

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

PRINTED: 09/04/2014
FORM APPROVED
OMB NO. 0938-0391

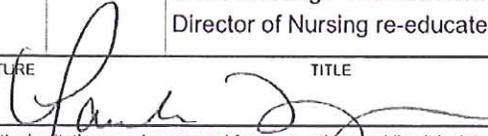


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351
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F 000	INITIAL COMMENTS A Recertification Survey/Abbreviated Survey (KY #22078) was conducted on 08/19/14 through 08/21/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E." KY #22078 was unsubstantiated with no deficiencies.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Heartland Villa Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and or regulatory or administrative proceedings, the deficiency, statements, facts, and conclusions that form the basis for the deficiency".	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received reasonable accommodation of needs as evidenced by the failure to honor dietary dislikes for four (4) unsampled residents (Residents B, C, D, and E). A review of the facility's Census and Condition, dated 08/19/14, revealed the facility's census was forty-two (42) and there were no residents who received tube feedings. The findings include: Review of the facility's policy/procedure titled	F 246	* Food Preferences were updated for resident's B,C,D and E by the Food Service Supervisor on 8/20/14. * The Food Service Supervisor and the Registered Dietitian updated all resident food preferences as of 9/2/14. * 8/20/14 The Registered Dietitian re-educated the Food Service Supervisor and Dietary personnel regarding the "Food Preferences" Policy and Procedure. A post test was completed on 8/20/14 and graded by the Registered Dietitian to validate understanding. The Assistant Director of Nursing re-educated nursing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE _____ (X5) DATE 9-16-14

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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F 246	<p>Continued From page 1</p> <p>"Food Preferences", last revised 05/05/13, revealed the facility should update resident food preferences at a minimum of quarterly. Food and Nutrition service employees should carefully read tray tickets during meal service, serve preferences, and offer substitutions for disliked items.</p> <p>1. Observation during the lunch meal, on 08/19/14 at 12:20 PM revealed Resident D received California Blend (blend of cauliflower, carrots, and broccoli). Review of Resident D's dietary card revealed Resident D disliked broccoli.</p> <p>Interview with Resident D, on 08/19/14 at 3:00 PM, revealed he/she nodded "yes" when asked if he/she regularly received disliked food items during meals.</p> <p>2. Observation during the lunch meal, on 08/20/14 at 12:15 PM revealed Resident C's plate contained carrots. Review of the Resident C's dietary card revealed Resident C disliked carrots. Further observation revealed Certified Nurse Aide (CNA) #1 fed Resident C a bite of carrots, Resident C nodded head "no" and stated "that is not good".</p> <p>Interview with CNA #1, on 08/20/14 at 12:45 PM, revealed he/she should have compared dietary cards against what the resident received and obtained a substitute if the resident received a food he/she disliked.</p> <p>3. Observation during the lunch meal, on 08/20/14 at 12:15 PM, revealed Resident B received greens. Review of Resident B's dietary card revealed Resident B disliked greens.</p>	F 246	<p>staff regarding meal tray service on 8/28/14. Post test were completed and graded by the Assistant Director of Nursing 8/29/14 to validate understanding.</p> <p>* The Food Service Supervisor and the AM cook are auditing meals daily for one week to determine food preferences are observed. After one week the audits will be conducted three times weekly for three weeks and then monthly for six months. The results of the audits will be presented in the Performance Improvement Committee meeting for further recommendations for six months and as needed.</p>	9/15/14	

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F 246	Continued From page 2 Interview with Resident B, on 08/20/14 at 08:08 AM, revealed he/she regularly received disliked food items during meals. 4. Observation during the breakfast meal, on 08/20/14 at 7:55 AM, revealed Resident E received scrambled eggs. Review of Resident E's dietary card revealed Resident E disliked eggs at breakfast. Interview with Resident E, on 08/20/14 at 7:55 AM, revealed he/she regularly received eggs "every morning". Interview with the Dietary Manager (DM), on 08/20/14 at 1:45 PM, revealed food preference questionnaires were completed within seventy-two (72) hours of admission and dislikes were listed on a resident specific dietary card. The DM stated she expected staff to check the diet order, dislikes, and preferences against what was on the tray during meal service. The DM revealed there was always a substitute item available. Interview with the Director of Nursing (DON), on 08/21/14 at 10:45 AM, revealed he/she expected staff to check diet orders and honor food preferences. Interview with the Administrator, on 08/21/14 at 10:55 AM, revealed staff should "pay attention to dietary meal cards" and obtain a substitute if the resident received an item he/she did not like. The Administrator revealed staff should communicate discrepancies to dietary.	F 246			
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315			

