

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

PRINTED: 07/26/2013  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/12/2013
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NAME OF PROVIDER OR SUPPLIER  BEAVER DAM NURSING & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1695 US HWY 231 S. BEAVER DAM, KY 42320
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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
F 000	INITIAL COMMENTS  A recertification survey was conducted on 07/10/13 through 07/12/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "D".	F 000	<b>Disclaimer: Preparation and 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 the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</b>	8/11/2013
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined the facility failed to ensure the residents' right to reside in and receive services in a facility with reasonable accommodation of the residents needs. The facility failed to ensure the emergency call light in three (3) resident bathrooms had cords long enough for the residents to reach if they were to fall on the floor.  Findings include:  A review of the facility's nursing policy/procedure	F 246	F 246  483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Criteria #1: The emergency call light cords for the resident bathroom shared by rooms 314/316, and the bathrooms for rooms 307 and 315 were lengthened to accommodate resident needs by the maintenance department on 07/12/13. Criteria #2: An audit of all resident bathroom emergency call light cords was completed on 07/12/13 by the maintenance department. All were noted to be of adequate length.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Holly Stehens DON 5/5/13</i>	TITLE	(X6) DATE
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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  <b>BEAVER DAM NURSING &amp; REHAB CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1595 US HWY 231 S. BEAVER DAM, KY 42320</b>		
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F 246	Continued From page 1 entitled, "Accommodation of Needs/Call Light", revealed the facility will provide each resident access to a communication system from his/her room, toilet and bathing area that will enable the resident calls to be received at the nurses' station. The facility will have a system that enables the resident to directly contact staff at the nurses' station.  Observation 07/10/13 at 12:45 PM and 4:00 PM revealed the emergency call-light pull chain/cord in the bathroom shared by rooms #314 and #316 and bathrooms in Room #307 and #315 were less than the length of a ballpoint pen or less than six (6) inches.  Interview with the Director of Nursing, on 07/12/13 at 3:25 PM, revealed she expected the chain on the call system to be of adequate length for residents to reach if they were on the floor.	F 246	<b>Criteria #3:</b> All nursing and housekeeping staff have received in-service education on residents' access to call light cords and to report any problems with call light cords to maintenance for repair, as provided by the DON/ADON on 08/08/13. <b>Criteria #4:</b> The maintenance department shall review the maintenance log for needed repairs daily (M-F). The CQI tool for the monitoring of emergency call light cords shall be completed monthly X2, and then every 6 months as per established CQI calendar under the supervision of the administrator.		
F 253 SS=E	<b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b>  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior related to thirteen (13) resident bathrooms with toilet plunger stored	F 253	<b>F 253</b>  <b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b> The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. <b>Criteria #1:</b> The plungers in the 13 rooms identified during the survey process were sanitized and placed in plastic bags on 07/12/13 by the housekeeping department. The 6 dusty ceiling vents identified during the survey process were cleaned on 07/12/13 by the housekeeping department.	<b>8/11/2013</b>	

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F 253	Continued From page 2 directly on the floor and not covered and six (6) bathrooms with dirty ceiling vent fans.  Findings include:  Observations on 07/10/13 at 4:00 PM and 07/12/13 at 3:37 PM of the bathrooms between resident rooms #105/107, #109/111, #113/115, #117/119, #112/114, #301/303, #307/309, #306/308, #401/403, and #402/404, and in bathrooms of rooms #116, #108, and #305 revealed there was a toilet plunger in each bathroom stored on the floor without the proper covering.  Interview with the Maintenance Director, on 07/11/13 at 4:15 PM, revealed he would expect the toilet plungers to be taken and sanitized after use and placed in a bag after they were cleaned.	F 253	<b>Criteria #2:</b> An audit of all resident bathrooms was completed on 07/12/13 to determine that all resident bathrooms were maintained with properly cleaned/covered toilet plungers and clean ceiling vents by the housekeeping department. <b>Criteria #3:</b> The housekeeping routine cleaning schedule has been reviewed/ revised to determine that the facility (which includes resident bathroom toilet plungers and ceiling vents) is maintained in a sanitary, orderly and comfortable manner. Housekeeping staff members received in-service education that included, but was not limited to: proper sanitizing and storage of toilet plungers after each use, and routinely cleaning of ceiling vents as provided by the DON/ADON on 08/08/13. <b>Criteria #4:</b> Maintaining clean resident bathrooms shall be monitored through routine visits by the housekeeping supervisor at least weekly. In addition, the CQI tool for the monitoring of a sanitary, orderly and comfortable interior shall be utilized weekly X 4 weeks and then every 6 months as per established CQI calendar under the supervision of the administrator.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to provide services to meet professional standards of quality related to staff following physicians orders for one resident (#16), not in the selected sample of thirteen (13) residents. Resident #16's physician's order stated to administer oxygen (O2) at four (4) liters	F 281	<b>F 281</b> <b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>	8/11/2013	

