discussed during the Nutritionally At Risk meeting weekly by the Registered Dietician, Dietary Manager, Director of Nursing, Assistant Director of Nursing, Unit Managers, and Social Services Director with interventions being discussed as indicated.</p>	2/28/15	

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F 281	Continued From page 3 Interview with the Administrator, on 01/29/15 at 1:00 PM, revealed she expected the staff to check residents' allergies prior to administering medications. She expected the staff to notify the physician and family of any medication error and to implement a plan to frequently assess the resident for adverse outcomes.	F 281	[4] Resident #12 is being weighed weekly by certified nurse aides. The physician will be notified by the licensed nurse of any weight loss of 3 pounds or greater for interventions as indicated. [5] Resident #12's comprehensive care plan reviewed and revised by the interdisciplinary care plan team on 2/9 & 2/12/15.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility's policy and procedure, it was determined the facility failed to implement interventions on the Comprehensive Care Plan for one (1) of fifteen (15) sampled residents (Resident #12), related to the failure to intervene when the resident refused weights, refused care which resulted in a (17) percent weight loss from 11/24/14 through 01/05/15 without consistent assessment and intervention until the resident's weight was stable.  The findings include:  Review of the facility's policy/procedure, titled "Comprehensive Care Plan", revised 04/03/13, revealed the comprehensive care plan should be developed based on assessed needs and care plan approaches would be communicated to staff for use in providing direction for care and the plan	F 282	<u>[2] How Other Resident's Who May Have Been Affected By This Practice Were Identified</u> [1] All residents will be weighed weekly for 4 weeks by certified nursing assistants to establish baseline parameters. Any refusals by the resident to be weighed will be addressed with the resident and/or the resident's responsible party by the licensed nurse with education of risks and possible outcomes to the resident and documented in the clinical record. [2] Resident refusals will be communicated to the resident's physician by the licensed nurse for further interventions if indicated. [3] Residents with a three [3] pound or greater weight loss will have physician notification by a licensed nurse for orders if indicated. Telephone orders will be written and documented in the clinical record by the licensed nurse. [4] Weight losses will be reviewed by the Nutritionally at Risk Committee consisting of the Registered Dietician, Dietary Manager, Director of Nursing, Assistant Director of Nursing, Unit Managers, and Social Services Director] each week to	2/28/15	

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F 282	<p>Continued From page 4</p> <p>of care would be reviewed and revised based on resident 's response.</p> <p>Record review revealed the facility admitted Resident #12 on 06/06/00 with diagnoses to include Dementia, Chronic Kidney Disease Stage III to IV, Anxiety, Hypertension, Leukocytosis, Depression, Hypothyroidism, Peripheral Vein Disease, and Joint pain.. Review of the Quarterly Minimum Data Set (MDS) assessment, completed on 11/26/14, revealed the facility assessed Resident # 12 as moderately impaired with a Brief Interview for Mental Status (BIMS) score of nine (9).</p> <p>Review of Resident #12's comprehensive care plan, dated 01/15/15, revealed documentation to include an approach regarding refusal of treatment, "Resident/MD aware-explained risk/benefits. Continued as resident allows."</p> <p>Interview with the Social Services Director, on 01/30/15 at 9:00 AM, revealed she had encouraged Resident #12 to participate in activities and tasks in the past but had not addressed it since the resident returned from the hospital. She stated the resident's refusal had been discussed during care plan meetings but he/she had not been asked to discuss it with the resident.</p> <p>Interview with the Director of Nursing (DON), on 01/30/15 at 10:00 AM, revealed she had discussed the resident's refusal to weigh and shower with Resident #12, but she stated there was no record or documentation.</p> <p>Interview with Medical Doctor (MD), on 01/30/15 at 9:45 AM, revealed he was aware there had</p>	F 282	<p>address the weight loss and recommend/ implement interventions.</p> <p>[5] Care plans will be reviewed and updated with any new orders received from the physician by a licensed nurse or the dietary manager for nutritional interventions as well as interventions to address resident refusals to be weighed.</p> <p><u>[3] Measures Implemented or Systems Altered to Prevent Re-Occurrence</u></p> <p>[1] Licensed nurses and Inter-Disciplinary Team were educated on 1/30/2015 by a Regional Resource Nurse and the Director of Nurses on maintaining acceptable parameters of nutritional Status For Each Resident.</p> <p>[2] Nutritional care plans will be reviewed by the Nutritionally At Risk Committee, [consisting of the Registered Dietician, Dietary Manager, Unit Managers, Director of Nursing, Assistant Director of Nursing and Social Services Director] to ensure interventions are appropriated.</p> <p>[3] Nutritional care plans will be reviewed and updated weekly as indicated by the Nutritional at Risk committee.</p> <p><u>[4] Monitoring Measures To Monitor On-going Compliance</u></p> <p>[1] The Director of Nursing, Dietary Manager, Assistant Director of Nursing, and the Unit Managers are responsible for monitoring the findings of the nutritionally at Risk committee. The Director of Nursing or the Dietary Manager will bring the findings of the Nutritionally at Risk Committee meetings to the Quality Assurance committee [consisting of the</p>	2/28/15

