

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

PRINTED: 09/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185338</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/10/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>124 WEST NASHVILLE ST</b> <b>PEMBROKE, KY 42266</b>		
(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 revisit conducted on 09/10/13 determined the facility was deemed to be in compliance with Federal Regulations as of 08/23/13, as alleged in the acceptable PoC.	{F 000}			

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

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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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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F 000	INITIAL COMMENTS  AMENDED: 08/21/13 Changed sample size to 15 and Deleted F281  A Recertification and an Abbreviated survey (KY #20246) were conducted on 07/17/13 through 07/19/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E." KY #20246 was unsubstantiated with no deficiencies cited.	F 000	Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157		

LABORATORY DIRECTOR OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Rebecca Cox* TITLE: Administrator DATE: 8/22/2013

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 157	<p>Continued From page 1 regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to notify the physician when there was a need to alter treatment for one (1) of fifteen (15) sampled residents (Resident #9).</p> <p>The findings include:</p> <p>Record review revealed the facility admitted Resident #9 on 07/16/13 with diagnoses which included Hypertension, Abscess/Infection and history of Breast Cancer, Status Post Amputation of the left fourth (4th) and fifth (5th) toes related to gangrene.</p> <p>Review of Resident #9's Immunization Record revealed the resident was administered a tuberculin skin test (TB) on 07/16/13. Further review revealed the results were obtained on 07/18/13 and indicated positive results. A review of a physician order, dated 07/18/13, revealed an order to obtain a chest x-ray.</p> <p>Review of the Radiology Report, dated 07/18/13, revealed a clinical impression which indicated that active TB could not be excluded and continued close clinical correlation was advised with recommendation for follow up to include a</p>	F 157	<ol style="list-style-type: none"> <li>1. The physician for resident #9 was notified of the chest x-ray results and recommendations by the Director of Nursing on 7/19/2013 with further orders noted.</li> <li>2. An audit of all current residents' records for the past thirty (30) days will be completed by 8/22/2013 by the Director of Nursing, Assistant Director of Nursing or Unit Manager to ensure that physician notification has occurred with any change in condition. Any identified as not having had appropriate physician notification will be immediately notified for further recommendations.</li> <li>3. All Licensed Staff will be re-educated on the requirement that the physician is notified of any resident with a change in condition. This re-education will be completed by the Director of Nursing or Assistant Director of Nursing by 8/22/2013 with no licensed nurse working after 8/22/2013 without having received this re-education.</li> <li>4. The Director of Nursing or Assistant Director of Nursing will complete a weekly audit of five (5) resident records for twelve (12) weeks to assure the physician was notified of any significant change in condition. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality</li> </ol>	
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F 157	Continued From page 2 sputum culture.  Interview with the Assistant Director of Nursing (ADON), on 07/19/13 at 11:10 AM, revealed she did not notify the attending physician of the clinical recommendations suggested on the chest x-ray report. She stated, "I would have expected the nurse on the unit to call the doctor and relay the clinical recommendations".	F 157	Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.  Compliance Date: 8-23-13	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164	1. An observation by the Director of Nursing on 7/19/2013 of care provided to resident # 4 noted that the privacy curtains were pulled and staff maintained the resident's privacy and dignity. 2. An observation of care being provided on 7/23/2013 to residents by the Director of Nursing and Assistant Director of Nursing noted that privacy curtains were pulled and no concerns were identified. 3. All direct care staff will be re-educated on the requirement to assure that privacy is being provided during care to include the pulling of privacy curtains during care. This re-education will be completed by the Director of Nursing or Assistant Director of Nursing with no direct care staff working after 8/22/2013 without having received this re-education. 4. The Director of Nursing and/or Assistant Director of Nursing will observe care being provided on five (5) residents per week for twelve (12) weeks to assure that privacy curtains are pulled and the resident's privacy and dignity are maintained. The results of these audits will	

