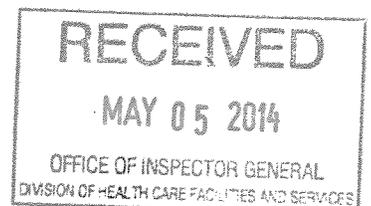


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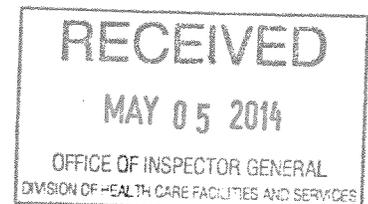
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/03/2014
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
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F 514	<p>Continued From page 24</p> <p>she was not aware of what type of tuberculin testing the resident had. LPN #5 indicated it could be a serious health problem to any resident if the allergies listed for the resident were not correct.</p> <p>Interview with LPN #2, on 04/02/14 at 10:00 AM, revealed she was unsure why the hard copy record and the computer documentation was not the same for Resident #5. She also stated she was unsure why Resident #5 had gotten the PPD tuberculin skin test and the reading was zero (0) millimeters. LPN #2 indicated she thought it was the responsibility of all of the facility nurses to ensure accurate documentation, but she was not sure who did any monitoring of the records for accuracy.</p> <p>Interview with the Director of Nursing (DON), on 04/03/14 at 5:30 PM, revealed the resident's clinical records should be accurate and the same whether in a hard copy or in a computer. She stated if the record was not accurate an error could occur which could impact adversely the health of a resident. The DON stated chart checks were to be done by the Unit Managers for new admissions and medical records staff for other records and she had not been made aware of any documentation errors.</p> <p>2. Interview with Licensed Practical Nurse (LPN) #8, on 04/03/14 at 4:15 PM, revealed Resident #2's tubing feeding was turned off on 04/02/14 and disconnected in order to obtain and administer Tylenol which was ordered for pain.</p> <p>However, review of the electronic Medication Administration Record (eMAR), dated 04/02/14,</p>	F 514	<p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? The Health Information Manager requested of pharmacy a list of current resident allergies, and for comparison printed off resident specific allergy information from the electronic medical record. These listings are being compared to all hard charts for any potential inconsistencies that need to be addressed. This will be completed by the Health Information Manager by 4/30/14. The documentation in question for Resident #5 was corrected on 4/2/14 by the Health Information Manager. All new admission charts are reviewed by the Unit Managers within 24 hours of admission and is also part of the daily Clinical Start Up review; these reviews involve verification of accuracy of hospital discharge orders to admission orders, including presence of identified allergies. All licensed nursing staff will be in-serviced on process for updating resident information /changes with dates/initials of licensed nurse making that correction by the Staff Development Coordinator by 4/30/14. All licensed nursing staff will be in-serviced in regards to PRN medication administration process that includes timely documentation of the medication administration by the Staff Development Coordinator by 4/30/14.</p>	



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F 514	<p>Continued From page 25 for Resident #2 revealed Tylenol was not documented as given.</p> <p>Continued interview with LPN #8 revealed she did not sign off the resident's ordered Tylenol as being administered. LPN #8 stated she forgot to sign off the medication and all medications should be signed off as soon as they are given to prevent them from being given twice.</p> <p>Interview with the Unit Manager, on 04/03/14 at 5:37 PM, revealed she did not monitor to ensure medications are signed as they are given. The Unit Manager revealed the Director of Nursing (DON) was monitoring documentation and she did not have access to eMAR variance reports.</p> <p>Interview with the DON, on 04/03/14 at 6:24 PM, revealed she monitored routine medications only and not the PRN medications. the DON revealed no one was assigned to monitor that PRN medications were being documented and did not know how they could monitor to ensure nursing was documenting. The DON revealed nurses should document all medications given, but it was just Tylenol that was given and not documented. The DON revealed nursing was supposed to document and you have to trust nurses are going to do what they are supposed to do.</p>	F 514	<p>How will the facility monitor performance to ensure solutions are sustained? New admission orders and information including allergies will be reviewed within 24 hours of admission by the Unit Managers. In the morning Daily Clinical Start-Up, new admissions are discussed and allergy identification and documentation will be ensured by the nursing management team. In addition, during the Daily Clinical Start-Up, the 24 hour nursing report is reviewed and any instance of PRN medication notation shall be reviewed for proper eMAR documentation at that time. The new admission chart review and Clinical Start Up is an on-going process and survey Plan of Correction is a standard component of the monthly Quality Assurance Process Improvement meeting; therefore any identified opportunities are reviewed for compliance on an on-going basis.</p>	5-1-14