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F 282	Continued From page 5 been a weight loss issue with Resident #12. He stated Resident #12 was particular and had refused meals, medications and other treatments in the past. The MD stated he saw the resident at the Wound Care Center on 01/29/15 however, he was not aware the resident had a significant weight loss. Further interview revealed the MD stated he was concerned there were no weights obtained from 11/24/14 until 01/05/15. He expected to be notified of significant changes since he did not have the means to weigh the resident in the office. The MD stated he was unaware the resident had refused to be weighed from 11/24/14 until 01/05/15.  Interview with the Administrator, on 01/30/15 at 10:45 AM, revealed she expected staff to follow the comprehensive care plan and notify the MD of frequent refusal to care. She stated staff should attempt to explain risks and benefits to the residents.	F 282	Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services Director, Medical Records Director, Maintenance Director, and Activities Director] for review and development of action plan to ensure services are provided in accordance with each resident's written plan of care.	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced	F 325	<b>F 325 483.25(i) Maintain Nutrition Status Unless Avoidable</b>  <b><u>Corrective Measures for Resident[s] Identified In the Deficiency</u></b> [1] On 2/9/2015, Resident #12 was placed on Nephro 240 cc with medication pass two times daily. [2] On 2/12/2015, Resident #12 Remeron was changed to 7.5 mgm daily at bedtime. [3] Resident #12 is addressed on NAR [Nutritional at Risk] weekly with interventions as indicated. [4] Resident #12 weighed weekly by certified nurse aides with physician notification by a licensed nurse of a weight loss of 3 pounds or greater and interventions as indicated. [5] Resident #12's comprehensive care plan reviewed and revised by the inter-	2/28/15

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F 325	Continued From page 6 by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure residents maintained his/her body weight for one (1) of fifteen (15) sampled residents (Resident #12). Resident #12 sustained a significant weight loss of thirty-eight (38) pounds resulting in a seventeen (17) percent weight loss in one (1) month from 11/24/14 through 01/05/15, without consistent assessment and intervention until the resident's weight was stable.  The findings include:  Review of the facility's policy/procedure titled, "Nutritionally at Risk (NAR) Program", revised 12/19/13, revealed the facility would identify residents at risk for nutritional complications and develop a plan to provide interventions. Further review revealed the facility will establish and maintain an ongoing program to address the needs of residents who exhibit the need for nutritional support, residents who are nutritionally at risk would be systematically identified and reviewed regularly by the Nutritionally at Risk Committee made up of an interdisciplinary group. The Committee would develop the interventions to be implemented to promote the nutritional health of each resident identified at risk, the progress of each resident would be evaluated routinely and the plan altered as indicated and the committee may determine that a resident's nutrition concern was resolved or stabilized and may recommend discontinuation from Nutritionally at Risk Committee monitoring.  Review of the facility's policy/procedure titled, "Weight and Height Monitoring", revised	F 325	disciplinary care plan team on 2/9 & 2/12/2015. <u>How Other Resident's Who May Have Been Affected By This Practice Were Identified</u> [1] All residents will be weighed weekly by certified nurse aides for 4 weeks to establish baseline parameters. [2] Residents with a 3 pound or greater weight loss will have physician notification done by a licensed nurse for orders if indicated. Responsible Party will be notified by a licensed nurse. [3] Care plans will be reviewed and updated with any new orders received from the physician by a licensed nurse, the dietary manager, or the registered dietician for nutritional interventions. <u>Measures Implemented or Systems Altered to Prevent Re-Occurrence</u> [1] Licensed nurses educated on 1/30/2015 by Regional Nurse and Director of Nursing on Maintaining Acceptable Parameters of Nutritional Status For Each Resident. [2] Weekly weights of 3 pounds or greater will be discussed weekly during the Abbreviated Quality Assurance meeting by the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Manager, and Unit Managers, to review for weight change trends, any significant changes will be reported to the physician by a licensed nurse and referred to the Nutritionally at Risk Committee for further review. [3] Residents identified with 3 pound weight loss or more will be discussed in	2/28/15	

