

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2014
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240
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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 A Recertification/Abbreviated Survey (KY#21880) was conducted 06/24/14 through 06/26/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "D". KY#21880 was substantiated with deficiencies cited.	F 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.	
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure services were provided by qualified persons in accordance with each resident's written plan of care for two (2) of twenty (20) sampled residents (Resident #1 and #4). The facility failed to follow the care plan for a pureed diet for Resident #1 and provide one (1) staff assist with ambulation for Resident #4. The findings include: Review of the Comprehensive Care Plan policy/procedure, last revised July 2013, revealed an individualized comprehensive care plan was developed to meet the resident's medical, nursing, mental, and psychological needs. 1. Observation of breakfast, on 06/25/14 at 8:20	F 282	What corrective action will be accomplished for those residents found to have been affected? Resident #1 receives only those foods allowed on MD prescribed Therapeutic Diet as indicated by Plan of Care and C.N.A. Assignment sheet. Resident #4 ambulated with assist of one (1) staff as indicated on Plan of Care and C.N.A. Assignment sheet.	7/21/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Francis M. Marko, CNHA ADMINISTRATOR TITLE
7/18/14 (X6) 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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F 282	<p>Continued From page 1</p> <p>AM, revealed Resident #1 received a fruit cup on his/her tray. State Registered Nurse Aide (SRNA) #3 attempted to feed the resident the fruit cup during the observation.</p> <p>Record review revealed the facility admitted Resident #1 on 01/31/14 with diagnoses which included Adult Failure to Thrive, Malignant Neoplasm of the Kidney, and Dementia. Review of the Significant Change Minimum Data Set, dated 05/21/14, revealed the facility assessed Resident #1 as severely cognitively impaired and required extensive assistance with eating. Review of the Physician's Orders, dated 06/20/14, revealed an order for a pureed diet. Review of the Nurse Aide Care Plan, dated 06/21/14, indicated Resident #1 was to receive a pureed diet.</p> <p>Interview with SRNA #3, on 06/26/14 at 8:15 AM, revealed she attempted to feed Resident #1 for breakfast on 06/25/14. She stated she was supposed to check the care plan for each resident as they were updated daily. She revealed the fruit cup on his/her tray was not pureed; therefore, she should have notified the nurse.</p> <p>Interview with the Director of Nursing (DON), on 06/26/14 at 2:00 PM, revealed a fruit cup would not be appropriate on a pureed diet. She expected staff to follow the diet order listed on the Nurse Aide Worksheet (care plan).</p> <p>2. Record review revealed the facility admitted Resident #4 on 12/24/13 with diagnoses which included Dementia, Syncope, Falls, Weakness, Hypertension, and Parkinson's with Tremors.</p> <p>Review of the Quarterly MDS assessment, dated 03/16/14, revealed the facility assessed the</p>	F 282	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents Plan of Care and C.N.A. assignment sheets checked and corrected by Charge Nurse and changes updated in red.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Procedure for C.N.A. Assignment sheet updates to include review and signature q shift by each C.N.A. and sheets turned in to the Unit Manager daily and Weekend Supervisor for review.</p> <p>Director of Nursing and/or Assistant Director of Nursing/Staff Development Coordinator provided in service education to all nursing staff regarding: a) change of process for updating C.N.A. Assignment sheets ; b) changes in signature requirement and monitoring of C.N.A. assignment sheets.</p>	

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F 282	Continued From page 2 resident's cognition as cognitively intact with a Brief Interview of Mental Status (BIMS) score of 14 and required the assistance of one staff for ambulation. Review of Resident #4's Comprehensive Care Plan, dated 03/06/14, revealed the resident should ambulate with one (1) assist using a walker. Observation, on 06/25/14 at 8:05 AM, revealed Resident #4 was ambulating on hallway 200 without the assistance of a staff member. Interview, on 6/24/14 at 9:35 AM with Certified Nurse Aide (CNA) #6, revealed Resident #4 ambulated to the bathroom requiring assistance but could ambulate throughout the facility without assistance. Interview, on 6/26/14 at 7:25 AM with CNA #5, revealed CNA worksheets serve as the care plan for each resident and indicated the level of care required and should be checked each shift for any changes. Interview, on 6/25/14 at 4:20 PM with the DON, revealed residents care planned for one (1) person assist should be provided that level of care.	F 282	How does the facility plan to monitor its performance to ensure that solutions are sustained? Unit Manager will monitor C.N.A. Assignment sheets daily and Weekend Supervisor will monitor on weekend for compliance. Audit of 2 resident care plans with changes and 2 corresponding C.N.A. assignment sheets weekly by Clinical Care team (Consisting of all unit managers, Director of Nursing, and Assistant Director of Nursing) for compliance and results reported to QA team monthly for follow up and recommendations.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	What corrective action will be accomplished for those residents found to have been affected? Resident #1 is offered a meal tray at each meal taken into room and offered to resident.	7/21/2014	