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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: 1967, 1974, 2011</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II Protected.</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments. Four (4) compartments per floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors. Upgraded in 2009</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system. New service installed in 2011.</p> <p>GENERATOR: Type II, 260KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code Survey was conducted on 04/01/14. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</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>Deficiencies were cited with the highest deficiency identified at an "F" level.</p>	K 000		

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

X *Rose Thurman*

TITLE

X *Administrator*

(X6) DATE

5/1/14

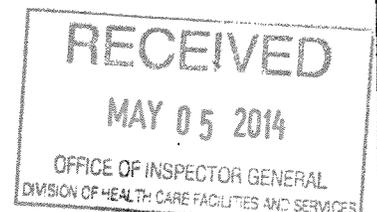
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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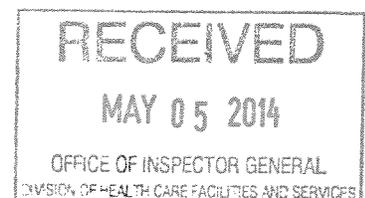
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K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect three (3) of twelve (12) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-three (123) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 04/01/14 at 9:32 AM, with the Maintenance Director revealed the door to the Housekeeping Supply Room located on the second floor, B Wing, did not have a self-closing device installed on the door.</p> <p>Interview, on 04/01/14 at 9:34 AM, with the</p>	K 029	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be negatively impacted by the deficient practice. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents are considered to have a potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The three identified door closures for housekeeping supply room, activity storage room, door to storage room next to beauty shop were ordered and installed as of 4/23/14. A facility wide assessment of all doors for the need for a self-closure was completed by the Maintenance Director on 4/23/14. No further needs identified at this time. Assessment of the proper functioning of the door closures shall be completed by the Maintenance Supervisor on an on-going basis as part of the routine facility rounds and any identified issues corrected and reported to the facility Quality Assurance Process Improvement committee.</p>	



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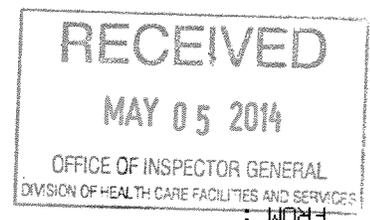
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K 029	<p>Continued From page 2</p> <p>Maintenance Director revealed the door to the room is typically closed and locked by the Housekeeping staff. He acknowledged the room was used for the storage of combustible items and should be equipped with a self-closing device.</p> <p>2. Observation, on 04/01/14 at 9:43 AM, with the Maintenance Director revealed the door to the Activities Storage Room located on the first floor, B Wing, did not have a self-closing device installed on the door.</p> <p>Interview, on 04/01/14 at 9:45 AM, with the Maintenance Director revealed the door to the room was typically closed and locked by the Activities staff. He acknowledged the room was used for the storage of combustible items and should be equipped with a self-closing device.</p> <p>3. Observation, on 04/01/14 at 11:07 AM, with the Maintenance Director revealed the door to the Storage Room located next to the Beauty Shop on the ground floor, B Wing, did not have a self-closing device installed on the door.</p> <p>Interview, on 04/01/14 at 11:09 AM, with the Maintenance Director revealed the door to the room was typically closed and locked by the Housekeeping staff. He acknowledged the room was used for the storage of combustible items and should be equipped with a self-closing device.</p> <p>Interview, on 04/01/14 at 2:57 PM, with the Administrator revealed he was not aware the doors to the three (3) rooms used to store combustibles items were not equipped with self-closing devices.</p>	K 029	<p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained? The results of the implemented plan of correction and follow up monitoring on daily rounds by the Maintenance Supervisor shall be reviewed at the facility monthly QA meeting for 2 months to ensure there are no additional issues or concern in regards to the measures implemented. In addition, maintenance concerns are reviewed monthly in the facility QA meeting and this would allow for review of any identified preventative maintenance issue that would include a problem with the self-closing devices. If identified, additional actions would be taken and followed up on for correction.</p>	5-1-14