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F 164	<p>Continued From page 3 contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure privacy for one (1) of fifteen (15) sampled residents (Resident #4). Observation revealed Nursing Staff performed Resident #4's skin assessment and failed to ensure the resident was provided privacy during the assessment.</p> <p>The findings include:</p> <p>Record review revealed the facility readmitted Resident #4 on 06/26/13 with diagnoses which included Chronic Obstructive Pulmonary Disease, Cerebral Vascular Accident, Coronary Artery Disease, and Decubitus Ulcers.</p> <p>Review of the facility's Lippincott's Textbook for Nursing Assistants (A Humanistic Approach to Caregiving) undated, revealed " The privacy curtain should be closed, or a room divider used, when you are providing care for your patients or residents."</p> <p>Observation of a skin assessment, on 07/19/13 at 10:37 AM, revealed Licensed Practical Nurse (LPN) #3 and LPN #4 left Resident #4 uncovered during the skin assessment with the door to the room being opened multiple times during the assessment, as well as the privacy curtain not pulled.</p> <p>Interviews with LPN #3 and LPN #4, on 07/19/13 at 11:30 AM, revealed the resident should have been covered as much as possible during the</p>	F 164	<p>be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 8/23/2013</p>	
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F 164	Continued From page 4 skin assessment and the privacy curtain should have been pulled prior to beginning the assessment.  Interview with the Director of Nursing (DON), on 07/19/13 at 3:55 PM, revealed she expected the nursing staff to pull the privacy curtain and keep the resident covered as much as possible during the assessment.	F 164		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  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, interview, and review of the facility's policy and procedure, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior.  Observation of rooms #22, #23, #27, #29, #31 and #32 on 07/17/13, during the initial tour of the facility, revealed the above mentioned rooms had bugs in the vent lights in the bathrooms.  Additional observations on 07/18/13 and 07/19/13 revealed bugs in the lights throughout the survey.  The findings include:	F 253	1. Light fixtures in rooms #34 and #38 were cleaned by the Maintenance Director on 7/20/13. 2. An audit of the facility including light fixtures will be conducted by the Administrator and the Maintenance Director by August 22, 2013 to identify any concerns with cleanliness and maintaining an orderly environment. Any issues identified will be addressed immediately. 3. All housekeeping staff will be re-educated on identifying issues with environmental cleanliness by 8/22/2013 by the Administrator or Housekeeping Supervisor with no housekeeping staff working past 8/22/2013 without having received this re-education.	

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F 253	<p>Continued From page 5</p> <p>Review of the facility's Housekeeping policy and procedure indicated that Housekeeping performs a variety of general task in cleaning resident rooms, inspects assigned area to ensure compliance with department standards and may perform other routine duties as assigned to create and maintain a safe, clean and orderly environment for residents, visitors, and associates.</p> <p>Observations during the initial tour, on 07/17/13 at 8:45 AM, revealed bugs were noted in the bathroom light dome in rooms #34 and #38.</p> <p>Interview with the Housekeeper, on 07/18/13 at 3:00 PM, revealed Housekeeping was responsible for cleaning all areas of residents' rooms and bathrooms. The Housekeeper stated that he/she was not aware of the bugs in the bathroom dome lights and was not capable of accessing light fixtures to clean.</p> <p>Interview with the Maintenance Director, on 07/18/13 at 3:15 PM, revealed Housekeeping and Maintenance were responsible for cleaning the bathroom dome lights.</p> <p>Interview with the Administrator, on 07/19/13 at 9:50 AM revealed she was not aware of bugs in the bathroom light domes.</p>	F 253	<p>4. The Administrator and Maintenance Director will conduct environmental rounds weekly for twelve (12) weeks to identify concerns with cleanliness and orderly environment. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 8/23/2013</p>		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p>	F 332	<p>1. Resident #15 was assessed on 07/17/2013 by the Director of Nursing and was noted to have no negative effects from the alleged deficient practice. The physician for resident # 15 was notified of the medication errors on 07/17/2013 by the Director of Nursing with no further orders given. On 07/29/2013, an observation of medication administration for resident # 15 by the Director of Nursing noted that the resident received their prescribed</p>		

