

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



PRINTED: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/07/2014
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1293 LAKE BARKLEY DRIVE KUTTAWA, KY 42058
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Kuttawa of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Kuttawa files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
F 371 SS=F	<p>483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and policy review it was determined the facility failed to store food under sanitary conditions as evidenced by a box of rice, thickener and powder sugar was stored open to air and closed bags of lettuce and bottles of water were observed to be stored with insects on them in the outside produce refrigerator.</p> <p>The findings include:</p> <p>Review of the Food Storage Policy, no date provided, revealed food items should be stored in accordance with good sanitary practice. Any opened products should be placed in seamless plastic or glass containers with fitting lids and</p>		<p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p>	

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

TITLE

(X6) DATE

*Cynthia Bruton*

*Administrator*

11.24.14

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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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1283 LAKE BARKLEY DRIVE KUTTAWA, KY 42055		
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F 371	<p>Continued From page 1 labeled and dated.</p> <p>Observation of the storage room, on 11/05/14 at 11:30 AM, revealed a box of rice, thickener and powder were open to air. Further observation revealed three (3) mouse traps stored under the storage room shelves.</p> <p>Interview with the Dietary Manager, on 11/05/14 at 11:30 AM, revealed she had been working as the Dietary Manager for three (3) weeks and that the boxed items should not be stored opened. The Dietary Manager stated she did not want items stored open because the food items could draw rodents and insects.</p> <p>Interview with Admissions and Marketing Specialist (Training the Dietary Manager), on 11/07/14 at 2:17 PM, revealed the staff would retrieve the food from the storage room and place the food in smaller containers. She stated there was a sealed container for the thickener, but there was no container for the rice and powdered sugar. The Admission and Marketing Specialist stated she had been training the Dietary Manager for the last three (3) weeks. She stated she was aware there was a Pest Control guy that would come out monthly and as far as she was aware there were no concerns with rodents. The Admission and Marketing Specialist stated we do not want food items opened in the storage room because we do not want to attract rodents.</p> <p>Observation of the outside produce refrigerator, on 11/05/14 at 11:16 AM, revealed small insects on an un-opened bag of lettuce, one box of distilled water and eight (8) gallon bottles of stored water.</p>	F 371	<p><b>F371- Corrective Actions for Targeted Residents</b></p> <p>On 11/7/14 the opened rice, thickener, and powdered sugar in the storage room were disposed of by the Dietary Manager. The cited unopened bag of lettuce was disposed of on 11/7/14 by the Dietary Manager. The bottled water containers were disinfected by the Dietary Manager on 11/7/14. The outside storage refrigerator was cleaned by the Dietary Manager on 11/7/14.</p> <p><b>Identification of Other Residents with Potential to be Affected</b></p> <p>Current residents have the potential to be affected by this practice. Dietary Staff working 11/7/14 was educated by the Dietary Manager regarding the need to store food under sanitary conditions by storing opened food in sealed containers and maintaining a clean, insect-free outside storage refrigerator.</p> <p><b>Systematic Change</b></p> <p>An in-service for the Dietary Staff was held on 11/14/14 by the Dietary Manager regarding the need to store food under sanitary conditions in the kitchen. This in-service especially focused on storing food items in closed boxes and sealed containers and also addressed Dietary Staff placing the outside storage refrigerator on a weekly cleaning schedule and reporting any visible indications of the presence of insects to the Dietary Manager immediately. Staff was educated at this time to keep outside produce refrigerator lid closed at all times except when stocking or removing items.</p>		

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F 371	Continued From page 2 Interview with the Night Cook, on 11/07/14 at 2:45 PM, revealed she went out to the produce refrigerator and had not noticed the insects on food items. The Night Cook stated it could be a problem, but she washed her produce before cooking. The Night Cook stated when she turned on the light in the produce refrigerator the light could be drawing the insects into the refrigerator.	F 371	<b>Systematic Changes (Cont.)</b> This in-service will be repeated for the Dietary Staff on 12/5/14 by the Dietary Manager to ensure staff is educated. The contracted Registered Dietician will be auditing cited issues in the Dietary Department for storing food under sanitary conditions at least monthly during their Compliance Visits. Results from these audits will be reported to the Administrator for review and recommendations. Newly-hired Dietary Staff will be educated by the Dietary Manager during their Orientation Period regarding the need to store food under sanitary conditions by storing opened food in sealed containers and cleaning the outside storage refrigerator weekly per the Dietary Cleaning Schedule.	
F 441 SS=D	483.85 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 isolate the resident. (2) The facility must prohibit employees with a		<b>Monitoring</b> A weekly audit of the kitchen will be conducted by the Dietary Manager regarding the storing of food under sanitary conditions, focusing on cited issues of storing opened food in sealed containers and maintaining a clean, insect-free outside produce refrigerator per the Dietary Cleaning Schedule, for 4 weeks; and then monthly. Results of these audits will be presented by the Dietary Manager to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% is met for 3 consecutive months; and then quarterly. The PI Committee consists of the Administrator, Medical Director, Consulting Pharmacist, Director of Nursing,	