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F 309	<p>Continued From page 3 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of twenty (20) sampled residents (Resident #1). The facility staff failed to offer Resident #1 a lunch tray on 06/24/14.</p> <p>The findings include:</p> <p>Observation, on 06/24/14 at 1:36 PM, revealed lunch trays were brought onto the 300 hall. The tray for Resident #1 was on the cart, per observation. At 2:30 PM, State Registered Nurse Aide (SRNA) #2 began putting dirty trays on the cart; however, the tray for Resident #1 was still on the cart.</p> <p>Record review revealed the facility admitted Resident #1 on 01/30/14 with diagnoses which included Adult Failure to Thrive, Malignant Neoplasm of the Kidney, and Dementia. The resident is currently on Palliative Care. Review of the Significant Change Minimum Data Set, dated 05/21/14, revealed the facility assessed Resident #1 as severely cognitively impaired and required extensive assistance with eating. Review of the Physician's Orders, dated 06/20/14, revealed an order for a pureed diet.</p> <p>Interview with SRNA #1, on 06/24/14 at 2:30 PM,</p>	F 309	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents are offered a meal tray at meal time for each meal.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Consumption sheets are updated to include a column which reflects that a tray is offered to the resident for each meal.</p> <p>The Consumption-sheet process is Updated to indicate that the C.N.A. responsible for the resident checks that a tray has been offered to each resident. At the end of each meal, the Charge Nurse is to review the Consumption sheet and document compliance. If a tray has not been offered, the sheet needs to have documentation of why. All residents need to have a tray offered unless they are out of facility.</p> <p>Director of Nursing and/or Assistant Director of Nursing/Staff Development Coordinator provided in service education to all nursing staff regarding: a) change of process for the consumption sheets;</p>	
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F 309	Continued From page 4 revealed she was unable to get the resident to eat any breakfast on 06/24/14. She revealed the resident's mouth was moistened; however, she did not attempt to feed the resident a lunch tray. Interview with SRNA #2, on 06/24/14 at 4:20 PM, revealed staff usually offer the resident a food tray; however, she offered the resident a pudding cup and thickened water instead of the tray (after 2:30 PM). Interview with the Director of Nursing (DON), on 06/26/14 at 2:00 PM, revealed Resident #1 does not eat well; however, she expected staff to offer a tray and feed the resident at every meal.	F 309	and b) compliance review each meal by the Charge Nurse with follow up as necessary. How does the facility plan to monitor its performance to ensure that solutions are sustained? Unit Managers will audit Consumption sheets weekly for compliance and results reported to QA team monthly for follow up and recommendations.	
F 314 SS=D	483.26(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure a resident having pressure sores received the necessary treatment and services to promote healing and prevent infection for one (1) of twenty (20) sampled residents (Resident #1).	F 314	What corrective action will be accomplished for those residents found to have been affected? Resident #1 's M.D. notified and new orders received related to change in pressure ulcer condition. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents with change in condition of pressure ulcer will be noted on the 24 hour report and MD notified of change.	7/21/2014