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F 332	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent or greater. The facility had two (2) errors out of thirty-one (31) opportunities to equal a six percent (6 %) medication error rate, involving one resident (Resident #15), in the selected sample.</p> <p>The findings include:</p> <p>Review of the facility's Medication Administration policy and procedure, undated, revealed the licensed nurse and/or medication assistant would check the following to administer medications: Right medication, right dose, right dosage form, right route, right resident, and right time. Verify the pharmacy prescription label on the drug and that the manufacturer's identification system matches the Medication Administration Record (MAR).</p> <p>Observation of a medication pass, on 07/17/13 at 9:10 AM, revealed Licensed Practical Nurse (LPN) #1 administered the following medications to Resident #15:</p> <ol style="list-style-type: none"> <li>1. Lactulose (laxative) 10 grams (gm)/ 15 milliliters (mls) solution, 15 ml administered by mouth</li> <li>2. Divalproex Sodium Delayed Release (Depakote- seizure), 250 mgs one tablet given by mouth</li> </ol> <p>Review of the Physician's Orders and the MAR for Resident #15, dated July 2013, revealed an order for the following:</p>	F 332	<p>medications as ordered with no medication errors noted.</p> <ol style="list-style-type: none"> <li>2. An observation of medication administration by the Director of Nursing and Assistant Director of Nursing on 07/29/2013 noted that the residents received their medications as ordered with no medication errors noted.</li> <li>3. All Licensed Staff will be re-educated on the 5 Rights to Administering Medications and accuracy by 8/22/2013 with no licensed staff working past this date without receiving this education. The re-education will be conducted by the Director of Nursing or the Assistant Director of Nursing.</li> <li>4. The Director of Nursing and/or Assistant Director of Nursing will observe medication administration for five (5) residents weekly for twelve (12) weeks to ensure that all medications are being administered per nursing standards and physician orders. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</li> </ol> <p>Compliance Date: 8/23/2013</p>	

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F 332	<p>Continued From page 7</p> <p>1. Lactulose 10 gms/15 mls solution, 30 mls daily 2. Depakote 500 mgs every morning</p> <p>Further review of the MAR, dated July 2013, revealed LPN #1 initialed the above medications as given at the ordered dosage.</p> <p>Interview with LPN #1, on 07/17/13 at 4:15 PM, revealed she read the order wrong for the Lactulose, and verified only 15 mls was given to the resident. She indicated the other 250 mgs of Depakote was given to the resident later in the shift as she realized her error. However, the surveyor did not observe the LPN administer the medications to Resident #15. She revealed she should check the order with the medication to ensure it is given at the proper dosage.</p> <p>Interview with the Director of Nursing (DON), on 07/19/13 at 10:20 AM, revealed she expected staff to check the MAR with the actual medication to ensure the right medication dosage was administered. She stated the facility did not conduct medication audits of staff, as it was "nursing school knowledge" to follow the five (5) rights of medication administration.</p>	F 332		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p>	F 371	<p>F371</p> <ol style="list-style-type: none"> <li>1. All undated and expired items were discarded on 7/17/2013 by the Dietary Service Manager.</li> <li>2. An audit was conducted of all food items by the Administrator on 8/1/2013 to ensure that all stored items were dated appropriately. None were noted.</li> <li>3. All Dietary staff will be re-educated on proper food storage by 8/22/2013 by the Dietary Service Manager with no Dietary staff working after 8/23/2013 without having received this re-education.</li> </ol>	

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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 371	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure refrigerated items were labeled and stored appropriately.</p> <p>The findings include:</p> <p>Review of the facility's "Refrigerators and Freezers" policy, undated, revealed the facility would observe food expiration guidelines. Expiration dates on unopened food would be observed and "use by" dates where indicated, once food was opened.</p> <p>Review of the label information for thickened sweetened tea, thickened orange juice, and thickened golden fruit punch, undated, revealed once opened, they could be refrigerated for up to five (5) days.</p> <p>Observation of the refrigerator, on 07/17/13 at 8:45 AM, revealed the following:</p> <ol style="list-style-type: none"> <li>one (1) package of vanilla wafers, placed in a zip lock bag with a discard date of 04/30/13</li> <li>one (1) opened carton of thickened sweetened tea, undated</li> <li>one (1) opened carton of thickened fruit punch, undated</li> <li>two (2) cartons of thickened orange juice, undated</li> </ol> <p>Interview with the Dietary Manager, on 07/17/13 at 2:05 PM; and, on 07/19/13 at 12:20 PM,</p>	F 371	<p>4. The Administrator and/or Dietary Services Manager will conduct audits to ensure that stored items are dated appropriately weekly for twelve (12) weeks. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of, at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 8/23/2013</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/19/2013
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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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 371	<p>Continued From page 9</p> <p>revealed she removed the bag of vanilla wafers from the refrigerator; they were stored in error. She stated the thickened liquids should not be stored more than four (4) days in the refrigerator once opened. However, she indicated staff did not date the items upon opening. She verified there were three (3) residents in the facility on thickened liquids.</p> <p>Interview with the Administrator, on 07/19/13 at 9:40 AM, revealed she expected staff to follow the facility's policy related to food storage in the refrigerator.</p>	F 371		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185338</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/03/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>124 WEST NASHVILLE ST</b> <b>PEMBROKE, KY 42266</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 08/23/13 as alleged.	{K 000}			

