

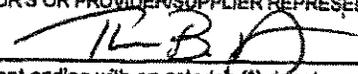
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - FRANKFORT	STREET ADDRESS, CITY, STATE, ZIP CODE 117 OLD SOLDIERS LANE FRANKFORT, KY 40601
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F 000	INITIAL COMMENTS	F 000		
F 226 SS=D	<p>A Recertification Survey was initiated on 03/03/15 and concluded on 03/06/15. Deficiencies were cited with the highest Scope and Severity of an "E".</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to implement its written policies and procedures which prohibited mistreatment, neglect, and abuse of residents and misappropriation of resident property for one (1) of nineteen (19) sampled residents (Resident #7).</p> <p>Resident #7 made an allegation of abuse/exploitation against a State Registered Nursing Assistant (SRNA) on 02/27/14, and the Social Worker (SW) and Administrator were notified. Although staff interviews indicated Resident #7, Resident #7's roommate and the perpetrator, SRNA #2 were interviewed, the facility failed to identify the allegation as abuse. In addition, the facility failed to conduct a thorough investigation, failed to protect residents by removing the perpetrator from resident care during an investigation, and failed to report the allegation to the State Agency.</p>	F 226	<p>F 226 Corrective Actions for Targeted Resident(s): Resident #7 who had requested a transfer to a facility closer to the resident's hometown was transferred to a facility of his/her choosing on 03/06/2015. Resident #7 was interviewed related to two other allegations he/she made and the facility reported. During these interviews, the resident did not exhibit or express any negative psycho/social affects from the allegation of abuse/exploitation. All staff are being in-serviced by the Director of Clinical Education (DCE), Executive Director, DNS, ADNS, Unit Manager, this in-servicing began on 03/17/2015, and will be completed on or before 04/14/2015. The In-service is on Abuse,</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: Executive Director (X6) DATE: 4/9/15

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

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F 226	Continued From page 1 The findings include: Review of the facility's policy titled "Investigation and Reporting of Alleged Violations of Federal and State Laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property", revised 03/01/13, revealed any employee who suspected an alleged violation should immediately notify the Executive Director (ED) or the District Manager (DM), who would in turn notify the appropriate State Agencies, in accordance with State Law. Per the Policy, all investigations should be conducted by the ED, Director of Nursing (DON), Director of Clinical Service (DOCS) or DM. Continued review revealed the results of all investigations were to be reported by the ED or DM to the appropriate State Agency, as required by State Law, within five (5) working days of the alleged violation. Further review revealed the investigation should include interviews of employees, visitors, residents, volunteers and vendors who might have knowledge of the alleged incident. In addition, all information was to be documented on the Verification of Investigation Form or a state required form. Furthermore, the Policy stated if the suspected perpetrator was an employee, the ED or DM should place the employee on immediate investigatory suspension while completing the investigation. Review of Resident #7's medical record revealed the facility admitted the resident on 3/14/13, with diagnoses which included Depressive Disorder and Cerebrovascular Accident (CVA). Review of the Annual Minimum Data Set (MDS) Assessment, dated 12/16/15, revealed the facility	F 226	Neglect, Misappropriation and Exploitation. Additionally, the Executive Director (ED) and Director of Nursing Service (DNS) have been assigned to complete two in-services on The Learning Center (The online education application the facility uses for in-services and on-going training and CEU's) - These two in-services will be completed by 3/31/2015. <u>Identification of Other Residents with Potential to Be Affected:</u> All residents of the facility have the potential to be effected. On 3/5/2015 the Social Services Director interviewed forty eight cognizant residents and asked if they had any concerns with the Living Center staff, with care, or had they witnessed or experienced inappropriate acts involving staff	
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F 226	<p>Continued From page 2</p> <p>assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact.</p> <p>Review of the Progress Notes, dated 02/27/15 at 3:24 PM and completed by the SW, revealed Resident #7 reported an aide had asked the resident for money and stated it happened a couple of months ago. Continued review revealed the resident reported the SRNA asked Resident #7 to buy her a \$90.00 coat, pay her light bill and buy her a ring. According to the SW's documentation, Resident #7 denied giving the SRNA any money or being offered anything in return for the money; however, the resident reported the SRNA said she would "hook up" with the resident when he/she was discharged from the facility. Further review revealed the SW completed an investigation of the resident's report, including a review of actions on Resident #7's money account while a living at the facility. Continued review revealed the Business Office Manager (BOM) met with Resident #7 to discuss account balances and transactions, and the resident was provided the ledger containing deposits and withdrawals from the account. Further review of the Progress Notes revealed Resident #7 expressed understanding of the information provided and did not have additional concerns. The Note stated Resident #7 was offered counseling services, but refused to attend after two (2) or three (3) sessions. In addition, the SW documented a Psychiatric (Psych) Services consult was initiated on 02/27/15.</p> <p>Interview with Resident #7, on 03/04/15 at 1:45 PM, revealed SRNA #2 had asked the resident to give her money, buy her jewelry and a coat, fix</p>	F 226	<p>members. All residents interviewed denied they had experienced any issues with staff. Beginning 3/27/2015 and completed by 4/03/2015, the Social Worker or Social Service Assistant will complete interviews with all residents who are interviewable to identify any allegations of abuse or neglect. Beginning the week of April 6, 2015 and ending April 10, 2015, five interviewable residents will be interviewed by either the Executive Director, DNS, Social Worker, or Licensed Nurse, these interviews will continue for four weeks to ensure any abuse, neglect, or misappropriation is identified, reported, and investigated. Beginning the week of March 30 and ending April 10, 2015, the Social Worker or Social Service Assistant will contact all interested parties or families of residents who</p>		