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K 029	Continued From page 3 Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		



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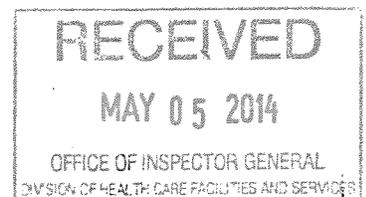
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K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-three (123) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had the proper signage displayed.</p> <p>The findings include:</p> <p>Observation, on 04/01/14 at 11:04 AM, with the Maintenance Director revealed the exit access doors located in the building's Main Entrance had a thirty second delayed egress sign posted on the exit door. The facility had all delayed egress magnetic unlocking devices removed on all of the exit doors. The delayed egress sign had not been removed from the door and could be confusing when trying to exit the facility in the event of an emergency. The operation of the Main Entrance door was controlled by the Receptionist.</p>	K 038		

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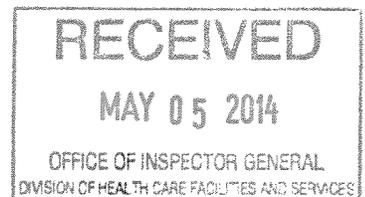
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K 038	Continued From page 5 Interview, on 04/01/14 at 11:06 AM, with the Maintenance Director revealed he was not aware the delayed egress signage was not removed with the thirty second delayed egress provisions since it went into effect. The Maintenance Director confirmed the door's magnetic catch had always allowed the door to automatically release with the activation of the building's fire alarm system. Interview, on 04/01/14 at 3:00 PM, with the Administrator revealed the posting of the thirty second delayed egress sign on the door was an oversight and could be confusing when trying to exit the building in the event of an emergency. Reference: NFPA 101 (2000 edition) 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 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	K 038	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice.	



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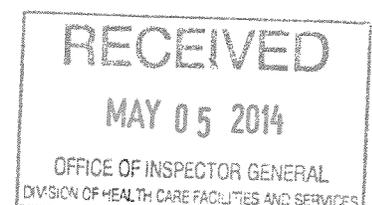
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K 038	Continued From page 6 in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) 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. 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	K 038	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Maintenance Supervisor removed the egress sign posted on the Main Entrance door when identified on 4/1/14. The Maintenance Supervisor reviewed all areas of egress in the facility to determine if additional signage issues were present, and all identified areas were confirmed as being resolved. Assessment of potential signage on egress shall be completed by the Maintenance Supervisor on an on-going basis as part of the routine facility rounds and any identified issues corrected and reported to the facility Quality Assurance Process Improvement committee. How will the facility monitor its performance to ensure that solutions are sustained? Plan of correction compliance is a standard section of the monthly Quality Assurance and Process Improvement meeting, therefore the Maintenance Supervisor shall report on the continued compliance with the plan of correction on an on-going basis.	5-1-14



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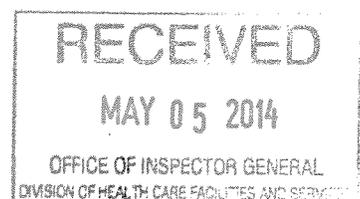
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K 038	Continued From page 7 DOOR CAN BE OPENED IN 15 SECONDS	K 038		
K 046 SS=F	7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to provide testing of emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect each of the (12) smoke compartments, residents, staff and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-three (123) on the day of the survey. The findings include: 1. Observation, on 04/01/14 at 9:19 AM, with the Maintenance Director revealed the battery-powered emergency light fixture located in the Medication Room on the second floor, at the B-Wing Nurse's Station, did not function when the test button was activated. Interview, on 04/01/14 at 9:21 AM, with the	K 046		