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

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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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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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: 1988.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1988 and upgraded in 1998, with 20 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1968.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is Propane.</p> <p>A standard Life Safety Code survey was conducted on 07/17/2013. Christian Heights was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty (60) beds with a census of Forty-Seven (47) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Rebecca Klein*

TITLE

*Administrator*

(X5) DATE

*8/22/2013*

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 HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Fire).	K 000	K025	
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b> 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 heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  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 NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-two (32) residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Forty-Seven (47) on the day of the survey. The facility failed to ensure the smoke barrier at room #10 failed to be complete from outside wall to outside wall.  The findings include:  Observations, on 07/17/13 at 9:45 AM with the	K 025	1. The ceiling in the bathroom of room 10 will be lowered and sheet rock added to make it fire rated for one (1) hour. This will be completed by Acc Drywall and Acoustical, LLC, by August 22, 2013. 2. An audit of all fire walls will be completed by the Maintenance Director by August 22, 2013, to ensure that all smoke barriers cover all areas appropriately with no smoke barriers compromised. Any concerns identified will be corrected by 8/22/2013. 3. The Maintenance Director was re-educated by the Administrator on the requirements regarding fire walls on August 8, 2013. 4. The Maintenance Director will conduct a monthly audit for three (3) months of all fire walls to ensure all smoke barriers cover all areas appropriately. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.  Compliance Date: 8-23-2013	

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266		
(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	
K 025	<p>Continued From page 2</p> <p>Maintenance Director, revealed the smoke partitions, extending above the ceiling located at room #10 does not go around the bathroom located in the room. The barrier is therefore compromised due to the opening for the bathroom.</p> <p>Interview, on 07/17/13 at 9:45 AM with the Maintenance Director, revealed he was unaware the bathroom door located in a smoke barrier compromised the barrier.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(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</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for the specific purpose.</li> </ol>	K 025			

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
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K 025	Continued From page 3 6.3.6.2 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		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty (60) beds with a	K 027	K027  1. The fire barrier door located outside room #10 was adjusted to not allow the passage of smoke. This adjustment was completed on July 19, 2013. A door closer was added by the Maintenance Director to the door to the medication room behind the nurses' station on hall 1, the door between the laundry and the soiled linen, and a door penetrating the smoke barrier next to room #11 on August 5, 2013. 2. The Administrator and Maintenance Director conducted a 100% audit on 8/7/13 to ensure all cross-corridor doors close properly to prohibit the passage of smoke and that all doors located in the smoke barrier had functioning door closers. All identified as not closing properly to prohibit the passage of smoke was adjusted by the Maintenance Director immediately. Any doors located in the smoke barriers that did not have functioning door closers were corrected immediately by the Maintenance Director. 3. The Administrator re-educated the Maintenance Director on assuring all cross-corridor doors close properly to prohibit the passage of smoke and conducting monthly rounds on cross-corridor doors to ensure proper closure. Additionally, the Maintenance Director was re-educated on the requirement for any door located in the smoke barrier to have functioning door	

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
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K 027	<p>Continued From page 4</p> <p>census of Forty-Seven (47) on the day of the survey. The facility failed to ensure one (1) set of doors in the smoke barriers had a gap less than 1/8 inch where the doors meet and three (3) doors located in the smoke barriers did not have functioning door closers.</p> <p>The findings include:</p> <p>Observation, on 07/17/13 between 11:00 AM and 1:00 PM with the Maintenance Director, revealed the cross-corridor doors located at room #10 would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Further observation revealed the door for the med room behind the nurses' station for hall 1, the door between the laundry and the soiled linen, and a door penetrating the smoke barrier next to room #11 did not have a functioning door closer to ensure the smoke barriers were properly sealed.</p> <p>Interview, on 07/17/13 between 11:00 AM and 1:00 PM with the Maintenance Director, revealed he was unaware the doors at room # 10 would not close all the way leaving a gap between the doors in the closed position and that any door that penetrates a smoke barrier must be self-closing.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p>	K 027	<p>closers. This education was completed by 8/7/13.</p> <p>4. The Maintenance Director will complete an audit of all cross-corridor doors monthly for three (3) months to ensure all doors close properly to prohibit the passage smoke. Further, the Maintenance Director will complete an audit monthly for three (3) months to ensure all doors located in the smoke barrier has functioning door closers. The results of these audits will be reviewed with the Quality Assurance Committee on a weekly basis until substantial compliance is achieved and then on a monthly basis for at least three (3) quarters in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 8-23-2013</p>	

