

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

PRINTED: 08/27/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2015
NAME OF PROVIDER OR SUPPLIER METCALFE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 701 SKYLINE DRIVE EDMONTON, KY 42129		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 242 SS=C	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, it was determined the facility failed to ensure all residents' drink preferences were honored for four (4) unsampled residents (Residents A, B, C, and D). Residents A, B, C, and D had a drink preference of regular coffee but received decaffeinated coffee without being offered the choice of regular coffee.</p> <p>The findings include: Interview with the Dietary Manager (DM) on 08/12/15 at 1:38 PM, revealed there was no policy related to choices or likes/dislikes regarding drinks. During the group interview on 08/12/15 at 10:30 AM, three of six residents present (Resident A, Resident B, and Resident C) stated they preferred to drink regular coffee, but were only served decaffeinated coffee. The residents</p>	F 242	<p>1. Caffeinated coffee was purchased/received by the dietary department and is available for residents upon request. Resident council meeting was held to inform residents of the availability of caffeinated coffee.</p> <p>2. Caffeinated coffee was purchased/received by the dietary department and is available for residents upon request. Resident council meeting was held to inform residents of the availability of caffeinated coffee.</p> <p>3. Resident food and beverage preferences shall be completed upon admission and revised prn per the resident's request. The Dietary Manager will be responsible for having documentation identifying residents that are to receive caffeinated coffee.</p> <p>4. The CQI indicator for the monitoring of resident rights for self-determination and participation in regards to food/beverage choices shall be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Administrator. Findings from these indicators will be reviewed in the facility CQI meetings.</p>	9/3/15

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

TITLE

(X6) DATE

Angie Neighbors

Administrator

9/1/15

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 242	Continued From page 1 further stated regular coffee was not available nor offered. Interview with Resident D on 08/12/15 at 11:37 AM revealed, "I don't drink their coffee. I drink my own coffee because I don't like decaffeinated coffee, and I have always drunk regular coffee for years." Further interview with Resident D revealed, "No one has offered me regular coffee, nor have I asked for regular coffee. I would drink their coffee if it was regular coffee." Interview with the DM on 08/12/15 at 1:38 PM revealed the facility had served decaffeinated coffee for years. The DM stated, "I don't order regular coffee." Further interview with the Dietary Manager revealed the facility offers only decaffeinated coffee for such reasons as the regular coffee interacts with medications and has a diuretic effect on the residents. The DM stated she did not know if any residents had been offered regular coffee or had asked for regular coffee.	F 242		
F 371 SS=D	483 35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1. The ice scoop container was replaced on 8/20/15. 2. An audit of all dietary storage equipment was completed to determine proper working function that promotes sanitary conditions. Any problematic storage equipment identified was repaired/ replaced by the target date listed. 3. Dietary staff received in-service education by the Dietary Manager on identifying and reporting broken/malfunctioning storage equipment to the Dietary Manager immediately. 4. The CQI indicator for the monitoring of dietary sanitary conditions shall be utilized monthly under the supervision on the Administrator. Findings from the indicators will be reviewed in the facility CQI meeting.	9/1/15

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F 371	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to maintain the kitchen in a sanitary manner. Observations on 08/13/15 revealed the storage container for the ice scoop was uncovered and the lid broken.</p> <p>The findings include:</p> <p>During the sanitation tour of the kitchen at 1:40 PM Central Daylight Time (CDT) on 08/13/15, observation revealed the storage container for the ice scoop was uncovered. Further observation revealed the ice scoop container lid was lying beside the storage container with broken hinges on the lid of the container. Observation inside the ice scoop container revealed black particles in the bottom of the container.</p> <p>An interview was conducted with a dietary staff member at 1:50 PM CDT on 08/13/15. The dietary staff member stated the hinges to the ice scoop storage container were broken and had been broken for approximately a month.</p>	F 371			

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1991 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (211) SMOKE COMPARTMENTS: 5 FIRE ALARM: Complete automatic fire alarm system. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system. GENERATOR: Type II diesel generator. A life safety code survey was initiated and concluded on 08/11/15, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	The preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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