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F 441	<p>Continued From page 3</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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 policy review it was determined the facility failed to maintain an infection control program for one (1) of fifteen (15) sampled residents (Resident #6). Staff were observed to be providing per care to Resident #6 and while moving from dirty to clean the staff member was observed to touch Resident #6's wheelchair, restraint belt and wheelchair alarm with the same soiled gloved hands.</p> <p>The findings include: Review of the Hand Hygiene Policy, revised 09/08, revealed the facility considered the hand hygiene to be the single most important factor in the control of infections. All employees shall utilize proper hand hygiene for each of the following conditions: after contact with a resident and before and after incontinent care.</p> <p>Observation of Certified Nursing Assistant (CNA)</p>	F 441	<p><b>Monitoring (Cont.)</b></p> <p>Assistant Director of Nursing, Maintenance Director, Housekeeping/laundry Supervisor, MDS/Care Plan Coordinator, Social Services Director Dietary Supervisor and Activities Director.</p> <p><b>F441</b></p> <p><b>Corrective Action for Targeted Residents</b> C.N.A. #3 was counseled on 11/7/14 by the ADON regarding the need to remove gloves and cleanse hands immediately after providing perineal care for a Resident, to prevent cross-contamination to other items.</p> <p><b>Identification of Other Residents with Potential to be Affected</b> Residents dependent on facility staff for perineal care have a potential to be affected by this practice. In-services began on 11/7/14 by the ADON for C.N.A.s who were working regarding the need for hand hygiene immediately following performing perineal care for a Resident, to prevent cross-contamination to other items.</p> <p><b>Systematic Changes</b> A mandatory in-service was held on 11/14/14 by the DON for facility C.N.A.s regarding the need to remove gloves and cleanse hands immediately after performing perineal care for a Resident, to prevent cross-contamination to other items.</p>	12/15/2014

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F 441	<p>Continued From page 4</p> <p>#3 and CNA #4 providing peri care to Resident #8, on 11/07/14 at 9:45 AM, revealed CNA #3 wiped Resident #8's perineal area from front to back with gloved hands. When the peri care was completed, CNA #3 placed Resident #8 in a wheelchair and wheeled Resident #8 out of his/her bathroom. CNA #3 then attached Resident #8's belt restraint to his/her waist and then went to the back of Resident #8's wheelchair and turned on the wheelchair alarm, with the same gloved hands that provided the peri care.</p> <p>Interview with CNA #3, on 11/07/14 at 1:58 PM, revealed she did not recognize that she had touched the belt restraint. CNA #3 stated she could remember touching the wheelchair alarm with the contaminated gloves. CNA #3 stated she did not want to do that because she could cross contaminate. She stated she should have removed her gloves, sanitized her hands and then placed Resident #8's alarm on.</p> <p>Interview with CNA #4, on 11/07/14 at 2:03 PM, revealed she had recognized CNA #3 touching Resident #8's personal items with contaminated hands, but did not say anything. CNA #4 stated we do not want to touch items with contaminated hands because items could be contaminated and spread germs.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 11/07/14 at 3:20 PM, revealed when a CNA was providing peri care, the staff member should wash their hands before touching the resident's restraint, alarms and wheelchair. The ADON stated she wanted the staff to wash their hands to prevent cross contamination and to prevent the spread of germs.</p>	F 441	<p><b>Systematic Changes (Cont.)</b></p> <p>This in-service will be repeated for facility C.N.A.s on 12/5/14 by the DON to ensure facility C.N.A.s are educated. Newly-hired C.N.A.s will be educated by the ADON during their Orientation Period regarding the need to cleanse hands immediately following performing perineal care for a Resident, to prevent cross-contamination to other items. The DON and ADON will conduct a skills checklist for perineal care, focusing on hand hygiene, bi-annually for C.N.A.s.</p> <p><b>Monitoring</b></p> <p>C.N.A.s will be observed performing Resident perineal care, focusing on hand hygiene immediately following procedure, by the DON and ADON weekly for 4 weeks, or until facility C.N.A.s have been observed. Results of these C.N.A. Observation Audits of performing perineal care, focusing on hand hygiene immediately following procedure, will be presented by the DON to the monthly Performance Improvement Committee for review and recommendations until desired threshold of 100% has been met for 3 consecutive months; and then quarterly. The PI committee consists of the Administrator, Medical Director, Consulting Pharmacist, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Housekeeping/Laundry Supervisor, MDS/Care Plan Coordinator, Social Services Director, Dietary Supervisor and the Activities Director.</p>	12/15/2014

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F 441	Continued From page 5 Interview with the Director of Nursing (DON), on 11/07/14 at 3:33 PM, revealed the staff were suppose to wash their hands and remove their gloves before touching other items after providing per care. The DON stated staff were to wash their hands to prevent the spread of infection to anyone. The DON stated she had had some training on the different Isolations, but not on hand hyglene which was a mandatory training that was scheduled for the month of December.	F 441			