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F 314	<p>Continued From page 5</p> <p>The findings include:</p> <p>Review of the Pressure Ulcer policy/procedure, last revised July 2013, revealed to notify the physician if infection was suspected in the wound.</p> <p>Review of the "Notification of Change in Resident's Condition or Status" policy/procedure, last revised April 2007, revealed the charge nurse/supervisor would notify the resident's attending physician when there was a need to alter the resident's treatment significantly.</p> <p>Observation of wound care, on 06/24/14 at 1:30 PM, revealed Resident #1 had a coccyx wound measuring 2.2 centimeters (cm) by 2.4 cm. There was yellow slough to the wound bed with dark necrosis to the left edge of the wound. The area surrounding the wound was dark red with foul odor noted.</p> <p>Record review revealed Resident #1 was admitted to the facility on 01/30/14 with diagnoses which included Adult Failure to Thrive, Diabetes, Dementia, and Malignant Neoplasm of the Kidney. Review of the Significant Change Minimum Data Set, dated 06/21/14, revealed the facility assessed Resident #1 as severely cognitively impaired and required extensive assist with bed mobility.</p> <p>Review of the clinical notes, dated 05/29/14, revealed the facility identified a Stage II pressure ulcer with measurements of 1.2 cm by 0.4 cm to the resident's coccyx. On 06/03/14, the wound had increased in size to 2.0 cm by 1.0 cm with notation of a red wound bed, dark discoloration to the center, slight odor and scant serous drainage.</p>	F 314	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Policy on Physician notification has been revised. Physician is to be notified of change in pressure ulcer and if no response times 3 days then Director of Nursing to be notified. MD to be contacted by Director of Nursing and if no response then Medical Director is to be consulted for interventions.</p> <p>Policy on Pressure Ulcer updated to include: Unit Managers measure and assess pressure ulcers weekly and complete weekly Wound Report. A weekly audit by charge nurses for documentation, timeliness of treatment, etc. (see exhibit) is completed and given to DON.</p>	

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F 314	<p>Continued From page 6</p> <p>The note revealed the physician was notified by fax; however, there was no documentation noted of a response. The clinical notes, dated 06/14/14, revealed there was a small necrotic area noted to the coccyx wound; however, there was no evidence of physician notification. On 06/16/14, the notes indicated the wound had increased in size to 2.0 cm by 2.0 cm with slight odor and redness. The note revealed the center of the wound looked to be necrotic. There was no evidence of physician notification. The clinical notes, dated 06/18/14, revealed the wound had increased in size to 2.3 cm by 2.1 cm with foul odor, redness, and slough noted to the wound bed. The notes indicated the facility attempted to notify the physician at 9:45 AM, 1:10 PM, and 3:15 PM, and was waiting for a return call. On 06/20/14, new treatment orders were received for the worsening coccyx wound.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/26/14 at 10:05 AM, revealed she was the nurse for Resident #1 on 06/03/14. She revealed odor and drainage to the resident's wound would indicate a possible infection; however, with no other signs or symptoms such as a fever, she felt it was appropriate to fax the physician and have the next shift follow up on the wound changes.</p> <p>Interview with LPN #2, on 06/26/14 at 9:40 AM, revealed she was the nurse for Resident #1 on 06/14/14. She documented the wound as having a necrotic area; however, when it was discussed with the next shift, she was informed it was already being addressed. She revealed it would still be her responsibility to notify the physician.</p> <p>Interview with LPN #3, on 06/26/14 at 10:50 AM, revealed she was the nurse for Resident #1 on</p>	F 314	<p>Director of Nursing and/or Assistant Director of Nursing/Staff Development Coordinator provided in service education to all nursing staff regarding: a) Policy and Procedure change for MD notification; and b) Policy and Procedure change for pressure ulcer monitoring and reporting.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>11p-7a Charge nurses will audit the wound report weekly for change and notification. Audit report given to QA team monthly for follow up and recommendations.</p>	

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F 314	Continued From page 7 06/16/14 and 06/18/14. She revealed Unit Manager #2 was notified of the resident's wound necrosis; however, it was her responsibility to notify the physician of the worsening wound. She did not actually speak with the physician about the resident's wound as attempts were made several times to contact with no response. Interview with the Unit Manager #2, on 08/26/14 at 1:05 PM, revealed the physician was notified numerous times of the resident's wound worsening with no response. On 06/20/14, she spoke with the physician's assistant with new treatment orders obtained at that time. Interview with the Director of Nursing (DON), on 08/26/14 at 2:00 PM, revealed she was aware Unit Manager #2 had attempted to contact the resident's physician about the wound for three (3) days with no response. She revealed staff should have notified her immediately if there was no response from the physician, as she would have notified the Medical Director for orders.	F 314			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 323	What corrective action will be accomplished for those residents found to have been affected? Resident #A does not have foods not allowed on present therapeutic diet in room. Resident #4 evaluated by Physical Therapy and ambulation assistance provided as recommended.	7/22/2014	