TITLE

(X5) DATE

Mary Neighbors

Administrator

9/1/15

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K 038	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain exits according to National Fire Protection Association (NFPA) standards. This deficient practice affected one (1) of five (5) smoke compartments, staff, and other occupants of the building. The facility has the capacity for 92 beds with a census of 81 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 08/11/15 at 10:55 AM with the Director of Maintenance (DOM), an exterior exit was observed leading to a locked gate in the courtyard area. The lock was a coded keypad type without an obvious method of operation to exit the gate. Exits must be maintained to the public way in case of fire or other emergency, so occupants of the building that are unfamiliar with the key pad would be able to exit the courtyard.</p> <p>An interview with the DOM on 08/11/15 at 10:55 AM revealed she was aware the exit needed to be maintained and that other facility staff was responsible to assure the courtyard exit was maintained according to Life Safety Code standards.</p> <p>The findings were revealed to the Administrator</p>	K 038	<ol style="list-style-type: none"> 1. The observed exterior exit is no longer designated as an exit or a way of exit access. That door is now identified by a sign that reads "NO EXIT" as per NFPA guidelines. 2. The observed exterior exit is longer designated as an exit or a way of exit access. That door is now identified by a sign that reads "NO EXIT" as per NFPA guidelines. 3. Maintenance staff have received in-service education by the Administrator on identifying exits that must be maintained to the public way in case of fire or other emergency. 4. The CQI indicator for the monitoring of facility exits shall be utilized monthly X 2 months and then quarterly thereafter as per the established CQI calendar under the supervision of the Administrator. 	9/1/15

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K 038	Continued From page 2 upon exit. Reference: NFPA 101 (2000 Edition). 7.2.1.5.4* A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 in. (86 cm), and not more than 48 in. (122 cm), above the finished floor. Doors shall be operable with not more than one releasing operation. 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 Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs.	K 038			
K 062 SS=F	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	K 062			

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K 062	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the sprinkler system was maintained according to National Fire Protection Association (NFPA) standards. This deficient practice affected five (5) of five (5) smoke compartments, staff, and eighty-one (81) residents. The facility has the capacity for 92 beds with a census of 81 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 08/11/15 at 11 20 AM with the Director of Maintenance (DOM), a record review of the facility's sprinkler system revealed documentation that a full flow trip test had been performed on 08/11/13. This test is performed to ensure the water in the sprinkler system reaches the hazard in a timely manner in a fire situation. The requirement is 60 seconds for the water to reach the test valve. The sprinkler systems exceeded the 60-second time limit at 144 seconds. An interview with the DOM on 08/11/15 at 11:20 AM revealed she depended on the sprinkler contractor to keep the sprinkler system in compliance.</p> <p>The findings were revealed to the Administrator upon exit.</p> <p>Reference: NFPA 13 (1999 Edition).</p> <p>4-2.3.1* Volume Limitations. Not more than 750 gal (2839 L) system capacity shall be controlled by one dry pipe valve. Exception: Piping volume shall be permitted to</p>	K 062	<ol style="list-style-type: none"> 1. The contracted vendor for sprinkler system service and repair has installed a quick opening device on the facility sprinkler system. 2. The contracted vendor for sprinkler system service and repair has installed a quick opening device on the facility sprinkler system. 3. The Director of Maintenance and the maintenance staff have received in-service education by the Administrator on communicating with the contracted sprinkler vendor personnel during each quarterly inspection to assure the facility is meeting the requirements per the NFPA. Inquiries will be addressed regarding any changes that are required to assure the sprinkler system is maintained to NFPA code. 4. The CQI indicator for the monitoring of the facility sprinkler system shall be utilized on a quarterly basis as per the established CQI calendar, in coordination with the contracted sprinkler inspections by the Director of Maintenance. 	9/1/15

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K 062	Continued From page 4 exceed 750 gal (2839 L) for nongrided systems if the system design is such that water is delivered to the system test connection in not more than 60 seconds, starting at the normal air pressure on the system and at the time of fully opened inspection test connection. A-4-2.3.1 The 60-second limit does not apply to dry systems with capacities of 500 gal (1893 L) or less, nor to dry systems with capacities of 750 gal (2839 L) or less if equipped with a quick-opening device.	K 062		