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F 281	Continued From page 3 a minute (LPM) per nasal cannula (NC) and observations revealed it was administered at five (5) LPM/NC.  Findings include:  A review of the facility policy entitled, "Oxygen Therapy Concentrator Setup", dated 01/01/07, revealed to adjust the O2 flow meter to the prescribed rate.  A record review revealed Resident #16 was admitted to the facility on 05/23/04 with diagnoses to include Paralysis Agitans, Primary Cardiomyopathy, Anxiety State, Cardiac Dysrhythmia, and Arteriosclerotic Cardiovascular Disease.  A review of the July 2013 physician orders revealed Resident #16 should receive O2 at four (4) LPM/NC to keep oxygen above 90%.  Observation on 07/10/13 at 12:45 PM and 4:28 PM revealed Resident #16's O2 was being administered at five (5) LPM/NC.  Interview with Licensed Practical Nurse (LPN) #3, on 07/10/13 at 4:35 PM, revealed Resident #16's O2 should be administered at 4 LPM/NC according to physician orders.  Interview with the Director of Nursing, on 07/12/13 at 3:25 PM, revealed O2 therapy should be administered per the physician's order.	F 281	The services provided or arranged by the facility must meet professional standards of quality. Criteria #1: Resident # 16 was immediate assessed, O2 adjusted to prescribed rate, and MD and family were notified on 07/10/13. Criteria #2: An audit of all residents receiving O2 was completed by administrative nurses on 07/10/13, no discrepancies were noted. Criteria #3: Facility protocol has been revised to have nurses check resents prescribed O2 therapy every 4 hours and pm to determine that flow rate is correct. Nurses received in-service education on facility O2 protocol on 08/08/13 as provided by DON/ADON. Criteria #4: O2 rate on each resident shall be monitored by charge nurses every 4 hours and documented. The O2 monitoring sheets shall be reviewed by the ADON weekly X 4 weeks, and then monthly as part of the CQI meeting under the supervision of the DON.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility	F 282	<b>F 282</b> <b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b> The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	8/11/2013	

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F 282	<p>Continued From page 4 must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure the care plan was correctly implemented for one resident (#4), in the selected sample of thirteen (13) residents and one resident (#15), not in the selected sample. The facility failed to implement the care plan for Resident #13 related to a mechanical soft diet and Resident #15 related to changing the resident's O2 tubing weekly.</p> <p>Findings Include:</p> <p>A review of the facility policy entitled Comprehensive Care Plan, dated 01/01/07, revealed residents should have a plan of care for assessed needs. The care plan should be developed based on assessed needs. Care plan approaches should be communicated to staff for use in providing direction for care.</p> <p>1. A review of the facility's policy entitled, "Mechanical Soft Diet", no date, revealed a resident on a mechanical soft diet should limit the amount of popcorn eaten.</p> <p>A record review revealed Resident #4 was admitted to the facility on 09/08/12 with diagnoses to include Chronic Airway Obstruction and</p>	F 282	<p><b>Criteria #1:</b> Resident #4's MD gave an order on 07/12/13 to allow for resident to eat popcorn as desired. Resident #4 signed a refusal form (Dietary Compliance) on 07/12/13 and his/her care plan was revised to reflect this on 07/12/13. Resident # 4's and #15's O2 tubing and filter were changed on 07/10/13 and weekly thereafter.</p> <p><b>Criteria #2:</b> A review of all resident snacks (not provided by the dietary department) was completed on 7.12.13 by nursing administration to identify possible non-compliance with prescribed diets. Proper notification, consent forms and care plan revisions were completed as indicated. All O2 tubing and filters were changed out on 7/10/13, and weekly thereafter by the respiratory services representative.</p> <p><b>Criteria #3:</b> Nursing staff members received in-service education which included, but was not limited to: how to determine resident's prescribed diet, allowable foods for modified diets, and necessary consents for non-compliance with prescribed diet. The respiratory services representative shall notify the DON/ADON if he/she will not be at the facility on the assigned date for the weekly change out of tubing and filter, so that facility staff can perform this duty.</p>		