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F 315 SS=D	<p>Continued From page 3</p> <p>RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide appropriate care and services for an indwelling urinary catheter to prevent urinary tract infections for one (1) of eleven (11) sampled residents (Resident #1). The findings include: Review of the facility's policy "Catheter: Indwelling Urinary - Care of ", last revised 01/02/14, revealed staff should perform catheter care twice a day and PRN. For a male resident staff should wash area around catheter insertion site and then wash from the tip of the penis down to the body. Include the scrotum and skin folds around and underneath the scrotum. If male is uncircumcised, the foreskin must be retracted and cleaned. Return the foreskin to its original position once the penis is dry. In addition, staff should cleanse the proximal third of the catheter with soap and water, washing away from the insertion site and manipulating the catheter as little as possible, then rinse. Staff should secure</p>	F 315	<ul style="list-style-type: none"> • RN #1 was re-educated on 8/19/14 by the Director of Nursing on the Urinary Catheter policy and procedure with return demonstration to the Director of Nursing Services, no other concerns identified. RN #1 completed Foley catheter care on Resident #1 on 8/19/14. Resident # 1 was assessed to determine signs and symptoms of an infection on 8/19/14. Resident #1 has been assessed for signs and symptoms of infection every shift for 14 days and has remained free from infection. Assessment results are documented in the resident's clinical record. • An Audit was conducted by the Director of Nursing Services and the Assistant Director of Nursing of all other residents to determine if any other resident had a urinary catheter on 8/19/2014. One other resident was identified in the facility with a Foley catheter and that resident was assessed by the licensed nurse on 8/19/14 to determine signs and symptoms of infection and the catheter bag was covered and off the floor. No concerns were identified. The resident has been monitored every shift for 14 days and has remained free from signs and symptoms of infection. Licensed nurses will monitor residents with indwelling catheter's every shift to determine catheter care has been provided twice a day and as needed and the catheter bag is off the floor and covered . Areas of concern will be 		

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F 315	Continued From page 4 catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor. Record review revealed the facility admitted Resident #1 on 05/10/13 with diagnoses which included Hemiplegia Affecting Dominant Side, Urinary Obstruction, Hyperplasia Prostate unspecified with Urinary Obstruction, Muscle Weakness, and History of Urinary Tract Infection. Review of the Annual Minimum Data Set (MDS) Assessment, dated 03/27/14, revealed the facility assessed Resident #1's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of "3" indicating the resident was not interviewable. Review of Resident #1's Care Plan, last reviewed 08/01/14, revealed the resident required an indwelling catheter due to Obstructive Uropathy secondary to Benign Prostatic Hypertrophy (BPH). Further review revealed interventions which included to keep catheter off floor, provide skin care after each incontinent episode and apply a moisture barrier. Observation of Resident #1's skin assessment conducted by Registered Nurse (RN) #1, on 08/19/14 at 3:05 PM, revealed stool was present and RN # 1 used wet wipes to remove the stool; then removed gloves, washed hands and donned new gloves. However, RN #1 did not provide urinary catheter care. Interview with RN #1, on 08/19/14 at 3:35 PM revealed he/she was "nervous and forgot" to provide urinary catheter care and he/she should have provided urinary catheter care. Interview with the Director of Nursing (DON), on 08/19/14 at 3:40 PM, revealed he/she expected staff to provide urinary catheter care every shift and whenever visible stool was present. Observation of Resident #1, on 08/20/14 at 9:05 AM and 2:30 PM, revealed the resident's urinary	F 315	corrected when identified. Results of the monitoring will be documented on the Treatment Administration Record. Assistant Director of Nursing re-educated all nursing staff on 8/21/14 to policies and procedures of Foley catheter care and the dignity bags. The education included that the dignity bag may not touch the floor or other dirty surface, and the catheter must be anchored below the bladder level with nothing obstructing the flow of urine. Post-test was completed and graded by the Assistant Director of Nursing on 8/28/14 to validate competency. Upon orientation, new staff will receive education on policies and procedures of Foley catheter care and dignity bags, including the post-test to validate competency. This education will be administered by the Director of Nursing and/or the Assistant Director of Nursing. The Director of Nursing and/or the Assistant Director of Nursing will conduct audits of the Treatment Administration Record documentation and observation of catheter care 3 times per week for 12 weeks to determine compliance with catheter care policy and procedures including covering		