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F 323	<p>Continued From page 8</p> <p>review it was determined the facility failed to ensure the environment remained as free of accident hazards as is possible for one (1) of twenty (20) sampled residents (Resident #4) and provide adequate supervision to prevent accidents for one (1) unsampled resident (Resident #A). Resident #A was observed with non-pureed food items at bedside, in reach, after a significant choking episode and Resident #4 who was at risk for falls, was observed ambulating unassisted despite the resident's care plan for assisted ambulation.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Record review revealed the facility admitted Resident #A on 11/21/13 with diagnoses which included Syncops and Collapse, Paralysis Agitans and Depressive Disorder. <p>Review of the Significant Change Minimum Data Set (MDS) assessment, dated 05/27/14, revealed the facility assessed the resident as cognitively intact with the Brief Interview of Mental Status score of "15" with assistance with meal tray set up and utilization of special utensils for eating.</p> <p>Review of the June 2014 Physician's Orders revealed Resident #A was to have a regular diet. Review of the resident's care plan, titled Alteration in nutrition/hydration, dated June 2014, revealed "allow adequate time to eat; provide cues; encouragement. Feed resident remaining food items". Review of the undated Nurse Aide Care Guide revealed to keep fluids next to resident at all times and encourage fluids.</p> <p>Review of Nursing Notes, dated 06/24/14 at 8:31 AM, revealed Resident #A became choked on a</p>	F 323	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>Residents on therapeutic diets have had their rooms audited and any non-allowed foods in room have been removed. Residents with ambulation assistance needs are identified by staff q shift.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? C.N.A. Assignment sheets reviewed and updated daily by Charge Nurse.</p> <p>C.N.A. each shift signs acknowledging that the C.N.A. has reviewed the Assignment sheet for the residents including the ambulation needs.</p>	

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F 323	<p>Continued From page 9</p> <p>bit of oatmeal and had difficulty clearing food from throat. The resident's Physician was on site and assessed the resident and ordered a speech evaluation and a stat chest x-ray. Crackling was noted in bilateral lower lungs.</p> <p>Review of the Speech Pathologist Evaluation, dated 06/24/14, revealed Resident #A was evaluated by the Speech Pathologist and the diet was down graded from regular to puree with honey-thickened liquids with total assist with all meals.</p> <p>Observation on 06/26/14 at 8:48 AM revealed Resident #A was in room sitting in a chair. The bed side table next to the resident had food items on it in reach that consisted of three (3) bags of gummy candy, a whole banana and a package of six (6) single serving pecan pies with one (1) remaining in the package. The resident indicated at the time, that the snacks were his/hers and he/she could eat them.</p> <p>Interview on 06/26.14 at 9:00 AM with Speech Pathologist revealed the resident had been screened due to having a major choking event on 06/24/14 and the diet had been downgraded to pureed. The Speech Pathologist stated there would be a choking risk involved if the resident attempted to eat the snacks located on the bedside table that were not pureed. She additionally stated, she had observed the items the day of the choking event (06/24/14). She stated she did not recommend the items be removed from the resident's reach and should have.</p> <p>2. Record review revealed the facility admitted Resident #4 on 12/24/13 with diagnoses which</p>	F 323	<p>Director of Nursing and/or Assistant Director of Nursing/Staff Development Coordinator provided in service education to all nursing staff regarding: a) C.N.A. responsibility to review and sign the assignment sheet q shift; b) requirement to follow the assignment sheet as it is the Care Plan for the nursing assistant; and c) the charge nurse to update daily changes to the C.N.A. Assignment sheet; d) foods not allowed on a therapeutic diet should be removed immediately from room when diet change occurs.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Charge Nurses are to monitor rooms weekly for compliance with foods at bedside and report to the Unit Manager.</p> <p>Unit Managers are to randomly audit 3 rooms weekly for compliance and report to the QA committee for recommendations.</p> <p>Unit Managers are to randomly audit 3 residents weekly for correct ambulation assistance and report compliance to the QA committee for recommendations.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166147	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
(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)	(X6) COMPLETION DATE
F 323	Continued From page 10 Included Dementia, Syncope, Falls, Weakness, Hypertension, and Parkinson's with Tremors. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 03/16/14, revealed the facility assessed the resident to require the assistance of one staff for ambulation. Review of the Comprehensive Care Plan, dated 03/06/14, revealed an intervention for the resident to ambulate with one (1) assist using a walker. Observation on 06/25/14 at 8:05 AM revealed Resident #4 to be ambulating to dining hall without assistance with the use of a walker. Interview on 06/24/14 at 09:35 AM with Certified Nursing Assistant (CNA) #6 revealed Resident #4 ambulates to bathroom with assistance but can ambulate everywhere else alone. Interview on 06/24/14 at 09:40 AM with Licensed Practical Nurse (LPN) #4 revealed the resident was able to ambulate to the dining room alone. Interview on 06/25/14 at 04:20 PM with Director of Nursing (DON) revealed staff not providing the amount of assistance the resident was assessed and care planned for placed the resident at risk for a possible fall.	F 323		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced	F 367	What corrective action will be accomplished for those residents found to have been affected? Resident #A does not have foods not allowed on present therapeutic diet in room.	7/21/2014