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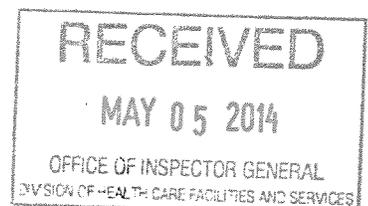
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/01/2014
NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
(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 046	<p>Continued From page 8</p> <p>Maintenance Director revealed the battery-powered emergency light fixture located in the Medication Room on the second floor, at the B-Wing Nurse's Station had functioned properly when he conducted the monthly ninety (90) second test for March, 2014.</p> <p>2. Observation, on 04/01/14 at 10:02 AM, with the Maintenance Director revealed the battery-powered emergency light fixture located in the Medication Room on the first floor, at the B-Wing Nurse's Station, did not function when the test button was activated.</p> <p>Interview, on 04/01/14 at 10:04 AM, with the Maintenance Director revealed the battery-powered emergency light fixture located in the Medication Room on the first floor, at the B-Wing Nurse's Station had functioned properly when he conducted the monthly ninety (90) second test for March, 2014.</p> <p>3. Record review, on 04/01/14 at 1:55 PM, with the Maintenance Director revealed the facility failed to conduct annual tests on all of the battery-powered emergency light fixtures within the facility, for 1-1/2 hours of continuous illumination. The facility tested each of the battery-powered emergency light fixtures for a monthly ninety (90) second test only.</p> <p>Interview, on 04/01/14 at 1:57 PM, with the Maintenance Director revealed he was not aware of the battery-powered emergency light fixture requirement, to be tested annually for 1-1/2 hours of continuous illumination.</p> <p>Interview, on 04/01/14 at 3:03 PM, with the Administrator revealed he was not aware of the</p>	K 046	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be negatively impacted by the deficient practice.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are considered to have a potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Education in regards to tag requirement of monthly and annual illumination testing was provided to the facility Administrator and Maintenance Supervisor on 4/1/14 by the Regional Director of Clinical Operations. New battery powered light fixtures were installed for the identified nursing stations on 4/7/14. The Maintenance Director completed 100% checks of all battery powered light fixtures for proper functioning on 4/1/14; no additional problems identified. In addition to the monthly 30-second test, an annual 90 minute test for continual illumination will be added to the preventive maintenance schedule.</p>	



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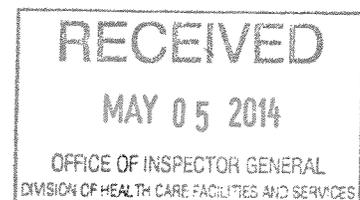
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL 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 046	Continued From page 9 requirement for battery-powered emergency light fixtures to be tested annually for 1-1/2 hours of continuous illumination and acknowledged the facility's requirement to conduct and document the annual 1-1/2 hour illumination test. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment	K 046	How will the facility monitor its performance to ensure that solutions are sustained? Plan of correction compliance is a standard section of the monthly Quality Assurance and Process Improvement meeting, therefore the Maintenance Supervisor shall report on the continued compliance with the plan of correction on an on-going basis.	5-1-14