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F 315	Continued From page 5 catheter bag was inside a dignity bag touching the floor. Observation at 1:30 PM, revealed the urinary catheter bag was inside a dignity bag, lying on the floor with the bedside table wheel on top of the dignity bag. Interview with Certified Nurse Aide (CNA) #5, on 08/21/14 at 10:40 AM, revealed the urinary catheter bag or dignity bag should not be touching the floor. Interview with DON, on 08/21/14 at 10:55 AM, revealed the urinary catheter bag and/or dignity bag should be anchored below bladder level and never touching the floor.	F 315	catheter bags. Any concerns identified will be addressed at that time. A summary of audit findings will be submitted to the monthly Performance Improvement Committee consisting at a minimum of the Administrator, Director of Nursing Services, Assistant Director of Nursing, Dietary Service Manager, Social Service Director, Director Activities Director and the facility Medical Director.	9/15/14	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure it was free of medication error rates of five (5) percent or greater involving one resident (A), not in the selected sample. There were two (2) errors out of thirty-four (34) opportunities to equal a five (5) percent medication error rate. The findings include: Review of the General Dose Preparation and Medication Administration policy/procedure, last revised 03/01/11, revealed to verify each time that the medication was the right drug at the right	F 332	<ul style="list-style-type: none"> Resident A was assessed by a licensed nurse for adverse reactions related to the medication error on 8/20/14. The physician and family were notified on 8/20/14. Resident A was assessed every shift for 72 hours by a licensed nurse to determine any adverse reactions. No concerns related to the medication error were identified. The 2 medications for Resident A were clarified with the physician on 8/20/14 and a direction change label was placed on the pharmacy label by a licensed nurse. LPN # 1 was re-educated on 8/20/14 by the Director of Nursing about proper medication administration and the medication administration competency was completed on 8/20/14. A MAR to cart audit was completed by a Registered Nurse and Certified Pharmacy Technician employed by Omnicare Pharmacy on 8/20/14 of all current residents to determine Medication 		