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F 226	<p>Continued From page 3</p> <p>her car and buy her a ring. Continued interview revealed SRNA #2 told Resident #7 they would get married when the resident was discharged from the facility. Resident #7 stated he/she reported this information to a nurse.</p> <p>Interview with Resident #7's roommate, on 03/04/15 at 1:50 PM, revealed he/she had overheard SRNA #2 asking Resident #7 for money, jewelry and to fix her car before.</p> <p>Interview with SRNA #1, on 03/04/15 at 2:30 PM, revealed she escorted Resident #7 on the bus for an appointment on 02/27/15 and the resident told her SRNA #2 requested money to buy a coat and pay utility bills, and asked for a ring, and stated they were going to get married. SRNA #1 stated she reported this to the DON and the SW as soon as she returned from the appointment on 02/27/15.</p> <p>Interview with SRNA #2, the alleged perpetrator, on 03/04/15 at 2:00 PM, revealed Resident #7 made an accusation about her to SRNA #1, stating she had asked the resident for money to pay bills and fix her car and she was going to marry the resident. She stated the Administrator had interviewed her and this was how she found out about the accusation. Continued interview revealed the Administrator asked SRNA #2 if she had ever been in the resident's room by herself, and if she had ever asked Resident #7 to pay her bills, give her money or told the resident they would get married. SRNA #2 further stated she denied all the allegations, and she was not suspended from work or told she was under investigation. Further interview revealed the DON told her not to go back into the Resident #7's room.</p>	F 226	<p>are unable to be interviewed to identify any allegations of abuse, neglect or misappropriation.</p> <p>Systemic Changes: Beginning on 04/06/2015, two family members/interested parties of residents who are not interviewable will be interviewed by the Administrator, DNS, Social Worker, or Social Service Assistant or a Licensed Nurse. This will continue for four weeks and then decrease to four interviews per month until modified by the Quality Assurance Performance Improvement (QAPI) Committee (Medical Director, Executive Director, Director of Nursing Service, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) to sustain removal of the deficient practice. To ensure the</p>		

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F 226	Continued From page 4 Review of the Punch Detail History of SRNA #2's time clock punches, revealed SRNA #2 worked on 02/28/15 from 6:25 AM until 3:03 PM, and 03/01/15 from 6:27 AM until 2:43 PM, and was off work on 03/02/15 and 03/03/15. Interview with the SW, on 03/06/14 at 1:42 PM, revealed she was told by SRNA#1 on 02/27/14 of Resident #7's complaint to her about SRNA #2 asking for money. She stated she and Minimum Data Set (MDS) Coordinator #1 went immediately to interview Resident #7, who explained SRNA #2 had asked for money to pay a light bill, buy a coat and buy a ring. She further stated Resident #7 reported SRNA #2 told him/her she would look the resident up after he/she was discharged. The SW stated this was an allegation of abuse and would be considered exploitation. Continued interview revealed the SW and she and MDS Coordinator #1 also questioned Resident #7's roommate on the same date, and the roommate was not aware of anything. Further interview revealed no other staff or residents were interviewed related to the allegation. Further interview revealed the SW did not interview SRNA #2, the perpetrator, and she was unsure if anyone ever interviewed her. Additionally, the SW revealed her role in abuse allegations was to interview the residents, and the Administrator did the investigating and the reporting to State Agencies. She further stated she did not remember if she had notified the Director of Nursing (DON) of the allegation, as per the facility's policy. Interview with MDS Coordinator #1, on 03/06/15 at 2:45 PM, revealed she had gone with the SW to interview Resident #7 "a few days ago", and	F 226	same family members/interested parties are not being interviewed each time, a list of resident family members/interested parties who have been interviewed is being maintained to ensure the facility interviews as many as possible. The DNS, ADNS, Unit Manager, or Treatment Nurse are conducting head-to-toe skin assessment on all facility residents to identify any signs or symptom of abuse. This will be completed by 4/10/2015. The Executive Director (ED) and Director of Nursing Service (DNS) were assigned by the DCE to complete two in-services on The Learning Center (The online education application the facility uses for in-services and on-going training and CEU's). These two in-services will be completed by 3/31/2015, as	
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F 226	<p>Continued From page 5</p> <p>the resident alleged a SRNA was asked him/her for money. She stated Resident #7 reported the SRNA asked for money to pay her rent, implied she and the resident would be a couple when he/she was discharged from the facility. Continued interview revealed she and the SW interviewed Resident #7's roommate who stated he/she had not heard anything about it. MDS Coordinator #1 stated she could not remember which SRNA Resident #7 had accused and she did not interview anyone else related to the allegation, as per the policy.</p> <p>Interview with the DON, on 03/06/14 at 2:09 PM, revealed after reading the SW's Note dated 02/27/14, she did not remember ever being informed of Resident #7's allegations. She stated the resident's allegations should have been reported to the Administrator, as well as State Agencies. Per interview, the allegations should have also been investigated to include interviews with the perpetrator, and interviews with staff who had cared for Resident #7 prior to the allegation.</p> <p>Interview with the Administrator on 03/06/15 at 3:30 PM, revealed if an allegation of abuse was reported, the facility's process was for the perpetrator to be immediately removed from resident care and suspended pending the outcome of the investigation. Continued interview revealed an investigation would be initiated to include interviews with the resident(s) involved, interviews with the staff caring for the resident at the time of the allegation, and all residents with a BIMS score of eight (8) or above would be interviewed. The Administrator revealed the State Agencies including the State Survey Agency, Adult Protective Services and law enforcement would be immediately notified if</p>	F 226	<p>will the Post examinations for them.</p> <p>Reeducation of all facility staff on Abuse, Neglect, Misappropriation and Exploitation is being conducted by the Executive Director, DNS, ADNS, Unit Manager, DCE, began on 03/17/2015, and will be completed on or before 04/14/2015. This reeducation, ensures and emphasizes the facility promptly reports all allegations, immediately protects our residents and a thorough investigation is completed. Additionally, the facility will review in it's daily morning stand up any resident or staff concerns to ensure we are capturing any potential allegation of abuse. Any identified potential allegation will be immediately acted upon. Any staff member with a concern an allegation may have occurred is to report</p>		