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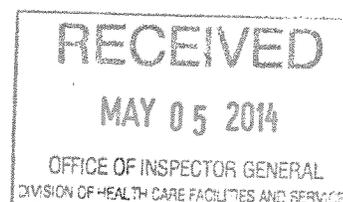
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1706 STEVENS AVENUE LOUISVILLE, KY 40205	
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K 046	Continued From page 10 that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect each of the twelve (12) smoke compartments, all residents, staff, and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-three (123) on the day of the survey. The findings include: Record review, on 04/01/14 at 1:37 PM, with the Maintenance Director revealed the facility had no	K 050	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be negatively impacted by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents are considered to have a potential to be affected by the deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Fire drills based on NFPA standards are part of the (TELS)- the facility's preventative maintenance scheduler. Fire drills shall be conducted at the frequency required by NFPA standards and are scheduled through the preventative maintenance program (TELS). In addition to the Maintenance Supervisor, the facility Administrator will monitor for compliance on a monthly basis utilizing the compliance reports from the (TELS) preventative maintenance scheduler. How will the facility monitor its performance to ensure that solutions are sustained? The status of fire drill completions shall be reviewed monthly in the facility Quality Assurance Process Improvement meeting on an on-going basis.	5-1-14



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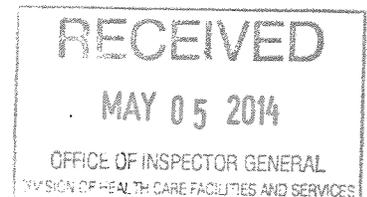
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K 050	Continued From page 11 documentation of a fire drill being conducted during the third shift in the first quarter of 2014. Interview, on 04/01/14 at 1:39 PM, with the Maintenance Director revealed he was aware of not conducting a fire drill during the third shift in the first quarter of 2014 and had planned on conducting the fire drill in the first week in April of 2014. Interview, on 04/01/14 at 3:06 PM, with the Administrator revealed he was not aware of a fire drill not being conducted during the third shift in the first quarter of 2014. Reference: NFPA 101 Life Safety Code (2000 Edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
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 maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke	K 062		



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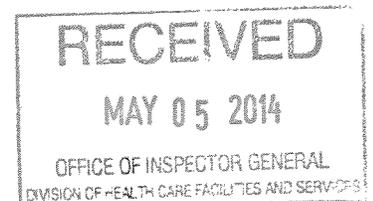
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K 062	<p>Continued From page 12</p> <p>compartments, approximately forty (40) residents, staff and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-three (123) on the day of the survey. The facility failed to ensure escutcheon plates were installed at all sprinkler heads throughout the facility.</p> <p>The findings include:</p> <p>Observation, on 04/01/14 at 9:59 AM, with the Maintenance Director revealed there were escutcheon plates missing at two (2) sprinkler heads located in the Activities storage room.</p> <p>Interview, on 04/01/14 at 10:01 AM, with the Maintenance Director revealed he was unaware of the escutcheon plates missing at the sprinkler heads.</p> <p>Interview, on 04/01/14 at 3:09 PM, with the Administrator revealed he was not aware of the escutcheon plates missing at the two (2) sprinkler heads.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>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,</p>	K 062	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Escutcheon plates were installed for the 2 identified sprinkler heads on 4/2/14. The Maintenance Director conducted a facility wide 100% audit of all sprinkler heads on 4/3/14, with no additional concerns identified. Any future issue identified on routine maintenance rounds of facility shall be corrected immediately.</p> <p>How will the facility monitor its performance to ensure that solutions are sustained? Plan of correction compliance is a standard section of the monthly Quality Assurance and Process Improvement meeting, therefore the Maintenance Supervisor shall report on the continued compliance with the plan of correction on an on-going basis.</p>	5-1-14



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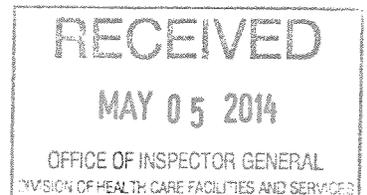
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
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K 062	Continued From page 13 corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING	K 066		



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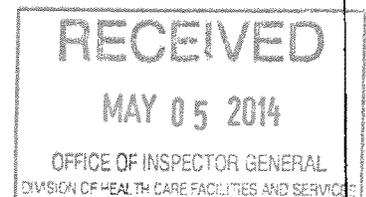
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K 066	<p>Continued From page 14 or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for the staff and residents were properly equipped for safe smoking, in accordance with NFPA standards. The deficiency had the potential to affect the staff and residents using the smoking areas. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-three (123) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 04/01/14 at 12:09 PM, with the Maintenance Director revealed the designated outdoor smoking area for the residents did not have an approved metal container with a self-closing lid to empty ashtrays into.</p>	K 066		