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F 282	<p>Continued From page 5</p> <p>Dysphagia, Oropharyngeal phase.</p> <p>A review of the physician orders, dated July 2013, revealed Resident #4 was on a Low Concentrated Sweets, No Added Salt (LCS/NCS), Mechanical Soft Diet. A review of the Comprehensive Care Plan for At risk for alteration in nutrition and potential for weight fluctuation, dated 12/9/2012, revealed an intervention to provide the resident with a LCS/NAS, mechanical soft diet. A review of the Individual Plan Report (report used by certified nursing assistants for care of residents), dated 07/11/13, revealed under meals and snacks, the following; LCS/NAS mechanical soft diet.</p> <p>Observation, on 07/10/13 at 4:25 PM and on 07/11/13 at 2:00 PM, revealed Resident #4 was eating microwave popcorn.</p> <p>Interview with Resident #4's roommate, on 07/11/13 at 9:30 AM, revealed Resident #4 usually has about three (3) bags of popcorn daily and the staff would pop it.</p> <p>Interview with Resident #4, on 07/11/13 at 10:10 AM, revealed the resident's son brings the popcorn and whoever is around that is not busy will pop the microwave popcorn. The resident stated the staff was not in the room while he/she was eating the popcorn. Resident #4 further stated that his/her meals were eaten in the room as well.</p> <p>Interview with CNA #5, on 07/12/13 at 10:20 AM, revealed Resident #4 likes regular microwave popcorn and has at least on bag per shift but did not eat the whole bag. CNA #5 further stated that</p>	F 282	<p><b>Criteria #4:</b> The CQI tool for the monitoring of compliance with prescribed diet (with snacks not provided by dietary department) shall be utilized monthly X 2 and then quarterly as per established CQI calendar under the supervision of the DON.</p> <p>The O2 tubing and filter weekly change log shall be reviewed weekly X 4 weeks, and then quarterly and prn as part of the CQI meeting under the supervision of the DON.</p>		

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F 282	<p>Continued From page 8</p> <p>the staff pops the microwave popcorn for Resident #4.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/11/13 at 4:05 PM, revealed a CNA popped the popcorn for the resident that day and Resident #4 has at least one (1) bag a day of the microwava popcorn. LPN #3 stated stated the popcorn was probably not a very good snack to be eating when on e mechanical soft diet, plus the resident does not sit in an upright position. The LPN stated the popcorn may have kernels or husks in it and it is a possibility the resident could choke and if the resident should choke he/she may not be able to yell or reach the call light. The LPN revealed she did not think Resident #4 should be eating popcorn while on a mechanical soft diet and having a diagnosis of dysphagia because of the risk of choking.</p> <p>Interview with the Speech Therapist, on 07/12/13 at 8:37 AM, revealed she would consider popcorn to be a regular diet food, and if someone wants something they can usually eat it but it does not take away the risk of aspiration. The Speech Therapist stated she would not recommend popcorn for a person on a mechanical soft diet with dysphagia.</p> <p>Interview with the Dietary Manager, on 07/12/13 at 10:15 AM, reveeled she would not give a resident on a mechanical soft diet with dysphagia soft popcorn and she was not aware of Resident #4 receiving microwave popcorn. The Dietary Manager further stated she did not know if the CNAs know the difference in the diets.</p> <p>Interview with the Director of Nursing, on</p>	F 282			