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F 226 Continued From page 6
there was harm. Per the Administrator, the facility had twenty-four (24) hours to notify the same entities if there was no harm. He further stated the facility had five (5) days to send the final report of investigation to the State Agencies.

Further interview with the Administrator, revealed he had not read the SW Note dated 02/27/15, until the Surveyor was questioning him. He stated the SW had made him aware of Resident #7's allegation of SRNA #2 asking for money 02/27/15, and he had asked the SW to follow up to make sure no money was taken from the resident. He revealed he had also spoken with SRNA #2 the same date, and she had denied the allegations. Per interview, he did not interview other residents or staff and did not write down his interview with SRNA #2, and the facility did not place SRNA #2 off duty. According to the Administrator, if an employee asked a resident for money it could be exploitation or a form of abuse; however, he had not recognized this situation as possible exploitation or abuse and had not implemented the facility's abuse policy. The Administrator indicated he should have implemented the policy though.

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 "Monthly Inspection" for preventive

F 226 the concern to their respective supervisor immediately. The Supervisor will ensure the resident is safe the alleged perpetrator is removed from the facility and the ED and DNS are called and an investigation is started.

Monitoring:
Beginning the week of 04/13/2015, five head-to-toe skin assessments will be completed weekly by either the Treatment Nurse, DNS, ADNS, Unit Manager, or the Director of Clinical Education (DCE). These assessments will continue for four weeks and then the assessments will decrease to one per month and remain ongoing until modified by the QAPI Committee to sustain the removal of the deficient practice. All resident concerns and allegations of abuse will be reviewed by

F 253

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F 253	<p>Continued From page 7</p> <p>maintenance, it was determined the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior.</p> <p>Observation revealed the door frames on residents' rooms and common areas had missing paint. In addition, there was peeling wallpaper and missing paint on the walls of residents' rooms and common areas. Also, the general bathroom on the North Unit had missing and cracked tile, and missing and cracked drywall.</p> <p>The findings include:</p> <p>Review of the facility's, "Monthly Inspection" for preventive maintenance, revealed actions to be performed monthly included, but were not limited to the following: check wall conditions (paint and wallpaper) and repair as needed; inspect wall cove base and repair as needed; inspect flooring and repair as needed; and inspect doors, hardware, bumper stops and frames, entrances and toilets, and repair or refinish as required.</p> <p>However, observation on initial tour of the facility, on 03/03/15 from 10:10 AM until 12:10 PM, revealed the North Shower Room had: broken and missing tile and a loose kick plate at the left of shower entrance; and the entrance area to the section which housed the toilet had missing base tiles on both sides of the wall. Continued observation revealed missing paint on the door frames for residents' rooms 101,102, 103, 104, 105, 106, 107, 108, 109, 111, 112, 113, 114, 115, 116, 117 19, 120, 123, 124, 125, 101, 202, 203,205, 208, 209, 210, 211, 213, 214, and 215, and missing paint on the door frames leading from the lobby into the hallways to the resident rooms, and at the entrance to the North Unit</p>	F 253	<p>QAPI each month for the next four months beginning April 2015 and ending in July 2015 or continued reviews will be conducted if recommended by the Quality Performance Improvement Committee.</p> <p>F 253 <u>Corrective Actions for Targeted Resident(s):</u> The North Shower Room had the tile replaced or installed, the kick plate replaced and installed, the entrance to the toilet area was repaired on both sides, this was completed by the Maintenance Director on 03/18/2015. The door frames of resident rooms 101,102,103,104,105,106, 107,108,109,111,112, 113, 114, 115, 116, 117, 119, 120, 123,124, 125, 202, 203, 205, 208, 209, 210, 211, 213, 214, and 215 we began painting on 3/23/2015</p>	04/15/2015