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F 332	<p>Continued From page 6</p> <p>dose, the right route, at the right rate, at the right time for the right patient. Confirm that the Medication Administration Record (MAR) reflected the most recent medication order.</p> <p>Observation, on 08/20/14 at 8:00 AM, revealed Licensed Practical Nurse (LPN) #1 administered the following medication to Resident A:</p> <ol style="list-style-type: none"> 1. Fluticasone Propionate Suspension 50 micrograms (mcg), one (1) spray in each nostril. 2. Levocetirizine 2.5 mg tablet by mouth. <p>Record review revealed Resident A was admitted to the facility on 11/11/11 with a diagnosis to include Allergic Rhinitis. Review of the Physician's Orders and MAR, dated August 2014, revealed the following orders:</p> <ol style="list-style-type: none"> 1. Fluticasone Propionate Suspension 50 mcg two (2) sprays in both nostrils one (1) time a day for Allergic Rhinitis. 2. Levocetirizine Dihydrochloride tablet, give 5 mg by mouth one (1) time a day for Allergic Rhinitis <p>Interview with LPN #1, on 08/20/14 at 10:40 AM, revealed the medication label did not match the MAR for both medications administered to Resident A. She should have compared the medication with the MAR to ensure it was the right dosage. She revealed if there was a discrepancy, it should have been clarified before medication administration.</p> <p>Interview with the Director of Nursing, on 08/21/14 at 9:45 AM, revealed she expected staff to ensure the medication label matched the MAR prior to medication administration. She revealed if</p>	F 332	<p>policy and procedures were followed to include orders matching medication labels . No other concerns were identified.</p> <ul style="list-style-type: none"> • Education for all licensed nurses was initiated on 8/25/14 by the Director of Nursing that included the 5 rights of administration, 3 way check, and medication administration basics. A post-test was administered by the Director of Nursing to determine competency. Education was completed and post test graded by the Assistant Director of Nursing as of 8/28/14. Upon hire, all licensed nurses will complete the 5 rights of administration, 3 way check, and medication administration basics. A post-test will be administered to determine competency. The post test will be administered by the Director of Nursing or the Assistant Director of Nursing. • The Director of Nursing and/or the Assistant Director of Nursing will audit medication administration 3 times per week for 12 weeks using the medication administration competency checklist to determine compliance with the policy and procedure of medication administration. Any concerns identified will be corrected at that time. A summary of the audit findings 		

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F 332	Continued From page 7 there was a discrepancy, the medication order should have been verified.	F 332	will be submitted to the monthly Performance Improvement Committee consisting of the Administrator, Director of Nursing Services, Assistant Director of Nursing, Dietary Service Manager, Social Service Director, Activities Director and the facility Medical Director for 3 months for further review and recommendations.	9/15/14	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441 441 • Resident #6 was assessed by a licensed nurse on 8/20/14 for signs and symptoms of an infection. The resident has been assessed by a licensed nurse every shift for 14 days and there have not been any signs or symptoms of an infection. Re-education for the CNA was completed on 8/21/14 by the Assistant Director of Nursing. • The 24 hours report is reviewed daily for new signs and symptoms of an infection. No other residents have been identified as having signs or symptoms of infection. • Re-education for all nursing staff was initiated on 8/22/14 related to hand washing and infection control practices by the Assistant Director of Nursing. The re-education included infection control policies and procedures, proper hand washing techniques, return demonstration, and a post-test to determine competency. Re-education and post-test was completed and graded by the Assistant Director of Nursing as of 8/28/14. Newly hired nursing			

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F 441	<p>Continued From page 8 infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility policy, it was determined the facility failed to ensure proper incontinent care and appropriate hand washing and gloving technique during the performance of perineal (incontinence) care for one (1) of eleven (11) sampled residents (Resident # 6).</p> <p>The findings include:</p> <p>Review of the facility's Hand Hygiene policy, last revised 10/01/2013, revealed employees should wash hands with soap and water after removing gloves, before and after direct patient care, immediately after contact with blood, body fluids, or other potentially infectious materials and when hands are visibly soiled or contaminated.</p> <p>Record review revealed the facility admitted Resident #6 on 07/08/14 with diagnoses which included Essential Hypertension, Diabetes Mellitus Type II, Hyperlipidemia, Encephalopathy Unspecified, Unspecified Cerebral Artery Occlusion with Infarct, Hemiplegia Affect unspecified side due to Cerebrovascular Disorder (CVD), Cognitive Deficit due to CVD, Abnormal Gait, Muscle Weakness, Dementia, Anxiety, Convulsions, Symbolic Dysfunction, Dysphagia and Irritable Bowel Syndrome.</p> <p>Review of the Initial Minimum Data Set (MDS) Assessment, dated 07/15/14, revealed the facility assessed Resident #6's cognition as severely</p>	F 441	<p>staff will be educated by the Director of Nursing and/or the Assistant Director of nursing on the Infection Control practices including washing hands and glove use during orientation and ongoing.</p> <ul style="list-style-type: none"> The Director of Nursing, Assistant Director of Nursing and/or Licensed Nurses will conduct infection control audits daily for 2 weeks, weekly for two months then monthly for 3 months to determine compliance with infection control policies and procedures including peri-care, hand washing and glove use. Results of the audit will be documented on the infection control monitoring tool. A summary of the audit findings will be submitted to the facility Performance Improvement Committee consisting of the Administrator, Director of Nursing Services, Assistant Director of Nursing, Dietary Service Manager, Social Service Director, Activities Director and the facility Medical Director for 6 months for further review and recommendation. 	9/15/14	