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F 282	<p>Continued From page 7</p> <p>07/12/13 at 3:25 PM, revealed "staff to feed resident" on Resident #4's care plan was a error and someone should have picked up on that. The DON further stated that microwave popcorn was a choking potential.</p> <p>2. A review of the facility policy "Oxygen (O2) Therapy Set-up", dated 01/01/2007, revealed it is the policy if the facility to administrator oxygen in a safe manner in accordance with accepted standards of practice and according to the State and Federal requirements. Cannula, mask and other delivery devices should be changed weekly. Items should be changed sooner if they become soiled.</p> <p>A record review revealed Resident #15 was admitted on 04/11/11 with diagnoses to include Chronic Ischemic Heart Disease ,Cerebrovascular Disease , Coronary Atherosclerosis of Artery Bypass Graft, and Transient Cerebral Ischemia.</p> <p>An observation on 07/10/2013 at 12:45 PM, revealed Resident #15's O2 tubing was dated 06/26/13.</p> <p>An interview with the Director of Nursing, on 07/10/13 at 5:00 PM, revealed the facility contracted a service to provide all of their respiratory services.</p> <p>An interview with the Respiratory Services representative, on 07/11/2013 at 5:00 PM, revealed he/she was there for a routine weekly visit. He/she stated he/she checks and changes every residents' tubing and aqua pack, if the facility hasn't completed it already for one reason or another. The representative revealed it was</p>	F 282			

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F 282	Continued From page 8 his/her responsibility to change the tubing and aqua packs on a weekly basis, that is the agreement between the service and the facility. He/she revealed it have been an oversight on his/her part.  An interview with the DON on 07/12/2013 at 3:31 PM, revealed the facility contracts the oxygen services out and they come here on a weekly basis to maintain the upkeep of all our oxygen concentrators, which includes aqua packs, tubing and changing of the filters, but we are ultimately responsible to make sure the service is being maintained.	F 282			
F 315 SS=D	<b>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</b>  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure proper treatment and care for a urinary indwelling catheter for one resident (#9), in the selected sample of thirteen (13) residents. Observations revealed Resident #9's urinary indwelling catheter tubing was on the	F 315	<b>F 315</b> <b>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</b> Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Criteria #1: Resident #9's catheter tubing was adjusted so as to not touch the floor on 07/11/13. Criteria #2: An audit of all residents with indwelling catheters was completed on 7/11/13 to determine that the drainage tubing was not touching the floor/ground.	8/11/2013	

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F 315	Continued From page 9 floor.  Findings include:  A record review revealed Resident #9 was admitted to the facility on 05/07/13 with diagnoses to include Adult Failure to Thrive and Hypertrophy (Benign) of Prostate with Urinary Obstruction. Brief interview of Mental Status was a fifteen (15) when interviewed by Social Services.  Observation on 07/10/13 at 12:45 PM and 4:02 PM revealed Resident #9 was in the outside smoking area with peers with his/her indwelling catheter tubing on the ground. Observation on 07/11/13 at 12:20 PM and 2:10 PM revealed Resident #9 was on the admission hall with indwelling catheter tubing in contact with the floor dragging as the resident was going down the hall.  Interview with the Director of Nursing, on 07/12/13 at 3:25 PM, revealed an indwelling catheter should be below the bladder but it should not be on the floor.	F 315	<b>Criteria #3:</b> All nursing staff received in-service education on proper placement of catheter drainage to tubing to prevent it from touching the floor on 08/08/13, as provided by the DON/ADON. <b>Criteria #4:</b> The placement of urinary drainage tubing shall be monitored pm through routine compliance rounds and reported in the morning QA meeting as indicated. The CQI tool for monitoring of catheter drainage tubing shall be utilized monthly X 2 and then every 6 months as per established CQI calendar under the supervision of the DON.		
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.	F 323	<b>F 323</b> 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.	8/11/2013	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  07/12/2013
NAME OF PROVIDER OR SUPPLIER  BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1895 US HWY 231 S. BEAVER DAM, KY 42320		
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F 323	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure the resident environment remained free of accident hazards when the medication room in the North nurses station was left with the door open and not locked and secured.  Findings include:  A review of the facility's "Medication Storage in the Facility" policy, no date, revealed Medication rooms, carts and medication supplies are locked or attended by persons with authorized access.  An observation, on 07/11/13 at 4:15 PM, revealed the medication room door was standing wide open and no staff was present in or around the medication room.  An interview with License Practical Nurse (#1), on 07/11/13 at 4:20 PM, revealed the medication room should be locked at all times. The LPN stated the facility's policy was to keep the door locked at all times.  An interview with Assistant Director of Nursing (ADON), on 07/11/13 at 4:30 PM, revealed the medication room should be locked at all times.  An interview with the Director of Nursing (DON), on 07/12/13 at 3:31 PM, revealed the medication	F 323	Criteria #1: The med room door was closed and secured immediately upon notification on 07/11/13, and staff members involved were in-serviced on that same day by the DON/ADON. A self closure mechanism was installed on the med room door by the maintenance department on 7/12/13. Criteria #2: All other med room doors have self closure mechanisms and are kept securely closed when nursing personnel are not present. Criteria #3: LN's and med techs received in-service education on keeping the med room doors closed and secured when they are not present on 08/08/13 as provided by the DON/ADON. Criteria #4: The CQI tool for the monitoring of the med rooms shall be utilized monthly X 2 and then quarterly as per established CQI calendar, under the supervision of the DON.		