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F 253	<p>Continued From page 8</p> <p>dining room. Furthermore, observation revealed a large area of missing paint below the overbed light in room 115, a large patch which was unpainted above the North Unit nurse's station, and a scuffed wall by the sink in room 128, and holes were noted on the right wall at the entrance to the South Unit dining room, and a long strip of drywall had been patched but not painted. Further observation revealed: missing baseboard along the wall in the hallway between rooms 207 and 208; and missing and/or peeling wall paper in the North dining room, room 215 above the bed, room 217 behind the bed, and on the wall leading from the hallway to the lobby.</p> <p>Interview with the Maintenance Director, on 03/06/15 at 11:00 AM, revealed if something needed repaired, the staff was to complete a work order and enter it into the computer. He stated he checked the work orders each morning, and he received a lot of work orders from staff related to scuffs. Per interview, he currently had a lot of work orders related to walls and floors needing repair, and he was aware of the peeling wallpaper and the areas he had patched which needed painting. The Maintenance Director stated he was aware of the North Unit general bathroom needing to be repaired, and he was to keep it patched until the remodel occurred. Continued interview revealed he followed the monthly inspections; however, he had to take care of safety issues first, and cosmetic issues had to come last. He stated he had been busy repairing beds and replacing light bulbs and furnace filters. The Maintenance Director acknowledged the facility was the residents' home, and it "shouldn't look like this".</p> <p>Interview with the Administrator, on 03/06/15 at</p>	F 253	<p>and they were completed by 3/27/2015. The door frames leading from the lobby into the hallways to the resident rooms and the entrance to the North Unit dining room were also painted by the Maintenance Supervisor by 3/27/2015.</p> <p>The missing paint below the over bed light in 115, the unpainted patch at the North Wing Nurse's Station, a scuffed wall by the sink in room 126, the holes noted on the right wall at the entrance to "South Unit dining room" (Main dining room), the long strip of drywall patched and not painted, as well as a missing baseboard between rooms 207 and 208, missing or peeling wall paper in the North dining room, room 215 above the bed, room 217 behind the bed and on the wall leading from the hallway to the lobby - these</p>		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - FRANKFORT			STREET ADDRESS, CITY, STATE, ZIP CODE 117 OLD SOLDIERS LANE FRANKFORT, KY 40601		
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F 253	Continued From page 9 11:30 AM, revealed he did a walking tour monthly and made a list of things he saw which needed to be repaired, and entered it into the computer as a work order. He stated all staff had been inserviced on entering work orders into the computer. The Administrator further stated the Maintenance Director worked hard and tried to get to all of the work orders, but he was the only maintenance staff for the building. Per interview, he planned to hire a part-time contract person to paint and patch the walls. Continued interview revealed the Administrator did have a problem with the way the general bathroom on the North Unit looked, and it needed to be remodeled. He stated the facility had plans to remodel the bathroom this year.	F 253	identified areas were started under repair on 3/27/2015 and will be corrected by 4/14/2015. <u>Identification of Other Residents with Potential to Be Affected:</u> All residents have the potential to be affected. An audit is being conducted by either the Executive Director, the Maintenance Director or the Housekeeping Supervisor of all resident rooms and common areas to ensure we are maintaining a sanitary, orderly, and comfortable environment. The audit was completed by March 27, 2015. In addition to the areas identified by the surveyors, it was determined on our Audit we would also paint the door frames for rooms 118,121, 122, 126, 201, 204, 206, 207, 212, 216, 217, 218, 219, 220,		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279			

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F 279	Continued From page 10 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy, it was determined the facility failed to ensure Comprehensive Care Plans were developed for each resident which included measurable objectives and timetables to meet a resident's mental and psychosocial needs identified in the comprehensive assessment for one (1) of eleven (11) sampled residents who were reviewed for Care Plans (Resident #5), out of a total sample of nineteen (19) residents. The findings include: Review of the facility's, "Interdisciplinary Care Plan" Policy, revised October 2009, revealed the Social Service (SS) staff would participate in the development of a Comprehensive Care Plan for each resident. Review revealed the SS staff would communicate residents' mental and psychosocial problems/needs, and concerns to the interdisciplinary team for inclusion in the care plan. Per the Policy, this would include: problems, needs, concerns, and strengths identified in the psychosocial assessment; areas triggered on the Minimum Data Set (MDS) and identified on the Resident Assessment Protocol (RAP) Summary as proceed to the care plan; historical issues currently managed with interventions which placed the resident at risk for decline in functioning; non-triggered needs for which the resident required on going support; and the discharge plan, if discharge was anticipated in the next ninety (90) days.	F 279	221, 222, 223, 224, and 225. <u>Systemic Changes:</u> Either the DCE, Housekeeping Supervisor, Executive Director, or Maintenance Director, will in-service all nursing staff and department heads on identifying areas in need of repair or replacement, and how to communicate via Building Engines (the facility work order system) for the items to be corrected. This in-service began on March 30, 2015 and will be completed by April 14, 2015. Additionally, either the Executive Director, Maintenance Supervisor or Housekeeping Supervisor will conduct a monthly audit of all rooms and common areas and identify areas in need of repair. Areas identified will be repaired or replaced by the next monthly audit. Additionally,		