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42268	
(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 027	Continued From page 5 Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Forty-Seven (47) on the day of the survey. The facility failed to ensure all egress doors had delayed egress signs with a contrasting background and curtains not blocking the signage.  The findings include:  Observation, on 07/17/13 at 10:37 AM with the Maintenance Director, revealed four (4) doors in the facility were equipped with signage for the	K 038	1. The signs on the delayed egress doors were changed to contrasting backgrounds and the curtains covering the doors were lowered to allow visibility of the signs on August 1, 2013 by the Maintenance Director. 2. A 100% audit was conducted on all doors for egress by the Administrator on August 7, 2013, to ensure signage was on a contrasting background and that signage is not covered by curtains. No concerns were identified. 3. The Maintenance Director was re-educated by the Administrator on ensuring that signage on delayed egress doors is on a contrasting background and not covered by curtains. This education was completed on August 7, 2013. 4. The Maintenance Director will complete an audit of all delayed egress doors monthly for three (3) months to ensure all signage is on contrasting backgrounds and not covered by curtains. The results of these audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality	

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K 038	<p>Continued From page 6</p> <p>delayed egress doors with no contrasting background on the signs. Further observation revealed three (3) doors had curtains that were blocking the delayed egress signage.</p> <p>Interview, on 07/17/13 at 10:37 AM with the Maintenance Director, revealed he was unaware the signs must have a contrasting background and the signage cannot be blocked by curtains..</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic</p>	K 038	<p>Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 8-23-2013</p>		

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266	
(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 038	Continued From page 7 fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.  (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.  (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.  (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.	K 038		

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K 038	Continued From page 8 Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.  (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038	K056 1. Ceiling fans on halls 1 and 2 that were blocking sprinkler heads within 1 foot of the sprinkler head extending 1 foot below the sprinkler head were removed by the Maintenance Director on July 29, 2013. Sprinkler heads in Room #19 will be changed by Tri-State Fire Protection by 8/22/2013 to ensure all sprinkler heads have the same response time. 2. A 100% audit of the sprinkler heads was conducted by the Administrator to ensure that all sprinkler heads had were not blocked by ceiling fans and had a clear spray path and no concerns were identified. Tri-State Fire Protection will conduct an audit by 8/22/13 to ensure that all sprinkler heads in each compartment will have the same response time. Any concerns identified will be corrected by 8/22/13. 3. The Maintenance Director was re-educated by the Administrator on August 7, 2013, on ensuring that sprinkler heads are not blocked by ceiling fans and that sprinkler heads have the same response time in each compartment. 4. The Administrator and Maintenance Director will conduct environmental rounds to ensure all sprinkler heads have the same response time per compartment and are not blocked by ceiling fans and have a clear spray path monthly for three (3) months. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) months in order to	
K 056 SS=E	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  This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified	K 056		

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEIGHTS NURSING AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 124 WEST NASHVILLE ST PEMBROKE, KY 42266
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K 056	<p>Continued From page 9</p> <p>for Sixty (60) beds with a census of Forty-Seven (47) on the day of the survey. The facility failed to ensure sprinkler heads were not blocked by ceiling fans and that all sprinkler heads matched in room #19.</p> <p>The findings include:</p> <p>Observations, on 07/17/13 between 11:00 AM and 1:00 PM with the Maintenance Director, revealed the sprinkler heads located in halls #1 and 2 were blocked by ceiling fans, within 1 foot of the sprinkler head, extending below the sprinkler heads.</p> <p>Interview, on 07/17/13 between 11:00 AM and 1:00 PM with the Maintenance Director, revealed he was aware the ceiling fans might not be in compliance because his sprinkler vendor had mentioned during his survey he might have to move them.</p> <p>Observations, on 07/17/13 at 12:05 PM with the Maintenance Director, revealed a standard response sprinkler head and quick response sprinkler head in the same compartment located in room #19.</p> <p>Interview, on 07/17/13 at 12:05 PM with the Maintenance Director, revealed he was not aware that the sprinklers had to have the same engagement heat if the sprinkler heads are located in the same compartment.</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</p>	K 056	<p>validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</p> <p>Compliance Date: 8/23/2013</p>	
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K 058	<p>Continued From page 10</p> <p>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 colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)</th> <th>Obstruction (in.)</th> </tr> </thead> <tbody> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 Edition) 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</p>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Obstruction (in.)	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 058		
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K 056	Continued From page 11 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.	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained in accordance with NFPA	K 062	K062  1. The sprinkler heads located in the kitchen and the kitchen storage closet were changed by Tri-State Fire Protection on July 31, 2013. 2. An audit of all sprinkler heads was conducted by the administrator revealed that no sprinkler heads had a buildup of corrosion on the sprinkler heads. This audit was completed on August 2, 2013. 3. The Maintenance Director was re-educated by the Administrator on auditing sprinkler heads to ensure there is no buildup of corrosion on sprinkler heads. This re-education was completed on August 8, 2013. 4. The Administrator and Maintenance Director will conduct environmental rounds monthly to ensure there is no corrosion buildup on sprinkler heads for three (3) months. The results of these audits will be reviewed by the Quality Assurance Committee on a	