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F 323	Continued From page 11 room should be locked at all times.	F 323	<b>F 328</b>  <b>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</b> The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.	8/11/2013	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure proper treatment and care for respiratory care for two residents (#15 and #16), not in the selected sample of thirteen residents. The facility failed to ensure the physician ordered amount of oxygen (O2) was administered to Resident #16 and failed to ensure the O2 tubing was changed weekly according to the care plan for Resident #15.  Findings include:  1. A review of the facility policy entitled, "Oxygen Therapy Concentrator Setup", dated 01/01/07, revealed to adjust the O2 flow meter to the	F 328			

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F 328	<p>Continued From page 12 prescribed rate.</p> <p>A record review revealed Resident #16 was admitted to the facility on 05/23/04 with diagnoses to include Paralysis Agitans, Primary Cardiomyopathy, Anxiety State, Cardiac Dysrhythmia, and Arteriosclerotic Cardiovascular Disease.</p> <p>A review of the July 2013 physician orders revealed Resident #16 should receive O2 at four (4) liters per minute (LPM) per nasal cannula (NC) to keep oxygen above 90%.</p> <p>Observation on 07/10/13 at 12:45 PM and 4:28 PM revealed Resident #16's O2 was being administered at five (5) LPM/NC.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 07/10/13 at 4:35 PM, revealed Resident #16's O2 should be administered at 4 LPM/NC according to physician orders.</p> <p>Interview with the Director of Nursing, on 07/12/13 at 3:25 PM, revealed O2 therapy should be administered per the physician's order.</p> <p>Facility policy dated 1/01/2007 and entitled, Oxygen Therapy Concentrator Setup, states "Adjust flow meter to prescribed rate".</p> <p>2. A review of the facility policy "Oxygen (O2) Therapy Set-up", dated 01/01/2007, revealed it is the policy if the facility to administrator oxygen in a safe manner in accordance with accepted standards of practice and according to the State and Federal requirements. Cannula, mask and other delivery devices should be changed weekly.</p>	F 328	<p><b>Criteria #4:</b> O2 rate on each resident shall be monitored by charge nurses every 4 hours and documented. The O2 monitoring sheets shall be reviewed by the ADON weekly X 4 weeks, and then monthly as part of the CQI meeting under the supervision of the DON. The O2 tubing and filter weekly change log shall be reviewed weekly X 4 weeks, and then quarterly and prn as part of the CQI meeting under the supervision of the DON.</p>		

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F 328	<p>Continued From page 13</p> <p>Items should be changed sooner if they become soiled.</p> <p>A record review revealed Resident #15 was admitted on 04/11/11 with diagnoses to include Chronic Ischemic Heart Disease, Cerebrovascular Disease, Coronary Atherosclerosis of Artery Bypass Graft, and Transient Cerebral Ischemia.</p> <p>An observation on 07/10/2013 at 12:45 PM, revealed Resident #15's O2 tubing was dated 06/26/13.</p> <p>An interview with the Director of Nursing, on 07/10/13 at 5:00 PM, revealed the facility contracted a service to provide all of their respiratory services.</p> <p>An interview with the Respiratory Services representative, on 07/11/2013 at 5:00 PM, revealed he/she was there for a routine weekly visit. He/she stated he/she checks and changes every residents' tubing and aqua pack, if the facility hasn't completed it already for one reason or another. The representative revealed it was his/her responsibility to change the tubing and aqua pecks on a weekly basis, that is the agreement between the service and the facility. He/she revealed it have been an oversight on his/her part.</p> <p>An interview with the DON on 07/12/2013 at 3:31 PM, revealed the facility contracts the oxygen services out and they come here on a weekly basis to maintain the upkeep of all our oxygen concentrators, which includes aqua packs, tubing and changing of the filters, but we are ultimately</p>	F 328			