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F 325	<p>Continued From page 7</p> <p>09/29/14, revealed the facility would identify resident weight variances and implement interventions. Further review revealed upon admission a height and weight were obtained and entered into the electronic record, then the residents would be weighed for three (3) consecutive days, then weekly for a minimum of four(4) weeks, then monthly or more frequently, if indicated, and the weights were to be entered into the electronic record. Weights were to be reviewed for weight change trends and significant changes, and any significant changes reported to the physician and referred to NAR for further review.</p> <p>Record review revealed the facility admitted the resident on 06/06/00 with diagnoses to include Dementia, Chronic Kidney Disease Stage III to IV, Anxiety, Hypertension, Leukocytosis, Depression, Hypothyroidism, Peripheral Vein Disease and Joint pain. Review of the Significant Change Minimum Data Set (MDS) assessment, completed 01/07/15, revealed the facility assessed Resident #12 as severely impaired with a BIMS score of four (4), and required extensive assistance with one (1) person physical assistance for eating.</p> <p>Review of the Treatment Administration Record (TAR), dated November 2014, included a treatment order to include, "obtain weight record two (2) times a week, Monday and Thursday during night shift (11:00 PM -7:00 AM)." Further review revealed each entry on the TAR for weights on Monday and Thursday read, "refused". On 11/24/14, the resident weighed 136 pounds, a weight gain of seventeen (17) pounds over the average. From August to October his/her weight was one hundred nineteen (119) pounds.</p>	F 325	<p>the weekly Nutritional at Risk meeting by the Registered Dietician, Dietary Manager, Director of Nursing, Assistant Director of Nursing, Unit Managers, and the Social Services Director with recommendations and interventions as indicated.</p> <p>[4] Unit Managers or the Director of Nursing will ensure the dietary recommendations are given to the resident's physician for review and orders as indicated.</p> <p>[5] Recommendations not addressed by attending MD will be given to the Medical Director for review and orders as indicated.</p> <p>[6] Resident weights will be obtained weekly by certified nursing assistants. Any resident refusing to be weighed will have refusals documented in the clinical record by a licensed nurse. Resident and or responsible party will be notified by a licensed nurse and education will be provided as to the risks and consequences of resident refusal to be weighed.</p> <p><u>Monitoring Measures to Maintain Ongoing Compliance</u></p> <p>[1] The Director of Nursing, Assistant Director of Nursing, and the Unit Managers are responsible for monitoring the findings of any resident refusals to be weighed. The Director of Nursing will bring the findings of any resident refusals to be weighed to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Social Services Director, MDS,</p>	2/28/15	

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NAME OF PROVIDER OR SUPPLIER  SPRING VIEW HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754		
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F 325	Continued From page 8 The next recorded weight was ninety-eight (98) pounds, obtained on 01/05/15, a twenty-one percent (21%) significant weight loss over forty-two (42) days.  Review of Resident #12's Nutritional Analysis, dated 11/24/14, revealed Resident #12's ideal body weight (IBW) was 115 pounds with a current height of sixty-three (63) inches and a BMI of twenty-three point seven (23.7). His/her diet was low potassium, mechanical soft with ground meals and gravy and no added salt. The percentage of meal intake was sixty-nine (69) percent, and Resident #12 fed himself/herself in his/her room. Further review revealed estimated caloric need was 1523-1827, and were based on calories/kilogram 25-30. Estimated protein needs 61-73, protein needs were based on grams/kilogram 1.0-1.2, estimated fluid needs were 1523-1827, fluid needs were based on milliliters/kilogram 25-30. Review of narrative notes revealed the quarterly review showed no chewing or swallowing issues. Resident #12 had an increased weight which was within normal limits per BMI and no new recommendations needed at this time.  Review of Resident #12's Meal and Fluid Detail Reports for October, November, December 2014, and January 2015 included the following: 10/01/14 - 10/31/14 revealed a monthly average intake of 23,055.00 milliliters (ml) of fluid, 11/01/14 - 11/30/14 revealed a monthly average intake of 40,596.00 ml of fluid. The month of December revealed fifteen (15) days 12/01/14 - 12/07/14, 12/09/14 - 12/11/14, 12/18/14, 12/20/14 - 12/25/14, with an intake of 20,725 ml of fluid.  Review of the Medication Administration Record	F 325	Activities Director, Medical Records Director, Maintenance Director] x 6 months for review and development of action plan to ensure residents maintain their body weight.	2/28/15	