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K 062	Continued From page 12 standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Forty-Seven (47) on the day of the survey. The facility failed to ensure sprinkler heads located in the kitchen area were free from corrosion.  The findings include:  Observations, on 07/17/13 at 12:40 PM with the Maintenance Director, revealed the sprinkler heads located in the kitchen and the kitchen storage closet had a buildup of corrosion on the sprinkler heads.  Interview, on 07/17/13 at 12:40 PM with the Maintenance Director, revealed he was unaware the sprinkler heads in the kitchen and storage closet had a buildup of corrosion.  Reference: NFPA 25 (1998 Edition).  2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	monthly basis for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.  Compliance Date: 8/23/2013	
K 072 SS-E	NFPA 101 LIFE SAFETY CODE STANDARD  Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072		

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K 072	<p>Continued From page 13</p> <p>exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, twenty-eight (28) residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Forty-Seven (47) on the day of the survey. The facility failed to ensure the exit corridor at the front exit was kept free and clear of impediments.</p> <p>The findings include:</p> <p>Observation, on 07/17/13 at 1:00 PM with the Maintenance Director, revealed two (2) couches, three (3) chairs, a table, a plant, copy machine, and two (2) shred it bins located in the egress path to the front exit of the building.</p> <p>Interview, on 07/17/13 at 1:00 PM with the Maintenance Director, revealed the facility has the area set up as the television viewing area and they currently have no where else for the residents to view television in a social area.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072	<p>K072</p> <ol style="list-style-type: none"> <li>1. The furniture will be removed from the means of egress by August 22, 2013.</li> <li>2. The Maintenance Director completed an audit of all egresses on August 7, 2013 to assure all were clear of impediments. No other areas of concern were identified.</li> <li>3. The Maintenance Director was re-educated by the Administrator on keeping egress paths clear of impediments on August 7, 2013.</li> <li>4. The Maintenance Director will conduct an audit monthly for three (3) months to ensure egress paths are clear of impediments. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.</li> </ol> <p>Compliance Date: 8/23/2013</p>	

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K 144 K 144 SS=F	Continued From page 14 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Forty-Seven (47) on the day of the survey. The facility failed to ensure the generator enclosure did not have any storage inside.  The findings include:  Observation, on 07/17/13 at 10:50 AM with the Maintenance Director, revealed the facility was equipped with an emergency generator. The enclosure for the generator had WD40, antifreeze, and oil stored inside the enclosure.  Interview, on 07/17/13 at 10:50 AM with the Maintenance Director, revealed he was not aware there could not be any items stored in the generator enclosure.	K 144 K 144	K144 1. All items stored inside the generator enclosure were removed on 7/17/13 by the Maintenance Director. 2. An audit was conducted by the Administrator on 8/1/2013 to ensure that no items were stored inside the generator enclosure. No items were noted. 3. The Maintenance Director was re-educated by the Administrator on not storing items inside the enclosure of the generator on August 7, 2013. 4. The Administrator and Maintenance Director will conduct audits to ensure no items are stored inside the enclosure of the generator weekly for twelve (12) weeks. The results of these audits will be reviewed by the Quality Assurance Committee on a monthly basis for at least three (3) months in order to validate continued compliance. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Social Services Director with the Medical Director attending at least quarterly.  Compliance Date: 8/23/2013	

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K 144	Continued From page 15  Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.	K 144			