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F 367	<p>Continued From page 11</p> <p>by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure each resident received a therapeutic diet as prescribed by the physician for one (1) of twenty (20) sampled residents (Resident #1) and one (1) unsampled resident (Resident A).</p> <p>The findings include:</p> <p>1. Review of the Dysphagia Puree (Level 1) Diet policy, undated, revealed foods to avoid on the diet included any non-pureed desserts or snacks, and any food item with chunks, lumps, or particles.</p> <p>Record review revealed Resident #1 was admitted to the facility on 01/31/14 with diagnoses to include Adult Failure to Thrive, Malignant Neoplasm of the Kidney, Dementia. Review of the Significant Change Minimum Data Set, dated 05/21/14, revealed the facility identified the resident as severely cognitively impaired and required extensive assistance with eating. Review of the Speech Therapy notes, dated 06/20/14, revealed the resident had continued decline in alertness with increased dysphagia. The note indicated the resident was a high aspiration risk secondary to lethargy. Review of the Physician's Orders, dated 06/20/14, revealed an order for a pureed diet.</p> <p>Observation of breakfast, on 06/25/14 at 8:20 AM, revealed Resident #1 received a fruit cup on his/her tray. State Registered Nurse Aide (SRNA) #3 attempted to feed the resident the fruit cup during the observation.</p>	F 367	<p>Resident #1 receives therapeutic diet as ordered by attending physician.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>Resident diets are checked against physician orders for accuracy and are served correctly.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Resident trays are checked for accuracy prior to leaving the kitchen by the tray checker.</p> <p>Policy and Procedure for Meal Serving updated to include trays are checked for accuracy by C.N.A. against the diet card prior to serving to the resident.</p> <p>Diet cards are checked weekly against the physician orders by the Dietary Manager and all discrepancies corrected and verified.</p>		

Meals, Serving

12.7

This procedure may involve potential and/or direct exposure to blood, body fluids, infectious diseases, air contaminants, and hazardous chemicals.

Protective Barriers

Handwashing
Gloves (as indicated)
Gown (as indicated)
Designated Waste Disposal (as indicated)

Purpose

The purpose of this procedure is to provide adequate nutrition for the resident in an enjoyable atmosphere.

Key Procedural Points

1. Check the tray for accuracy against the diet card, by CNA, prior to serving it to the resident to be sure that everything is on the tray (i.e., silverware, napkin, special devices, straw, etc.) and any inappropriate items are removed. Report or replace missing items.
2. If food has been spilled, clean it off the tray before serving the tray to the resident. If necessary, return the tray to the kitchen for a replacement tray.
3. Be sure the right tray is served to the right resident.
4. Encourage the resident to feed himself or herself. However, assist the resident as necessary (i.e., cut meats, open cartons, butter bread, position the napkin, etc.).
5. Allow the resident plenty of time to eat. Do not rush the resident.
6. Be sure the resident's face and hands are washed after he or she has finished the meal.
7. Should it become necessary to attend to another resident during the serving process, wash your hands before and after attending to such resident.
8. Check that hot foods are hot (but not too hot) and cold foods are cold.
9. Take care in serving hot foods to avoid burns. Do not offer foods hot enough to burn residents with visual problems, who are weak, shaking, or who may be unable to grasp objects.
10. Be alert to the dangers of choking while residents are eating.
11. Be sure that everyone is served.
12. Report all complaints about the food. Try to obtain specific information from the resident about the nature of the complaint such as tastes bad, too cold, too hard to chew, etc.