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F 325	Continued From page 9 (MAR), dated January 2015, revealed Resident #12 received two doses of Megace 400 mg/10 ml on 01/08/15 and 01/09/15.  Review of the Medical Nutritional Therapy Assessment, dated 01/05/15, revealed the resident's IDW was 115 pounds, current height sixty-three (63) inches and current weight ninety-eight (98) pounds, BMI seventeen point four (17.4). Further review revealed Resident #12 experienced a significant change to overall health related to recent illnesses and a significant weight loss and was added to the NAR on 01/06/15 related to a low BMI. Review of the narrative assessment documented by the Registered Dietician (RD) revealed a recommendation for ensure pudding twice daily for added calories, monitoring and evaluation of weekly weights and meal intakes.  Interview with the Registered Dietician (RD), on 01/30/15 at 8:30 AM, revealed she usually saw residents on a quarterly basis. The RD stated since Resident #12's weight was stable on 11/24/14, she planned to follow up with the resident in February 2015, but since his/her weight decreased, the Dietary Manager began a significant change assessment on 01/05/15, identified for Nutritionally at Risk (NAR) on 01/06/15, and Ensure pudding and Megace was started. The RD stated Nepro was placed on the resident's tray at lunch and supper. She stated there was no log that was specific to the Nepro, and the CNAs added the intake amount to the overall meal intake.  Record review revealed Resident #12 was admitted to the hospital on the dates to include 01/09/15 through 01/12/15 and returned to the	F 325		2/28/15	

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F 325	<p>Continued From page 10</p> <p>facility on 01/12/15 with Physician's Orders, dated 01/12/15, to include discharge diagnosis of Acute Renal Failure (ARF), Regular diet and Nepro two (2) cans.</p> <p>Interview with the Director of Nursing (DON), on 01/30/15 at 8:30 AM, revealed Resident #12 was out of the facility and admitted to the hospital two (2) times in December 2014 and one (1) time in January 2015. The dates and admission diagnosis included: 12/12/14 - 12/16/14 Stage Four Renal Failure and Hypertension; 12/25/14 - 12/31/14 Urinary Tract Infection and Hypertension; 01/09/15 - 01/12/15 Renal Failure and Dehydration.</p> <p>Interview with the Unit Manager (UM) 200 Unit, on 01/30/15 at 11:24 AM revealed she was responsible for entering all resident weights into the electronic medical record and expected the Certified Nurse Aide (CNA) to enter any additional weights on the TAR and in the kiosk. Further review revealed she expected the CNA to tell the charge nurse when a resident refused to weigh. She stated residents were assigned specific shower days each week and a color copied log was kept in the shower room for the CNAs to document the residents' weight. The UM stated it was her responsibility to place the weekly weight log in the shower room every Friday. This form was located in the shower room The UM stated it would make sense for the resident be weighed on another shower day if the nurse knew the previous shower day weight had not been obtained. Further interview revealed there was no process in place to ensure missed weights were obtained on another day.</p> <p>Interview with Registered Nurse (RN) #2, on</p>	F 325		2/28/15

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F 325	<p>Continued From page 11</p> <p>01/30/15 at 11:06 AM, revealed he/she refused to be weighed or get out of bed at times. RN #2 stated the resident refused showers at times, but would agree to a bed bath. Further interview revealed the facility had notified the family when the resident refused care.</p> <p>Interview with RN #3, on 01/29/15 at 3:15 PM, revealed she documented in the nursing notes whenever she was told that a resident refused to be weighed. Further interview revealed residents were weighed every day for three (3) days after returning from the hospital during night shift. Further review revealed there was no evidence that Resident #12 was weighed on 01/13/15, 01/14/15, or 01/15/15 following an inpatient hospitalization.</p> <p>Interview with CNA #1, on 01/29/15 at 5:05 PM, revealed she worked on 12/28/14. She stated "we were giving baths and were told to stop baths and begin to weigh all residents because weights were not obtained on Friday, 12/28/14 and Saturday, 12/27/14". She said he/she was unsure why there was no evidence of Resident #12's weight and did not recall the weight.</p> <p>Interview with CNA #2, on 01/29/15 at 3:05 PM, revealed she had worked at the facility for two (2) years and residents were routinely weighed on the weekends, either Friday, Saturday, or Sunday. The residents were weighed in the shower room on the day the resident was scheduled for a shower. She stated if a resident refused, the CNA was expected to ask the resident three (3) times and if the resident continued to refuse the CNA informed the charge nurse. She stated Resident #12 typically ate 75% of breakfast meal and occasionally refused to eat.</p>	F 325		2/28/15