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F 279	<p>Continued From page 11</p> <p>Review of Resident #5's medical record revealed the facility admitted the resident on 12/22/14, with diagnoses which included Anemia, Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Pressure Ulcer, Other Noninfectious Lymphedema, Cellulitis and Abscess unspecified site, Edema, Anorexia, and a Cough. Review of the Admission Minimum Data Set (MDS) Assessment, dated 12/29/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of nine (9) indicating moderate cognitive impairment. Further review of the Admission MDS, Section E, revealed the facility assessed the resident as having behavioral symptoms not directed toward others. Review of the Admission MDS Care Area Assessment (CAA) revealed the resident triggered for behavioral symptoms and the CAA Worksheet indicated a care plan had been developed for behavioral symptoms. However, review of Resident #5's Comprehensive Care Plan revealed no documented evidence a care plan had been developed for behavioral symptoms as indicated in the CAA.</p> <p>Interview with the SS Director, on 03/06/15 at 11:45 AM, revealed Resident #5 had past and continued behavioral symptoms of yelling out instead of using his/her call bell, and yelling out due to confusion from Dementia. Per interview, it was the SS Director's responsibility to complete the MDS sections in the areas of Psychosocial, Mood, and Behavioral Disturbance, and develop the Comprehensive Care Plans for the areas triggered. Continued interview revealed since Resident #5 had triggered for behavioral disturbance and continued to have behavioral disturbances, a behavioral disturbance care plan should have been developed. However, the SS</p>	F 279	<p>the Department Head daily round sheets have been modified to address specific environmental issues to ensure items in need of repair or cleaning are addressed, documented and reported in our daily stand up meetings.</p> <p>Monitoring: All audit findings and Department Head round sheets rounds will be presented to QAPI Committee (Medical Director, Executive Director, Director of Nursing Service, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for review for the next four months beginning April 2015 and ending in July 2015 or continued audits will be conducted if recommended by the Quality Performance Improvement Committee.</p>	04/15/2015	

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F 279	Continued From page 12 Director revealed not being able to find no evidence the behavioral disturbance care plan had been developed related to the resident's behaviors. Interview with the Director of Nursing (DON), on 03/06/15 at 3:20 PM, revealed the SS Director was responsible for developing a care plan on behavioral disturbances. Per interview, it would be her expectation if Resident #5's CAA triggered for behavioral disturbance, and the behavior was still occurring, she would expect the behavioral disturbance to be care planned.	F 279	F 279 <u>Corrective Actions for Targeted Resident(s):</u> Resident #5 had a comprehensive care plan completed for the mental / psychosocial identified need per CAA on 3/9/2015 by the Social Services Director.		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure services were provided by the facility in accordance with each residents written Comprehensive Care Plan for one (1) of nineteen (19) sampled residents (Resident #4). Resident #4's Comprehensive Care Plan specified the suprapubic catheter was to be changed according to Physician's Orders. Review of the Physician's Orders for February 2015, revealed the resident's suprapubic catheter was to be changed each month. However, review of the Treatment Administration Record	F 282	<u>Identification of Other Residents with Potential to Be Affected:</u> All active residents have the potential to be effected. All MDS (Minimum Data Set) comprehensive assessments and RAPs (Resident Assessment Protocols) with correlating CAA triggers (Care Area Assessment) listed on the CAA triggered report were reviewed by the RNAC, Social Services and DNS by 3/20/2015 with verification of compliance on care plan development per CAA triggered direction for care needs were identified on the		

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F 282	<p>Continued From page 13</p> <p>(TAR) and the Progress Notes, revealed the suprapubic catheter was changed on 01/28/15, and not changed again until 03/05/15 after Surveyor Intervention.</p> <p>The findings include:</p> <p>Review of the facility's, "Interdisciplinary Care Plan" Policy, revised October 2009, revealed the interdisciplinary care plan was implemented to guide the facility in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.</p> <p>Review of Resident #4's medical record revealed the facility admitted the resident on 12/09/14, with diagnoses which included Depressive Disorder, Paraplegia, Pressure Ulcers and a Suprapubic Catheter related to Urine Retention, and a history of Urinary Tract Infections (UTIs). Review of the Admission Minimum Data Set (MDS) Assessment dated 12/16/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a fifteen (15) out of fifteen. Further review revealed the facility assessed the resident as having an indwelling catheter.</p> <p>Review of the March 2015 (Physician's) Orders Summary Report revealed orders to change Resident #4's Suprapubic Catheter every month related to Unspecified Urinary Retention.</p> <p>Review of Resident #4's Comprehensive Plan of Care, initiated 12/26/14, revealed a problem of alteration in elimination of bladder related to a Suprapubic Urinary Catheter. Continued review revealed the goal stated Resident #4 would have</p>	F 282	<p>comprehensive care plan. No additional concerns were identified.</p> <p>Systemic Changes: The DNS in-serviced the RNAC, ADNS, and Social Services on 3/9/2015 on how the Interdisciplinary team (IDT) process works and following CAA triggered directions from resident comprehensive assessment - MDS /RAP of individual needs to ensure they are appropriately identified on the care plan.</p> <p>Monitoring: Effective 3/24/2015 the RNAC (RN Assessment Coordinator) is to provide a scheduled comprehensive assessment listing and CAA trigger report to DNS (Director of Nursing Services) or ADNS (Assistant Director of Nursing) for a 10% weekly review to ensure compliance with</p>		