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240		
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F 367	<p>Continued From page 12</p> <p>Interview with SRNA #3, on 06/26/14 at 8:15 AM, revealed she attempted to feed Resident #1 for breakfast on 06/25/14. She revealed the fruit cup on his/her tray was not pureed; therefore, she should have notified the nurse.</p> <p>Interview with the Director of Nursing (DON), on 06/26/14 at 2:00 PM, revealed a fruit cup would not be appropriate on a pureed diet. She revealed staff should have removed the fruit cup from the tray.</p> <p>2. Record review revealed the facility admitted Resident #A on 11/21/13 with diagnoses which included Syncope and Collapse, Paralysis Agitans and Depressive Disorder.</p> <p>Review of the Significant Change MDS assessment, dated 05/27/14, revealed the facility assessed Resident #A's cognition as cognitively intact with a BIMS score of "15" indicating the resident was Interviewable and the resident required set up of meal trays and utilized special utensils for eating.</p> <p>Review of the June 2014 Physician's Orders, revealed Resident #A was to have a regular diet and he/she had care plan interventions of allowing time to eat, provide cues and encouragement.</p> <p>Review of a Nursing Note, dated 06/24/14 at 8:31 AM, revealed Resident #A choked on a bit of oatmeal and had difficulty clearing food from throat. The resident was assessed by his/her Physician and he ordered a speech evaluation and a stat chest x-ray. Crackling was noted in bilateral lower lungs.</p>	F 367	<p>Director of Nursing and/or Assistant Director of Nursing/Staff Development Coordinator provided in service education to all nursing staff regarding: a) Therapeutic Diets and b) change is Meal Serving policy.</p> <p>Dietary Manager provided in service education to all Dining Services employees on Therapeutic Diets and tray card check.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Dietitian or Dietary Manager will audit 3 therapeutic diet trays weekly for accuracy and report compliance to QA committee monthly for recommendations.</p>		

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F 367	<p>Continued From page 13</p> <p>Review of a Speech Pathologist Evaluation, dated 06/24/14, revealed Resident #A was evaluated by the Speech Pathologist, and the diet was down graded from regular to puree with honey-thickened liquids with total assist with all meals.</p> <p>Observation, on 06/26/14 at 8:48 AM, revealed Resident A was in his/her room sitting in a chair. Food was observed on the bed side table next to the resident (in reach) and consisted of three (3) bags of gummy candy, a whole banana and a package of six (6) single serving pecan pies with one (1) remaining in the package. The resident indicated at the time, that the snacks were his/hers and he/she could eat them.</p> <p>Interview, on 06/26.14 at 9:00 AM with Speech Pathologist, revealed the resident had been screened due to having a major choking event on 06/24/14 and the diet had been downgraded to pureed. The Speech Pathologist stated there would be a choking risk involved if the resident attempted to eat the snacks located on the bedside table that were not pureed. She additionally stated, she had observed the items the day of the choking event (06/24/14). She stated she did not recommend the items be removed from the resident's reach and should have.</p>	F 367			

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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240
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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: 1977.</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: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1977, upgraded in 1998 with 102 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system installed in 1977.</p> <p>GENERATOR: Type II generator installed in 1977. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 06/24/2014. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for One-Hundred Fourteen (114) beds with a census of One-Hundred (100) 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>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Hances M Marko, CNHA</i>	TITLE <i>Administrator</i>	(X8) DATE <i>7/18/14</i>
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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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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
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K 000	Continued From page 1 Fire).	K 000		
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors of resident rooms were in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of five (5) smoke compartments, ninety (90) residents, staff and</p>	<p>K 018</p> <p>What corrective action will be accomplished for those residents found to have been affected?</p> <p>Bathroom door hinge stops that were worn on 200, 300 and 400 wing have been replaced</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All bathroom door stops have been inspected and replaced as needed to be sure the door does not open over 90 degrees.</p>	7/31/2014	