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F 325	<p>Continued From page 12</p> <p>She stated she offered substitutes and cues to encourage Resident #12 to eat. CNA #2 stated she had noticed the resident's clothes fit more loosely than before December 2014.</p> <p>Interview with the Medical Doctor (MD), on 01/30/15 at 9:45 AM, revealed he was aware there had been a weight loss issue with Resident #12. He stated Resident #12 was particular and had refused meals, medications and other treatments in the past. The MD stated he saw the resident at the Wound Care Center on 01/29/15; however, he was not aware Resident #12 had a significant weight loss. Further interview revealed the MD stated he was concerned there were no weights obtained from 11/24/14 until 01/05/15 and he expected to be notified of significant changes since he does not have the means to weigh Resident #12 in the office. Further interview with the MD stated the weight loss would be unavoidable if the creatinine had been constantly elevated, but it was not elevated all the time.</p> <p>Interview with the facility Medical Director, on 01/30/15 at 10:15 AM, revealed he was recently made aware of Resident #12's weight loss and had not discussed it with the resident's primary MD. The Medical Director's expectation was for the facility to notify the MD about a significant weight loss unless the weight loss was part of an intended medical recommendation. He stated if a resident was hospitalized, the primary MD should have a record of the resident's weight. He stated, "I contend that if the resident has been in the hospital, then weights have been recorded and the primary physician would be aware."</p> <p>Interview with the DON, on 01/30/15 at 10:30 AM,</p>	F 325		2/28/15
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F 325	Continued From page 13 revealed she expected the CNA to notify the charge nurse if a resident refused to be weighed.  Interview with the Administrator, on 01/30/15 at 10:45 AM, revealed she expected the CNA to notify the charge nurse if a resident refused to weigh and staff should use a variety of measures and explain rationale for tasks when a resident refused.	F 325	<b>F 332 483.25 (M)(I) Free of Medication Error Rates of 5% or More</b>  <u>Corrective Measures for Resident[s] Identified in the Deficiency</u> [1] Resident B's physician was notified on 1/29/2015 by the Director of Nursing of the medication not administered with meals. The physician gave orders for no change to Metformin dosage time. The physician order indicates the Metformin does not have to be given with meals. [2] Resident B assessed by a licensed nurse on 1/29/2015 for signs and symptoms of adverse effect related to Metformin administration times. None were noted. [3] Resident A's physician was notified by the licensed nurse on 1/28/2015 for an order to change Potassium to liquid form. [4] Resident A was assessed by a licensed nurse on 1/28/2015 for signs and symptoms of adverse effects from receiving crushed potassium. None were noted.  <u>How Other Resident's who May have Been Affected By this Practice Were Identified</u> [1] Residents receiving Metformin were audited by the Regional Resource Nurses on 1/29/2015 to identify times the medication was due. [2] Physicians were notified and orders received for Metformin administration times to be changed to be given with meals [3] Residents receiving Potassium were audited by the Regional Resource Nurses	2/28/15	
F 332 SS=D	<b>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b>  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and a review of the facility policy on General Dose Preparation and Medication Administration and Medication Administration Schedule, it was determined the facility failed to ensure the medication administration error rate was less than five (5) percent. Observation of medication passes revealed 38 medication administration opportunities with two (2) medication errors, for a medication administration error rate of five point two percent (5.2%). Registered Nurse (RN) #1 administered a medication that was on the Do Not Crush List, and Licensed Practical Nurse (LPN) #1 failed to administer a medication with breakfast.  The findings include:  Review of the facility policy, "General Dose	F 332			