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F 328	Continued From page 14 responsible to make sure the service is being maintained.	F 328			

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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: 1964, 1975, 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 07/11/13. Beaver Dam Nursing and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for fifty eight (58) beds with a census of fifty two (52) 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 Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Holly Jackson RN* DON 8/5/13

TITLE: \_\_\_\_\_ (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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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "E" level.	K 000	<p><b>Disclaimer: Preparation and 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 the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.</b></p> <p>K045 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.</p> <p>Criteria 1 -The exterior exits identified during the survey; the exit located in the kitchen that did not have a light fixture installed outside to provide the required illumination for exit discharge and the exit located in the 400 Hall that had a light fixture installed with only one bulb have been corrected. A light fixture with two bulbs has been installed for the kitchen outside exit and the light fixture for the 400 Hall exit has been replaced with a light fixture with two bulbs by the (maintenance supervisor). Criteria 2 - All exterior exits have been inspected by the Maintenance Supervisor and any exits identified to have only a single light fixture for illumination or no light fixture have been corrected to meet this standard. Criteria 3 -The Maintenance Supervisor has received in-service education from the Administrator on 8/6/2013 to assure that all exterior exits have the required illumination for exit discharge. Criteria 4 - The CQI Indicator, ES-3 which includes assuring that the exterior exits have illumination for exit discharge shall be completed by the Maintenance Supervisor monthly X 2, then quarterly thereafter under the supervision of the Administrator.</p>	8/11/13	
K 045 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>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 NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty two (52) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observation, on 07/11/13 between 8:30 AM and 12:00 PM, with the Maintenance Director revealed the exit located in the Kitchen did not have a light fixture installed outside to provide the required illumination for exit discharge. Further observation revealed the exit located in the 400 Hall had a light fixture installed with only one bulb.</p> <p>Interview, on 07/11/13 between 8:30 AM and 12:00 PM, with the Maintenance Director revealed he was not aware the exits did not have</p>	K 045			

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K 045	<p>Continued From page 2 the required illumination for egress lighting.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.7 DISCHARGE FROM EXITS 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.</p> <p>7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met: (1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (2) The level of discharge shall be protected throughout by an approved, automatic sprinkler</p>	K 045		

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K 045	Continued From page 3 system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1). Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following: (a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m). (b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames. (c) The foyer shall serve only as means of egress and shall include an exit directly to the outside. (3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure. Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6. Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3	K 045			

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K 045	Continued From page 4 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means. 7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. 7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.) 7.7.6 Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met: (1) The roof construction has a fire resistance rating not less than that required for the exit enclosure. (2) There is a continuous and safe means of egress from the roof.  7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and	K 045			

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K 045	<p>Continued From page 5</p> <p>passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels.</p> <p>7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not</p>	K 045		

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NAME OF PROVIDER OR SUPPLIER  BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1898 US HWY 231 S. BEAVER DAM, KY 42320	
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K 045	Continued From page 6 result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	<p><b>K056</b> The facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards.</p> <p>Criteria 1 – The areas identified during the survey, two standard response type sprinkler heads installed in the Maintenance Hall which is connected to the 300 Hall which has a quick response type sprinkler head; closets located in the Conference Room, Therapy Room, Medical Records Room and the Time Clock Nook; light fixtures installed within twelve inches of a sprinkler head located in the Administration Hall, 200 Hall and the 400 Hall; and the wardrobe type closets located in rooms #404, 402, 405, 406, 403, 102, 104, 105, 106, 107, 108, 109, 110, 112, 113, 114, 115, 117, and 118 that did not have adequate sprinkler coverage have been corrected by the facility contracted sprinkler vendor and the Maintenance Supervisor.</p> <p>Criteria 2 – All areas of the facility have been inspected by the facility contracted sprinkler vendor and the Maintenance Supervisor to assure there are no other areas not properly covered by the sprinkler system, that there are no other standard response heads installed in the same compartment with quick response heads, and no sprinkler heads are within 12' of a light fixture.</p> <p>Criteria 3 – The Maintenance Supervisor has received in-service education from the Administrator on 8/6/2013 to assure there is no other area in the facility that would not meet this standard.</p> <p>Criteria 4 – The CQI Indicator, ES-3 which includes assuring that there is proper sprinkler coverage in all areas of the facility, that sprinkler heads are not installed closer than 12" to a sprinkler head, and that there are no quick response sprinkler heads installed in the same compartment as standard response sprinkler heads, will be completed by the Maintenance Director on a monthly basis X2, then quarterly thereafter under the supervision of the Administrator.</p>	8/11/13
K 056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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 building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty two (52) on the day of the survey. The facility failed to ensure complete sprinkler coverage, sprinkler heads were not blocked by light fixtures, and sprinkler heads were of the same temperature rating and response type in a compartment.</p> <p>The findings include:</p>	K 056		