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K 018	<p>Continued From page 2</p> <p>visitors. The facility has the capacity for one-hundred fourteen (114) beds and at the time of the survey, the census was one-hundred (100).</p> <p>The findings include:</p> <p>Observation, on 06/24/14 at 12:35 PM with the Maintenance Personnel, revealed the corridor doors to resident rooms on the 200 hall had the potential to be blocked from closing by the resident bathroom doors. The doors had a hinge stop installed to keep the bathroom doors from opening over 90 degrees but the hinge stops were worn throughout the hall.</p> <p>Interview, on 06/24/14 at 12:36 PM with the Maintenance Personnel, revealed he was unaware the hinge stops were no longer functioning on the bathroom doors.</p> <p>Observation, on 06/24/14 at 12:50 PM with the Maintenance Personnel, revealed the corridor doors to resident rooms on the 300 hall had the potential to be blocked from closing by the resident bathroom doors. The doors had a hinge stop installed to keep the bathroom doors from opening over 90 degrees but the hinge stops were worn throughout the hall.</p> <p>Interview, on 06/24/14 at 12:51 PM with the Maintenance Personnel, revealed he was unaware the hinge stops were no longer functioning on the bathroom doors.</p> <p>Observation, on 06/24/14 at 1:00 PM with the Maintenance Personnel, revealed the corridor doors to resident rooms on the 400 hall had the potential to be blocked from closing by the resident bathroom doors. The doors had a hinge</p>	K 018	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Bath room door stops will be added to the monthly room checks audit. Door stops will be monitored for wear and effectiveness and replaced as needed.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Maintenance technician will report to QA monthly the compliance results of the monthly monitor for recommendations.</p>	

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K 018	<p>Continued From page 3</p> <p>stop installed to keep the bathroom doors from opening over 90 degrees but the hinge stops were worn throughout the hall.</p> <p>Interview, on 06/24/14 at 1:01 PM with the Maintenance Personnel, revealed he was unaware the hinge stops were no longer functioning on the bathroom doors.</p> <p>The census of one-hundred (100) was verified by the Administrator on 06/24/14. The findings were acknowledged by the Administrator and verified by the Maintenance Personnel at the exit interview on 06/24/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with</p>	K 018		

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K 018	Continued From page 4 19.3.6.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted	K 025	What corrective action will be accomplished for those residents found to have been affected? Smoke Barrier walls extending above room 201 and 301 will have 5/8" sheet rock applied to the wall and it is sealed to the roof decking using sheet rock tape, fire caulk and sheet rock mud. The sheet rock will be applied by private contractor.	7/31/2014

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185147	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 200 STERLING DR. HOPKINSVILLE, KY 42240	
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K 025	<p>Continued From page 5 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred fourteen (114) beds and at the time of the survey, the census was one-hundred (100).</p> <p>The findings include:</p> <p>Observation, on 06/24/14 at 8:30 AM with the Maintenance Personnel, revealed the smoke partition, extending above the ceiling located at the administrators office had large penetrations around the pipes going through the wall.</p> <p>Interview, on 06/24/14 at 8:31 AM with the Maintenance Personnel, revealed he was unaware the wall had the large penetrations around the piping.</p> <p>Observation, on 06/24/14 at 8:45 AM with the Maintenance Personnel, revealed the smoke partition, extending above the ceiling located at resident room #201 had three (3) penetrations around the pipes going through the wall. Further observation revealed the wall was not sealed properly at the top next to the roof decking.</p>	K 025	<p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All Smoke barrier walls in the attic have been inspected and penetrations and gaps repaired and sealed.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Smoke barrier walls will be inspected after any installation or maintenance done in the attic. The inspection will be completed by maintenance supervisor and repairs made as needed and documented.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Smoke barrier walls will be inspected quarterly by Maintenance Supervisor or designee for compliance and noted on QA report. Compliance will be reported to QA committee quarterly for follow up and recommendations.</p>	