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42065	
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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: 1958 and 1983.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1980 and upgraded in 1997, with thirty-eight (38) smoke detectors and fourteen (14) heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1984 and upgraded in 2012.</p> <p>GENERATOR: Type II generator installed in 1991. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/06/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixty-five (65) beds with a census of sixty-two (62) on the day of the survey.</p> <p>The findings that follow demonstrate non-compliance with Title 42, Code of Federal</p>	K 000	<p>Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Kuttawa of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Kuttawa files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.</p> <p>Christian Care Center of Kuttawa believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Cynthia Burton* TITLE: *Administrator* (X5) DATE: *11.24.14*

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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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 027	<b>K 027</b> <b>Corrective Action Taken to Targeted Area</b>  On 11-7-14 the cross-corridor doors located in hall 300 hall next to the Administrator's office were adjusted by the Maintenance Director to close completely and create a seal that resists the passage of smoke.  <b>Identification of Areas with Potential</b>  On 11-6-14 the maintenance director inspected facility's cross-corridor doors and found no other areas affected.  <b>Systematic Changes</b>  The Maintenance Director will audit cross-corridor doors for correct operation weekly for 4 weeks, then monthly for 3 months and then as required during fire drills, etc.  <b>Monitoring</b>  The Maintenance Director will report his findings monthly to the Performance Improvement Committee for review and determine ongoing compliance. The PI Committee consists of the Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director,	
K 027 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors, located in a smoke barrier, would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, nineteen (19) residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and the census was sixty-two (62) on the day of the survey.  The findings include:  Observation, on 11/06/14 at 2:25 PM, with the			

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K 027	<p>Continued From page 2</p> <p>Director of Maintenance, revealed the cross-corridor doors located in the 300 Hall next to the Administrators office would not completely close when tested, leaving a gap of approximately half an inch (1/2 ") between the door with the astragal and the other door. The door with the astragal was obstructed from fully closing due to the top of the door rubbing the door frame header. The door did have enough clearance between the top of the door and the frame to operate reliably. The pair of doors could not close completely and resist the passage of smoke in the event of an emergency.</p> <p>Interview, on 11/06/14 at 2:26 PM, with the Director of Maintenance, revealed he was not aware the cross corridor doors would not completely close and would not be capable of resisting the passage of smoke in the event of an emergency.</p> <p>The census of sixty-two (62) was verified by the Administrator on 11/06/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 11/06/14.</p> <p>Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for</p>	K 027	<p>K 027 Cont.</p> <p>Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	11/07/14

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42055	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 027	Continued From page 3 wood doors.  Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 062	<b>K 062</b>  <b>Corrective Action Taken to Targeted Area</b>  On 11/7/14 the Maintenance Director removed the insulation blocking the sprinkler head above room #447 and # 336 in the attic  <b>Identification of Areas with Potential</b>  On 11/7/14 the Maintenance Director inspected sprinkler heads in the attic to ensure compliance and found no other areas affected.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the sprinklers were installed, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect two (2) of eight (8) smoke compartments, twenty (20) residents, staff and visitors. The facility has the capacity for sixty-five (65) beds and at the time of the survey, the census was sixty-two (62). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor			

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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1283 LAKE BARKLEY DRIVE KUTTAWA, KY 42066	
(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 062	<p>Continued From page 4 problems.</p> <p>The findings include:</p> <p>Observation, on 11/06/14 at 10:50 AM with the Director of Maintenance, revealed the sprinklers installed in the attic above room #447 closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads.</p> <p>Interview, on 11/06/14 at 10:51 AM with the Director of Maintenance, revealed he was not aware the insulation was covering the sprinkler heads in the attic.</p> <p>Observation, on 11/06/14 at 11:10 AM with the Director of Maintenance, revealed the sprinklers installed in the attic above room #336 closest to the eaves were blocked from developing a full spray pattern by blow-in type insulation covering the sprinkler heads.</p> <p>Interview, on 11/06/14 at 11:11 AM with the Director of Maintenance, revealed he was not aware the insulation was covering the sprinkler heads in the attic.</p> <p>The census of sixty-two (62) was verified by the Administrator on 11/08/14. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 11/08/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of</p>	K 062	<p>K 062</p> <p><b>Systematic Changes</b></p> <p>The Maintenance Director will conduct weekly inspections of the attic sprinkler heads for 4 weeks, then monthly for 3 months to ensure substantial compliance. The maintenance Director will place these inspections on a monthly preventive maintenance schedule.</p> <p><b>Monitoring</b></p> <p>The Maintenance Director will report his findings monthly to the Performance Improvement Committee for review and determine ongoing compliance. The PI Committee consists of the Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.</p>	11/07/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188318	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  11/08/2014																								
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1263 LAKE BARKLEY DRIVE KUTTAWA, KY 42065																									
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K 062	<p>Continued From page 5</p> <p>corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>Reference: NFPA 13 (1999 ed.) 5-6.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr> <td>(B) Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>21/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>31/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>51/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>71/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>91/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>161/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).</p>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B) Less than 1 ft	0	1 ft to less than 1 ft 6 in.	21/2	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18	K 062		
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NAME OF PROVIDER OR SUPPLIER  CHRISTIAN CARE CENTER OF KUTTAWA, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 1253 LAKE BARKLEY DRIVE KUTTAWA, KY 42055		
(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 062	Continued From page 8 Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.  Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with 5-5.5.2.	K 062			