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K 056	<p>Continued From page 7</p> <p>Observation, on 07/11/13 between 8:30 AM and 12:00 PM with the Maintenance Director revealed sprinkler heads were installed within the same compartment that were not of the same temperature or response rating. Two (2) standard response type sprinkler head were installed in the Maintenance Hall which is connected to the 300 Hall which has the quick response type sprinkler heads installed.</p> <p>Interview, on 07/11/13 between 8:30 AM and 12:00 PM, with the Maintenance Director revealed he was not aware of the mixed sprinkler heads located within the same compartment.</p> <p>Observation, on 07/11/13 between 8:30 AM and 12:00 PM, with the Maintenance Director revealed no sprinkler heads were installed within closets located in the Conference Room, Therapy Room, Medical Records Room, and the Time Clock Nook.</p> <p>Interview, on 07/11/13 between 8:30 AM and 12:00 PM, with the Maintenance Director revealed he was not aware the closets did not have sprinkler protection.</p> <p>Observation, on 07/11/13 between 8:30 AM and 12:00 PM, with the Maintenance Director revealed light fixtures were installed within twelve (12) inches of a sprinkler head located in the Administration Hall, 200 Hall, and the 400 Hall.</p> <p>Interview, on 07/11/13 between 8:30 AM and 12:00 PM, with the Maintenance Director revealed he was not aware of the requirement.</p> <p>Observation, on 07/11/13 between 8:30 AM and</p>	K 056		

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K 056	<p>Continued From page 8</p> <p>12:00 PM with the Maintenance Director revealed wardrobe type closets located in rooms #404, 402, 405, 406, 401, 403, 102, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 117, and 118 did not have adequate sprinkler coverage.</p> <p>Interview, on 07/11/13 between 8:30 AM and 12:00 PM, with the Maintenance Director confirmed the observation.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13.8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p>	K 056		

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K 056	<p>Continued From page 9</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 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="0"> <thead> <tr> <th style="text-align: right;">Maximum Allowable Distance</th> <th></th> </tr> </thead> <tbody> <tr> <td style="text-align: right;">Distance from Sprinklers to</td> <td style="text-align: right;">of Deflector</td> </tr> <tr> <td style="text-align: right;">above Bottom of</td> <td></td> </tr> <tr> <td style="text-align: right;">Side of Obstruction (A)</td> <td style="text-align: right;">Obstruction (in.)</td> </tr> <tr> <td style="text-align: right;">(B)</td> <td></td> </tr> <tr> <td style="text-align: right;">Less than 1 ft</td> <td style="text-align: right;">0</td> </tr> <tr> <td style="text-align: right;">1 ft to less than 1 ft 6 in.</td> <td style="text-align: right;">2 1/2</td> </tr> <tr> <td style="text-align: right;">1 ft 6 in. to less than 2 ft</td> <td style="text-align: right;">3 1/2</td> </tr> <tr> <td style="text-align: right;">2 ft to less than 2 ft 6 in.</td> <td style="text-align: right;">5 1/2</td> </tr> <tr> <td style="text-align: right;">2 ft 6 in. to less than 3 ft</td> <td style="text-align: right;">7 1/2</td> </tr> <tr> <td style="text-align: right;">3 ft to less than 3 ft 6 in.</td> <td style="text-align: right;">9 1/2</td> </tr> <tr> <td style="text-align: right;">3 ft 6 in. to less than 4 ft</td> <td style="text-align: right;">12</td> </tr> <tr> <td style="text-align: right;">4 ft to less than 4 ft 6 in.</td> <td style="text-align: right;">14</td> </tr> <tr> <td style="text-align: right;">4 ft 6 in. to less than 5 ft</td> <td style="text-align: right;">16 1/2</td> </tr> <tr> <td style="text-align: right;">5 ft and greater</td> <td style="text-align: right;">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> <p>Reference: NFPA 13 (1999 Edition)</p>	Maximum Allowable Distance		Distance from Sprinklers to	of Deflector	above Bottom of		Side of Obstruction (A)	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		
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K 056	Continued From page 10 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.  Reference: NFPA 101 (2000 edition)  19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type	K 056			