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K 025	<p>Continued From page 6</p> <p>Interview, on 06/24/14 at 8:46 AM with the Maintenance Personnel, revealed he was unaware the wall was penetrated around the piping and it was not sealed properly to the roof decking.</p> <p>Observation, on 06/24/14 at 8:53 AM with the Maintenance Personnel, revealed the smoke partition, extending above the ceiling located at resident room #301 had a penetration around a pipe going through the wall. Further observation revealed the wall was not sealed properly at the top next to the roof decking.</p> <p>Interview, on 06/24/14 at 8:54 AM with the Maintenance Personnel, revealed he was unaware the wall was penetrated around the pipe and it was not sealed properly to the roof decking.</p> <p>Observation, on 06/24/14 at 9:00 AM with the Maintenance Personnel, revealed the smoke partition, extending above the ceiling located at room #401 had a penetration around a pipe going through the wall.</p> <p>Interview, on 06/24/14 at 9:01 AM with the Maintenance Personnel, revealed he was unaware the wall had a penetration around the pipe.</p> <p>The census of one-hundred (100) was verified by the Administrator on 06/24/14. The findings were acknowledged by the Administrator and verified by the Maintenance Personnel at the exit interview on 06/24/14.</p> <p>Actual NFPA Standard:</p>	K 025		

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K 025	Continued From page 7 NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025 1		

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K 046 K 045 SS=D	Continued From page 8 NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred fourteen (114) beds and at the time of the survey, the census was one-hundred (100). The findings include: Observation, on 06/24/14 at 1:10 PM with the Maintenance Personnel, revealed the exterior exits at the friendship hallway had a single light for illumination of the outside of the exit. Interview, on 06/24/14 at 1:11 PM with the Maintenance Personnel, revealed he was unaware the exterior exit was only equipped with one light. The census of one-hundred (100) was verified by the Administrator on 06/24/14. The findings were acknowledged by the Administrator and verified by the Maintenance Personnel at the exit	K 045 K 045	What corrective action will be accomplished for those residents found to have been affected? Lights that illuminate exit doors at Friendship House hallway have been replaced with fixtures that have 2 bulbs. How the facility will identify other residents having the potential to be affected by the same deficient practice? Exit paths have been audited and all exits are illuminated with light fixtures that have 2 bulbs. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Exit path lighting monitored daily by maintenance technician and bulbs replaced as indicated. Exit path fixtures audited daily by Security Guard in PM and any lights out noted on report for maintenance.	7/17/2014

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K 045	Continued From page 9 Interview on 06/24/14. Actual NFPA Standard: NFPA 101 (2000 edition) 7.8.1.4* Required Illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	How does the facility plan to monitor its performance to ensure that solutions are sustained? Maintenance Technician will report to QA monthly on compliance of lights and fixtures. QA committee to make recommendations as needed.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the cooking appliances in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is certified for one-hundred fourteen (114) beds with a census of one-hundred (100) on the day of the survey. The facility failed to ensure the grease fryer was properly separated from stove top. The findings include: Observation, on 06/24/14 at 10:33 AM with the Maintenance Personnel, revealed the grease fryer was located ten (10) inches from the cooking surface.	K 069	What corrective action will be accomplished for those residents found to have been affected? An 8 in stainless steel baffle has been installed on the left side of the gas stove adjacent to the fryer. This baffle creates a barrier between the fryer and the open flame of the gas stove. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any new equipment with open flame will have an 8" baffle installed for a barrier.	7/16/2014

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K 069	<p>Continued From page 10</p> <p>Interview, on 06/24/14 at 10:33 AM with the Maintenance Personnel, revealed he was unaware the grease fryer did not have proper separation from the cook top.</p> <p>The census of one-hundred (100) was verified by the Administrator on 06/24/14. The findings were acknowledged by the Administrator and verified by the Maintenance Personnel at the exit interview on 06/24/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 96 (1998 Edition) 9-1.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.</p>	K 069	<p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Dining Services Manager and Maintenance Technician in serviced by Administrator on LSC requirement that all deep fat fryers shall be installed with at least 16' between fryer and open flame or have an 8" stainless steel baffle between them.</p> <p>8" baffle monitored on monthly equipment check by Dietary Manager for placement.</p> <p>How does the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Kitchen equipment audit reported to QA monthly for compliance and recommendations.</p>	