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F 332	Continued From page 14  Preparation and Medication Administration," dated 12/01/07, revealed medications were to be administered within 60 minutes of the scheduled time of administration, except for before and after meals, which are based on scheduled meal times and administered within 30 minutes of the meal. In addition, the staff should crush oral medications, only in accordance with pharmacy guidelines and facility policy.  1. Observation of a medication administration pass, on 01/28/15 at 8:35 AM, revealed Potassium, a medication that assists with nerve and muscle coordination, was crushed and administered to Resident A.  Review of Resident A's Physician Orders and the MAR for January 2015, revealed no indication of whether or not to crush any medications. A review of the facility's Do Not Crush List revealed potassium was listed as non-crushable.  Interview with RN #1 on 01/28/15 at 9:05 AM, after looking at the Do Not Crush list, revealed the medication was listed and stated he should have referred to the list and should not have crushed the Potassium.  2. Observation of a medication administration pass, on 01/29/15 at 9:25 AM, revealed LPN #1 administered Metformin, a diabetic medication, to Resident B.  Review of the MAR and the physician orders, dated January 2015, revealed the initial telephone order for the medication was received 01/21/15, to have been administered by mouth twice a day. A review of the facility's drug book recommendation revealed the medication was to	F 332	on 01/29/15 to identify any residents requiring medications to be crushed, to have liquid potassium ordered. [4] Residents requiring their medications to be crushed were audited by the Regional Resource Nurses on 1/29/2015 to identify any medications that are not recommended to be crushed and whether or not they needed to be changed to a different form. <u>Measures Implemented or Systems Altered To Prevent Re-Occurrence</u> [1] Licensed nurses were educated on 1/30/2015 by the Director of Nursing on the importance of not crushing medications that have time released or extended release properties. [2] Licensed Nurses were educated by the Director of Nurses on 1/29/2015 on Medication Crushing. Any medications with the letters CC,CD,CR,XR,LA,SR,TR,XL are medications that typically are not to be crushed because they could be extended released. [3] All new Admission orders, Re-Admission orders, and any new telephone orders for current residents will be brought to the daily Abbreviated Quality Assurance meeting Monday-Friday for auditing by the Director of Nursing, Assistant Director of Nursing, or Unit Managers to determine if the resident is receiving a medication that is recommended not to be crushed. Residents requiring a medication to be crushed and are receiving a medication this is recommended to not be crushed will	2/28/15	

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F 332	<p>Continued From page 15</p> <p>have been administered with meals. A review of the meal service times revealed breakfast was served at 7:00 AM to 7:25 AM and dinner was served from 5:00 PM to 5:25 PM.</p> <p>Interview with LPN #1, on 01/29/15 at 9:30 AM, revealed Resident B "did not want to take the medication before breakfast as this made the resident "sick to his/her stomach" and the MAR does not specify what time to administer the medication, other than twice a day (BID) at 8:00 AM and 8:00 PM.</p> <p>Interview with the Director of Nursing (DON), on 01/29/15 at 9:48 AM, revealed the Metformin should have been given with meals and the Potassium should not have been crushed and she would have expected the staff to follow the facility's policies.</p>	F 332	<p>have their physician notified by a licensed nurse to change the medication to a different form.</p> <p>[4] Unit Managers will audit Medication Administration Records weekly x 6 months to ensure residents requiring their medications to be crushed are receiving appropriate forms of medications.</p> <p>[5] Any variances will be addressed immediately.</p> <p><u>Monitoring Measures To maintain On-going Compliance</u></p> <p>[1] The Director of Nursing, Assistant Director of Nursing, and the Unit Managers will be responsible for monitoring of the medication administration audit. The Director of Nursing will bring the findings of the Medication Administration Audit to the Quality Assurance Committee [consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services, Activity Director, Activity Director, MDS Coordinator, Maintenance Director, Unit Managers, Admissions Director] every month x six months for review and development of action plan to ensure that medication is administered in appropriate therapeutic form and time.</p>	2/28/15	

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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: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1992, with 6 smoke detectors and 0 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1992 and added onto in 2008.</p> <p>GENERATOR: Type II generator installed in 2007. Fuel source is Propane.</p> <p>A standard Life Safety Code Survey was conducted on 01/29/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy-one (71) beds with a census of fifty-nine (59) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p> <p style="text-align: right;">2/28/15</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessie R. [Signature] TITLE: NHA (X6) DATE: 03/08/15