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F 282	<p>Continued From page 14</p> <p>no complications from use of the Suprapubic Catheter, such as, pain, infection or obstruction. Further review revealed the Interventions included Suprapubic Catheter care every shift and as needed, and to change the Suprapubic Catheter as per Physician's Orders.</p> <p>Review of the TAR for January 2015, revealed the Suprapubic Catheter was initialed as changed on 01/28/15. However, review of the February 2015, revealed no documented evidence the Suprapubic Catheter was changed as per the care plan. In addition, continued record review of the Progress Notes documented for February 2015, revealed no documented evidence Resident #4's Suprapubic Catheter had been changed.</p> <p>Interview, on 03/06/15 at 10:30 AM, with Licensed Practical Nurse (LPN) #1 revealed she was assigned to Resident #4 on the date the Suprapubic Catheter was to be changed in February. She stated she did not change the Suprapubic Catheter though because she was an LPN, and she thought a Registered Nurse (RN) had to change the Suprapubic Catheter. Per interview, she notified the Weekend Supervisor, who was also an LPN, of the need for Resident #4's Suprapubic Catheter to be changed, and the LPN Weekend Supervisor should have passed it on to the Night Supervisor who was a RN.</p> <p>Interview with the Director of Nursing (DON) on 03/06/15 at 11:32 AM, revealed the Medication Administration Records (MARs) and TARs were not routinely audited. Per interview, she was unaware Resident #4's Suprapubic Catheter had not been changed for the month of February until the Surveyor asked questions on 03/05/15. She</p>	F 282	<p>care plan completion this review will continue for 12 weeks. The DNS will monitor and report the results of the review to the QAPI team monthly on status.</p> <p>F 282 <u>Corrective Actions for Targeted Resident(s):</u> Resident #4 had the Supra Pubic catheter changed on 3/5/2015 with no adverse results identified.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> Only one other resident in the facility had a supra pubic catheter. This resident's supra pubic catheter was reviewed for change services provided as per care plan and no concerns were identified. Potential exist for all residents to be effected - An audit was completed by the DNS comparing the</p>	04/15/2015	

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F 282	Continued From page 15 stated she talked to LPN #1 that day, and was told by LPN #1, she did not change the Suprapubic Catheter because she thought an RN had to change it. The DON revealed the facility was in the process of trying to clarify if a LPN could change a Suprapubic Catheter or not. Further interview revealed she was on call the weekend Resident #4's Suprapubic Catheter was to be changed, and the LPN could have called her or could have written on the Shift Report the catheter was not changed. The DON stated she could find no documentation Resident #4's Suprapubic Catheter had been changed since 01/28/15, and she had ensured the catheter was changed last night, 03/05/15.	F 282	comprehensive care plans to the March 2015 physician orders and no additional concerns were identified on care service delivery per care plan direction.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441	<u>Systemic Changes:</u> Direct care staff (Licensed Nurses and Certified Nursing Assistants) are being in-serviced by DNS on compliance requirements for care delivery per comprehensive care plan developed according to identified resident independent needs and communication of any concerns interfering with immediate care delivery as per care plan for additional intervention to ensure compliance - this in-service began on 3/25/2015 and will be completed on or before 04/14/2015.		

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F 441	<p>Continued From page 16</p> <p>isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection for one (1) of four (4) sampled residents who were observed for colostomy, perineal and Foley catheter care and skin assessments and dressing changes (Resident #4), of a total sample of nineteen (19) residents.</p> <p>Observation of colostomy care, a skin assessment and dressing changes for Resident #4 revealed the nurse used poor infection control technique regarding glove use and hand washing during provision of care.</p>	F 441	<p>Monitoring: Weekly the DNS (Director of Nursing) will audit 10% of active resident comprehensive care plans for compliance of care delivery per Physician orders with follow up rounds to ensure the care directives are implemented and in place for the residents audited. This audit will be completed for 12 weeks. Monitored results will be reported to QAPI monthly by the DNS for progress status.</p> <p>F441 <u>Corrective Actions for Targeted Resident(s):</u> Upon notification of hand washing procedure concern during the survey observation - Resident #4 had dressings removed on the pm shift of 3/4/2015 with colostomy care completed and dressings</p>	04/15/2015	