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K 056	Continued From page 11 I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056			
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.  Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13  Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3	K 074	K074 Draperies, curtains, including cubical curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Criteria 1 -The privacy curtain identified during the survey in the 100 Hall Shower has been replaced with a privacy curtain that has 18" of mesh of 1/2 inch at the top by the Maintenance Director. Criteria 2 - All areas of the facility have been inspected by the Housekeeping Director to assure there are no other privacy curtains that do not have the required 18 inches of 1/2 inch mesh at the top. Criteria 3 -The Maintenance and Housekeeping Supervisors have been in-serviced by the Administrator on 8/7/2013 to assure they understand all privacy curtains must have 18 inches of 1/2 inch mesh at the top of the curtain. Criteria 4 - The CQI Indicator, ES-3 will be utilized by the Housekeeping Supervisor monthly X 2, then quarterly thereafter under the supervision of the Administrator to assure compliance with this standard.	8/11/13	

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K 074	Continued From page 12  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty two (52) on the day of the survey.  The findings include:  Observation, on 07/11/13 at 8:58 AM, with the Maintenance Director revealed the privacy curtain to the shower located within the 100 Hall Shower Room did not have eighteen inches of mesh of 1/2 inch at the top. The shower curtain was installed against the ceiling with only twelve inches of mesh at the top.  Interview, on 07/11/13 at 8:56 AM, with the Maintenance Director revealed he was not aware the shower curtain did not have the required mesh at the top.  NFPA 13 Cubicle curtains; Reference to: NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler	K 074			

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K 074	Continued From page 13 systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (48 cm) below the sprinkler deflector; using a ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074			
K 075 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure trash	K 075	K 075 The facility failed to ensure trash collection receptacles with capacities greater than 32 gallons were stored in accordance with NFPA standards. Criteria 1 – The trash can cited during the survey which is used for paper shredding has been replaced with a container that does not exceed 32 gallons. Criteria 2 – The Maintenance Director has inspected all facility trash containers to assure none are used that exceed 32 gallons unless they are located in a room protected as a hazardous area when not attended. Criteria 3 –The Maintenance and Housekeeping Supervisor have received in-service education from the Administrator on 8/7/2013 to assure they do not use trash containers that exceed 32 gallons unless the containers are stored in a room protected as a hazardous area when not attended. Criteria 4 – The CQI Indicator, ES-3 will be used by the Maintenance Supervisor on a monthly basis X 2, then quarterly thereafter, under the supervision of the Administrator to assure compliance with this standard.	8/11/13	

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NAME OF PROVIDER OR SUPPLIER  BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1696 US HWY 231 S. BEAVER DAM, KY 42320	
(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 075	<p>Continued From page 14</p> <p>collection receptacles with capacities greater than 32 gallon were stored in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for fifty eight (58) beds with a census of fifty two (52) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/11/13 at 10:54 AM, with the Maintenance Director revealed a trash can for paper shredding with a capacity over thirty two (32) gallons was left unattended in the Administration Hall.</p> <p>Interview, on 07/11/13 at 10:54 AM, with the Maintenance Director revealed he was not aware of the requirement for trash receptacles with capacities greater than thirty two (32) gallons.</p> <p>19.7.5.5 Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gal/ft<sup>2</sup> (20.4 L/m<sup>2</sup>). A capacity of 32 gal (121 L) shall not be exceeded within any 64-ft<sup>2</sup> (5.9-m<sup>2</sup>) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. Exception: Container size and density shall not be limited in hazardous areas.</p>	K 075		