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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K 000	Continued From page 1 Fire).	K 000		
K 056 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the sprinklers were installed, in accordance with National Fire Protection Association(NFPA) Standards. The deficient practice has the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-one (71) beds and at the time of the survey, the census was fifty-nine (59). According to CMS S&amp;C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems.</p> <p>The findings include:</p>	K 056	<p><b><u>NFPA 101 Life Safety Code Standard K 056:</u></b> It is the practice of Spring View Health and Rehab Center, Inc. to meet the Life Safety Codes as stated in the NFPA 101 Life Safety Code Standard.</p> <p><b><u>Corrective Actions for those identified in the deficiency:</u></b> The deficiency had the potential of affecting (2) of four (4) smoke compartments, all residents, staff and visitors. Upon identification of the issue the (4) sprinkler heads which were obstructed from developing a full spray pattern by light fixtures being installed within twelve (12) inches of the sprinkler heads, On 2/27/15, the sprinkler heads will be re-located to ensure they are not obstructed by light fixtures or any other object, in accordance with NFPA standards. On 2/5/15, 100 % audit was conducted by the Regional Maintenance Director and the facility Maintenance Director ensuring positioning of all other facility sprinkler heads would provide the appropriate spray pattern, according to the NFPA safety code. No other issues were noted. The maintenance Director completed 100% audit on all other sprinkler heads to ensure no obstructions caused by headers from where the old water fountain was located.</p>	2/28/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185309	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  01/29/2015
NAME OF PROVIDER OR SUPPLIER  SPRING VIEW HEALTH & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 718 GOODWIN LANE LEITCHFIELD, KY 42754	
(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 056	<p>Continued From page 2</p> <p>1) Observation, on 01/29/15 at 10:06 AM with the Maintenance Director, revealed four (4) sprinkler heads were obstructed from developing a full spray pattern by light fixtures being installed within twelve (12) inches of the sprinkler heads. The light fixtures extended down from the ceiling below the sprinkler deflector.</p> <p>Interview, on 01/29/15 at 10:07 AM, with the Maintenance Director revealed he was aware of the requirement; however, he had not noticed the obstructed sprinkler heads.</p> <p>2) Observation, on 01/29/15 at 11:10 AM with the Maintenance Director, revealed a nook located in the 100 Hall that did not have a sprinkler head installed.</p> <p>Interview, on 01/29/15 at 11:11 AM, with the Maintenance Director revealed a recently removed water cooler formerly set in the nook and made it impossible to notice a sprinkler head was not installed.</p> <p>The census of fifty-nine (59) was verified by the Administrator on 01/29/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 01/29/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6</p>	K 056	<p><u>Other identified who may have been impacted by the deficient practice:</u> The deficiency had the potential of affecting (2) of four (4) smoke compartments, all residents, staff and visitors. On 2/5/15, 100 % audit was conducted by the Regional Maintenance Director and the facility Maintenance Director ensuring positioning of all other facility sprinkler heads would provide the appropriate spray pattern, according to the NFPA safety code. No other issues were noted. On 2/5/15, the Regional Maintenance Director and the facility Maintenance Director conducted an audit ensuring no other sprinkler heads were obstructed. No other issues noted.</p> <p><u>Measures Implemented or Systems Alerted to Prevent Re-occurrence:</u> Plant Service Director was re-educated on 2/5/15 by the Regional Plant Service Dir regarding NFPA standards, sprinkler obstruction, light fixtures obstructing sprinklers and observing/rounding facility to be aware of any and all potential obstructions on ongoing basis. All Staff re-educated by facility Maintenance Director and staff development nurse not to place objects in front of sprinkler heads or in any way that would cause obstruction, initiated 2/23/15. Education will continue in general orientation for all staff, ongoing. Orientation manual was updated on 2/23/15.</p> <p>2/28/15</p>

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K 056	<p>Continued From page 3</p> <p>through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.</p> <p>Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="1"> <thead> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>Maximum Allowable Distance of Deflector Obstruction (in.) (B)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056	<p><b><u>Monitoring Measures to Maintain On-going Compliance:</u></b></p> <p>Facility Maintenance Director will conduct audits monthly x 12 months ensuring sprinkler heads are not obstructed from developing a full spray pattern by light fixtures are any other obstruction. Facility Maintenance Director will conduct audits monthly times 12 months ensuring no sprinkler heads are obstructed by any and all objects within facility. Results will be reported monthly to the Quality Assessment and Assurance committee for review and further recommendations.</p> <p style="text-align: right;">2/28/15</p>
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector Obstruction (in.) (B)																								
Less than 1 ft	0																								
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5 ft and greater	18																								
K 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19 3.5.6, NFPA 10</p>	K 064																							

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K 064	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain fire extinguishers in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-one (71) beds and at the time of the survey, the census was fifty-nine (59).</p> <p>The findings include:</p> <p>Observation, on 01/29/15 at 10:35 AM, with the Maintenance Director revealed the K Class fire extinguisher located in the kitchen did not have a placard installed to indicate the fire suppression shall be activated prior to using the fire extinguisher.</p> <p>Interview, on 01/29/15 at 10:36 AM with the Maintenance Director, revealed the sign must have been removed when the kitchen was painted and re-installing the sign must have been over looked.</p> <p>The census of fifty-nine (59) was verified by the Administrator on 01/29/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 01/29/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p>	K 064	<p><b><u>NFPA 101 LIFE SAFETY CODE STANDARD K064:</u></b> It is the practice of Spring View Health and Rehab Center, Inc. to meet the Life Safety Codes as stated in the NFPA 101 Life Safety Code Standard.</p> <p><b><u>Corrective Actions for those identified in the deficiency:</u></b> The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. On 2/5/15, the facility Maintenance Director installed a placard on the K Class fire extinguisher located in the kitchen to indicate the fire suppression shall be activated prior to using the fire extinguisher. On 2/5/15, housekeeping and maintenance staff was re-educated to not remove the placard during renovation, housekeeping or cleaning. This was started 2/23/15.</p> <p><b><u>Other identified who may have been impacted by the deficient practice:</u></b> On 2/5/15, all housekeeping and maintenance was re-educated to not remove the placard during renovation, housekeeping or cleaning. On 2/5/15, facility maintenance Dir conducted 100% audit to ensure there were no other missing placards regarding other fire extinguishers. No issues were noted.</p> <p>2/28/15</p>