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F 441	<p>Continued From page 17</p> <p>The findings include:</p> <p>Review of the facility's, "Handwashing/Hand Hygiene", revised August 2014, revealed all personnel should follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. The Policy revealed staff were to use an alcohol based hand rub or alternatively, soap and water for the following situations: before and after direct contact with residents; after contact with a resident's intact skin; after contact with blood or body fluids; after handling used dressings or contaminated equipment; and after removing gloves. The Policy stated the use of gloves did not replace handwashing/hand hygiene. Further review revealed integration of glove use along with routine hand hygiene was recognized as the best practice for preventing healthcare associated infections.</p> <p>Record review revealed the facility admitted Resident #4 on 12/09/14, with diagnoses which included Paraplegia, Colostomy, Pressure Ulcers (PUs) and Depressive Disorder. Review of the 12/16/14 Admission Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #4 as cognitively intact. Continued review of the MDS revealed the facility assessed Resident #4 to have PUs which included one (1) Stage II PU, two (2) Stage III PU, and one (1) Stage IV PU.</p> <p>Observation, on 03/04/15 from 10:50 AM through 11:30 AM, of Resident #4's skin assessment, colostomy care and dressing changes, performed by Registered Nurse (RN) #1, revealed the nurse cleansed the resident's colostomy site with soap</p>	F 441	<p>reapplied using the appropriate hand washing procedure by a Licensed Nurse with no adverse outcomes.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> All residents have the potential to be effected. No other residents were adversely affected. Treatment cart handles, lock and keys as well as the identified door handles for the identified unit of RN#1 were cleaned and sanitized by DNS 3/4/2015 upon notification of the gloves / hand washing concern, to decrease the risk of other residents or staff affected adversely.</p> <p><u>Systemic Changes:</u> One on one education with the identified RN#1 with review of Infection Control policy and hand washing</p>	
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F 441	<p>Continued From page 18</p> <p>and water, rinsed and dried the area, and applied skin prep, a wafer and the colostomy bag. Observation revealed the nurse then removed her gloves, and without washing or sanitizing her hands, took the treatment cart key out of her pocket and opened the treatment cart drawer to obtain a clip for the colostomy bag. Continued observation revealed RN #1 then washed her hands and proceeded to perform the dressing changes. RN #1 was observed to cleanse the PU to the right ischium with Normal Saline (NS) and a gauze pad, removed her soiled gloves, and without washing or sanitizing her hands took the keys out of her pocket again, opened the treatment cart drawer, and removed a measuring device. Per observation, the nurse then washed her hands, donned new gloves and completed the dressing change. Observation revealed RN #1, removed her gloves, washed her hands and cleaned and dressed the PU on the resident's left buttock. After performing the dressing to the resident's left buttock, RN #1 was observed with the same soiled gloves, to pick up two (2) bags of soiled linen and soiled dressings and exit Resident #4's room without washing or sanitizing her hands. Further observation revealed RN #1 proceeded down the hall and opened the door to the dirty utility room with her soiled gloves on.</p> <p>Interview with RN #1 on 03/04/15 at 11:30 AM, revealed she should have washed her hands each time she removed her soiled gloves after providing care, and before obtaining items from the treatment cart. She stated she should have washed her hands prior to exiting the room after provision of care, but didn't think she needed to because she was carrying bags of soiled linens and dressings.</p>	F 441	<p>policy in relation to dressing changes, skin assessment and colostomy care was performed on 3/5/2015 by DCE (Director of Clinical Education)</p> <p>All staff will be educated on the Infection Control process with an emphasis on hand washing and glove usage this education is in process and will be completed by 4/12/2015 by DCE (Director of Clinical Education)</p> <p>A return demonstration of competencies per duty designation for direct care staff - licensed nurses and certified nursing assistants on the areas of colostomy care, assessment of skin, clean / sterile dressing changes and hand washing procedures will be completed by 4/14/2015.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185159	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - FRANKFORT			STREET ADDRESS, CITY, STATE, ZIP CODE 117 OLD SOLDIERS LANE FRANKFORT, KY 40601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 19 Interview with the Director of Nursing (DON) on 03/06/15 at 4:00 PM, revealed RN #1 should have washed her hands each time she took off her gloves after providing care. Per interview, the nurse should have washed her hands before exiting the room also, as per the facility's policy.	F 441	<u>Monitoring:</u> One on one skills observation of direct care staff will be conducted to validate Infection Control compliance with hand washing procedures, colostomy care, skin assessment and dressing changes - these observations will be completed 5 times a week x 12 weeks by either the DNS, (Director of Nursing, ADNS (Assistant Director of Nursing), DCE (Director of Clinical Education), Unit Manager, or Weekend LPN / RN Supervisors. Results of these audits or observations will be reported by the DNS to the QAPI committee monthly for review.	04/15/2015	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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acceptable

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185159	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - FRANKFORT	STREET ADDRESS, CITY, STATE, ZIP CODE 117 OLD SOLDIERS LANE FRANKFORT, KY 40601
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1973, 1992

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type V (000)

SMOKE COMPARTMENTS: Three (3) smoke compartments

FIRE ALARM: Complete fire alarm system with five (5) heat detectors and thirty-seven (37) smoke detectors

SPRINKLER SYSTEM: Complete automatic dry sprinkler system.