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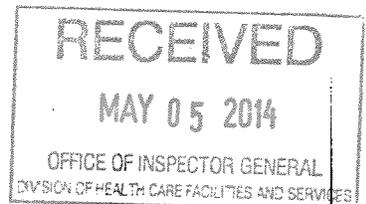
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K 066	Continued From page 15 Interview, on 04/01/14 at 12:11 PM, with the Maintenance Director revealed he was not aware of the requirement for the designated, outdoor smoking area for residents to be equipped with an approved metal container with a self-closing lid to empty ash trays into. 2. Observation, on 04/01/14 at 12:22 PM, with the Maintenance Director revealed the designated outdoor smoking area for the staff did not have an approved metal container with a self-closing lid to empty ashtrays into or a fire extinguisher available for use. Interview, on 04/01/14 at 12:24 PM, with the Maintenance Director revealed he was not aware of the requirements for the designated, outdoor smoking area for the staff to be equipped with an approved metal container with a self-closing lid to empty ash trays into and a fire extinguisher available for use. Interview, on 04/01/14 at 3:12 PM, with the Administrator revealed he was aware of the requirements and had been planning on purchasing a metal container with a self-closing lid for the disposal of tobacco waste. Reference: NFPA 101 Life Safety Code (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or	K 066	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Approved metal containers (2) were ordered on 4/23/14, received and placed in smoking area on 4/28/14. Education in regards to the tag requirement was provided to the facility Administrator and Maintenance Supervisor on 4/1/14 by the Regional Director of Clinical Operations. Placement and proper functioning of the new metal containers with self-closing lids in the smoking area shall be reviewed on daily rounds of the Maintenance Supervisor and/or Administrator. How will the facility monitor its performance to ensure that solutions are sustained? Plan of correction compliance is a standard section of the monthly Quality Assurance and Process Improvement meeting, therefore the Maintenance Supervisor shall report on the continued compliance with the plan of correction on an on-going basis.	5-1-14	



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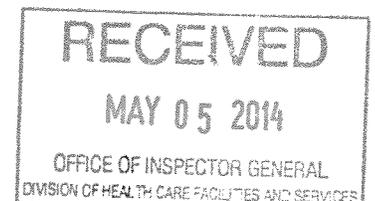
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K 066	Continued From page 16 oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety In Long Term Care Facilities NFPA 101 LIFE SAFETY CODE STANDARD	K 066		
K 069 SS=F	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by:	K 069		



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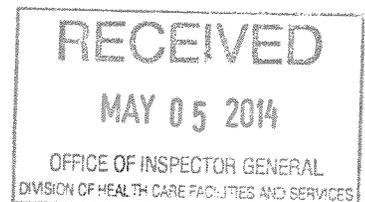
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K 069	<p>Continued From page 17</p> <p>Based on record review and interview, it was determined the facility failed to ensure the kitchen hood and exhaust system was being maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-three (123) on the day of the survey.</p> <p>The findings include:</p> <p>Record Review, on 04/01/14 at 1:49 PM, with the Maintenance Director revealed the hood and ducts over the commercial cooking equipment was last cleaned on 09/29/13 and was due to be cleaned in February of 2014. The exhaust hood and ducts are required to be cleaned a minimum of bi-annually.</p> <p>Interview, on 04/01/14 at 1:51 PM, with the Maintenance Director revealed he was aware of the exhaust hood and duct system cleaning to be past due. The vendor contracted by the facility to do the cleaning could not accommodate the facility's kitchen schedule. The facility was negotiating with a new vendor for future services.</p> <p>Interview, on 04/01/14 at 3:15 PM, with the Administrator confirmed that the vendor contracted by the facility to do the exhaust hood and duct cleaning was being replaced with a new vendor.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition).</p> <p>9.2.3 Commercial Cooking Equipment.</p>	K 069	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? A scheduled cleaning of the exhaust hood and duct system in the kitchen has been scheduled for 4/26/14. A 6 months cleaning schedule for the kitchen exhaust hood and duct system shall be added to the (TELS)- facility preventative maintenance scheduler. How will the facility monitor its performance to ensure that solutions are sustained? Plan of correction compliance is a standard section of the monthly Quality Assurance and Process Improvement meeting, therefore the Maintenance Supervisor shall report on the continued compliance with the plan of correction on an on-going basis.</p>	5-1-14