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K 064	<p>Continued From page 5</p> <p>9.7.4 Manual Extinguishing Equipment. 9.7.4.1* Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.</p> <p>Reference: NFPA 10 (1998 edition)</p> <p>3-7 Fire Extinguisher Size and Placement for Class K Fires.</p> <p>3-7.1 Fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media (vegetable or animal oils and fats).</p> <p>3-7.2 Maximum travel distance shall not exceed 30 ft (9.15 m) from the hazard to the extinguishers.</p> <p>Reference: NFPA 10 (1998 edition)</p> <p>4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and lamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (g) Pressure gauge reading or indicator in the operable range or position</p>	K 064	<p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> On 2/5/15 the Regional Maintenance Director re-educated the facility maintenance Director on the NFPA standard regarding placards and fire extinguishers. Facility Maintenance Director will audit the placards monthly x 12 months to ensure the placards are in place. All housekeeping and maintenance staff re-educated by facility Maintenance Director regarding not moving placards for any reason.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u> Facility Maintenance Director will audit the placards monthly x 12 months to ensure the placards are in place. All findings will be reported to the QA committee monthly for review and further recommendations.</p> <p>2/28/15</p> <p><u>NFPA 101 Life Safety Code Standard K 147:</u> It is the practice of Spring View Health and Rehab Center, Inc. to meet the Life Safety Codes as stated in the NFPA 101 Life Safety Code Standard.</p>

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K 064	<p>Continued From page 6</p> <p>(h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units)</p> <p>(i) HMIS label in place</p> <p>4-3.3 Corrective Action.</p> <p>When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.</p> <p>Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.</p> <p>Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).</p>	K 064	<p><u>Corrective Actions for those identified in the deficiency:</u></p> <p>The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. On 2/5/15, the power strip was removed from the refrigerator that was in the Admissions Office. On 2/5/15, the facility Maintenance Director and all staff were re-educated by the Reg Maintenance Director regarding NFPA standards on power strips within the facility.</p> <p><u>Other identified who may have been impacted by the deficient practice:</u></p> <p>On 2/5/15, all staff were re-educated regarding power strips and facility contraband in conjunction with NFPA 101, within nursing facilities. On 01/28/2015 the facility Maintenance Assistant conducted a 100% audit to ensure no other power strips within facility that did not meet NFPA standards. No other issues noted.</p> <p>2/28/15</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></p> <p>Maintenance Director will conduct audits weekly x 3 weeks, then monthly x 12 months ensuring there are no power strips within facility that are not in accordance with NFPA standards. Facility Maintenance Director will educate all staff regarding not having power strips per facility contraband according to NFPA standards. Education will continue to general orientation for new staff by staff</p>
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147	
SS=D	Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2		

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K 147	<p>Continued From page 7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy-one (71) beds and at the time of the survey, the census was fifty-nine (59).</p> <p>The findings include:</p> <p>Observation, on 01/29/15 at 10:10 AM with the Maintenance Director, revealed a refrigerator was plugged into a power strip located in the Admissions Office.</p> <p>Interview, on 01/29/15 at 10:11 AM with the Maintenance Director, revealed he was aware of the requirements for the proper use of power strips; however, he was not aware the power strip was being misused.</p> <p>The census of fifty-nine (59) was verified by the Administrator on 01/29/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 01/29/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in</p>	K 147	<p>development nurse. Orientation Review by maintenance was updated on 2/23/15.</p> <p><b><u>Monitoring Measures to Maintain On-going Compliance:</u></b> Maintenance Director will conduct audits weekly x 3 weeks, then monthly x 12 months ensuring there are no power strips within facility that are not in accordance with NFPA standards. Findings will be reported to the quality assurance committee monthly for review and recommendations.</p> <p>2/28/15</p>

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K 147	<p>Continued From page 8</p> <p>accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ol style="list-style-type: none"> <li>(1) As a substitute for the fixed wiring of a structure</li> <li>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>(3) Where run through doorways, windows, or similar openings</li> <li>(4) Where attached to building surfaces</li> </ol> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147	2/28/15