GENERATOR: Type II generator. Fuel source is propane gas.

A Standard Life Safety Code Survey was conducted on 03/03/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred (100) beds with a census of ninety-four (94) on the day of the survey.

Deficiencies were cited with the highest deficiency of a scope and severity of an "E".

K 000

K 052
Corrective Actions for Targeted Resident(s):
The smoke detectors are being tested/inspected by SafeCare Incorporated the week of April 6, 2015 in accordance with NFPA 70 National Electrical Code and NFPA 72.

Identification of Other Residents with Potential to Be Affected:
All active residents have the potential to be effected. The Administrator and Maintenance Supervisor conducted a review of all tests and inspections required for Life Safety from Fire and the review found no other deficient practices regarding tests or inspections. This review was completed on 3/30/2015.

RECEIVED
MAR - 9 2015

APR - 8 2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Executive Director* (X6) DATE *4/9/15*

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

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K 000 K 052 SS=E	<p>Continued From page 1</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> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.8.1.4</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure smoke detectors were inspected, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, fifty-eight (58) residents, staff and visitors.</p> <p>The findings include:</p> <p>Review of the facility's smoke detector maintenance and inspection records on 03/03/15</p>	K 000 K 052	<p>Systemic Changes:</p> <p>The Maintenance Supervisor and Executive Director will review all tests and inspections required for Life Safety from Fire each month beginning with the March 30, 2015 review and continue monthly reviews for four (4) months until June 2015 and then quarterly to sustain the removal of the deficient practice.</p> <p>Monitoring:</p> <p>The Maintenance Supervisor or the Executive Director will submit the review of tests and inspections and Life Safety code Environmental Binder to the Quality Assurance Improvement (QAPI) Committee (Medical Director, Executive Director, Director of Nursing Service, Social Services, Dietary Manager, Activities Director, Therapy and Nurse Managers) for four (4)</p>	
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K 052	<p>Continued From page 2</p> <p>at 3:58 PM, with the Maintenance Director, revealed the facility failed to ensure bi-annual sensitivity testing was performed on smoke detector heads located in the facility. Continued review revealed the last documented sensitivity testing of the smoke detector heads were performed on 01/25/13. Interview, with the Maintenance Director at the time of the review, revealed the facility had switched companies who performed the maintenance of the smoke detectors, and the sensitivity testing must have been overlooked by the new company.</p> <p>Reference: NFPA 72 (1999 Edition) 7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the 	K 052	<p>months beginning in April 2015 and ending in July 2015 and then quarterly and remain ongoing until modified by the QAPI Committee to sustain the removal of the deficient practice.</p> <p>K 072 <u>Corrective Actions for Targeted Resident(s):</u> The Maintenance Supervisor cleared the outside sidewalk leading from the North Short Hall of the snow and ice build up on 03/03/2015.</p> <p><u>Identification of Other Residents with Potential to Be Affected:</u> All residents of the facility have the potential to be effected. The Executive Director and Maintenance Supervisor did a walk through of the entire building March 24, 2015 to ensure all means of egress were</p>	04/15/2015	

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K 052	Continued From page 3 control unit where its sensilivity is outside its listed sensilivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensilivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.	K 052	free of obstructions or impediments. No obstructions or impediments were observed. Systemic Changes: The Maintenance Supervisor or Executive Director will inspect all means of egress each month beginning with the March 24, 2015, to ensure they are free of obstructions or impediments and continue monthly inspections for four (4) months until June 2015 and then quarterly to sustain the removal of the deficient practice. The Executive Director notified (April 8, 2015) the facility Snow Removal Vendor of their failure to meet the provisions of our agreement requiring the "...snow and ice removal services to keep sidewalks, access ramps...on the facility's grounds accessible and		
K 072 SS=D	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 exits, access to, egress from, or visiblity of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency according to National Fire Protection Association (NFPA)	K 072			

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K 072	<p>Continued From page 4 standards. The deficiency had the potential to affect one (1) of nine (9) exits, twenty-two (22) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 03/03/15 at 3:08 PM, with the Maintenance Director, revealed the outside sidewalk leading from the North Short Hall had an accumulation of ice and snow. Interview, with the Maintenance Director at the time of observation, revealed the facility did have a policy regarding keeping sidewalks clear of snow and ice. Further interview, revealed the snow had been pushed upon the sidewalk when an outside contractor had plowed snow from the parking lot.</p> <p>The findings were acknowledged by the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition) 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>unobstructed by snow/ice." Additionally, the facility Maintenance Supervisor, Executive Director, or acting Nurse Supervisor will visually inspect all means of egress prior to and after the parking lot has been plowed to ensure they are free of impediments when there is snow/ice accumulation.</p> <p>Monitoring: The Maintenance Supervisor or the Executive Director will submit to the QAPI Committee the monthly inspections of the means of egress for four (4) months beginning in April 2015 and ending in July 2015 and then quarterly and remain ongoing until modified by the QAPI Committee to sustain the removal of the deficient practice.</p>	04/15/2015	