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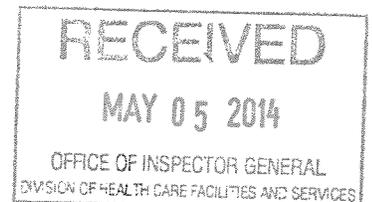
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K 069	Continued From page 18 Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K 069			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of twelve (12) smoke compartments, approximately sixty (60) residents, staff, and visitors. The facility has one-hundred and fifty-four (154) certified beds and the census was one-hundred and twenty-three (123) on the day of the survey. The findings include: 1. Observations, on 04/01/14 at 8:07 AM, with the Maintenance Director revealed a small refrigerator, a microwave oven, a coffee maker and a scented wax candle warmer were plugged into a power strip located in the Assistant Director of Nursing (ADON) office on the second floor, C Wing.	K 147			



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K 147	<p>Continued From page 19</p> <p>Interview, on 04/01/14 at 8:09 AM, with the Maintenance Director revealed he was aware of power strips being prohibited for use with appliances and acknowledged that the electrical circuit could have been overloaded.</p> <p>2. Observation, on 04/01/14 at 9:17 AM, with the Maintenance Director revealed a refrigerator was plugged into a power strip located in the Medication Room on the second floor, at the B-Wing Nurse's Station.</p> <p>Interview, on 04/01/14 at 9:19 AM, with the Maintenance Director revealed he was aware of power strips being prohibited for usage with appliances.</p> <p>3. Observation, on 04/01/14 at 10:31 AM, with the Maintenance Director revealed the hydrocollator (therapy equipment containing hot water) located within the Physical Therapy Room, was plugged into a standard electrical wall outlet instead of a ground fault circuit interrupter (GFCI) outlet as required in wet areas.</p> <p>Interview, on 04/01/14 at 10:33 AM, with the Maintenance Director revealed he was not aware of the hydrocollator being plugged into a standard electrical wall outlet and stated the requirement of medical equipment containing water was to be plugged into a GFCI outlet. The hydrocollator used within the Physical Therapy Room had recently been relocated within the Physical Therapy Department.</p> <p>Interview, on 04/01/14 at 3:18 PM, with the Administrator revealed he was aware of the requirements for use of power strips, but not aware of their misuse within the facility. Also, he</p>	K 147	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? On 4/1/14, items were removed from the identified power strip in the Assistant Director of Nursing Office. In addition, the power strip was removed from the second room Medication Room. A GFCI outlet was installed replacing the standard outlet in the Physical Therapy Room on 4/2/14. A facility wide audit was conducted by the Maintenance Supervisor for additional improper use of power cords or need for GFCI outlets was completed on 4/4/14, with no additional concerns identified. Review of these opportunities shall be a part of the routine daily walk through of the facility by maintenance and/or administrator with corrections made immediately as identified. How will the facility monitor its performance to ensure that solutions are sustained? Plan of correction compliance is a standard section of the monthly Quality Assurance and Process Improvement meeting, therefore the Maintenance Supervisor shall report on the continued compliance with the plan of correction on an on-going basis.</p>	5-1-14



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K 147	Continued From page 20 was not aware of the hydrocollator being plugged into a standard electrical outlet, instead of a GFCI outlet required in wet areas. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			