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F 441	<p>Continued From page 9</p> <p>impaired with a Brief Interview for Mental Status (BIMS) score of "7" indicating the resident was not interviewable.</p> <p>Observation of perineal care, on 08/20/14 at 3:00 PM, revealed Certified Nurse Aide (CNA) #2 and CNA #4 assisted Resident #6 to the commode in the women's shower room and removed the resident's incontinent brief. Further observation revealed CNA #2 wiped stool from Resident #6 using wet wipes; then assisted the resident into a clean brief and touched the resident, gait belt and wheelchair without removing her gloves and washing her hands.</p> <p>Interview with CNA #2, on 08/20/14 at 3:30 PM, revealed she should have removed her gloves and washed her hands after cleaning stool and prior to touching Resident #6, the gait belt and the wheelchair.</p> <p>Interview with the Director of Nursing (DON), on 08/21/14 at 14:20 PM, revealed she expected staff to remove gloves and wash hands after providing perineal care and before touching the resident, gait belt and wheelchair.</p>	F 441			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185399	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351
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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: 1995.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (111).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1995, with 36 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1995.</p> <p>GENERATOR: Type II generator installed in 1995. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 08/21/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty-five (45) beds with a census of forty-one (41) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE 9-16-14	(X6) DATE
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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	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Heartland Villa Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.</p> <p>*8/26/14, the quick foam was removed from the fire wall and replaced with Red 4 hour fire barrier sealant.</p> <p>*8/22/14, all fire walls were audited for use of quick foam in any other penetrations and none were found.</p> <p>*The Administrator and Maintenance Director were educated by the Regional Property Manager on 8/21/14 regarding products that meet the regulatory requirement and follow up steps necessary any time a vendor is working with or around fire walls.</p> <p>* Fire walls are are audited monthly and after any service contractor has completed work that could result in a penetration of the wall. Inspection results will be reviewed in the monthly Performance Improvement Meeting attended by the Interdisciplinary Team for the next six months and as needed for further recommendations. The meeting is attended by the Administrator, Medical Director,</p>	
K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for forty-five (45) beds and at the time of the survey, the census was forty-one (41).</p> <p>The findings include:</p> <p>Observation, on 08/21/14 at 11:19 AM with the Maintenance Director, revealed the smoke barrier, extending above the ceiling located by the</p>	K 025		

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K 025	<p>Continued From page 2</p> <p>Dining Room had unrated expandable foam installed to seal penetrations.</p> <p>Interview, on 08/21/14 at 11:19 AM with the Maintenance Director, revealed he was not aware of the use of expandable foam.</p> <p>The census of forty-one (41) was verified by the Administrator on 08/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/21/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 	K 025	<p>Director of Nursing, Assistant Director of Nursing, Director of Maintenance, Social Services Director, Food Service Director and Activity and Environmental Services Director.</p>	9/15/14
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K 025	<p>Continued From page 3</p> <p>8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions:</p> <p>(1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier.</p> <p>(2) It shall be protected by an approved device that is designed for the specific purpose.</p> <p>K 027 NFPA 101 LIFE SAFETY CODE STANDARD SS=D</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-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 19.2.2.6. 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</p> <p>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</p>	K 025	<p>* 9/8/14, The doors were sanded to remove paint build up to prevent hindrance of the doors closing. The Director of Maintenance adjusted the hinge on the fire door and the tension on the self closing apparatus to ensure that the doors close completely and prevent the passage of smoke in case of emergency.</p> <p>* 8/21/14, all fire doors were tested to ensure they close completely to prevent the passage of smoke in case of emergency. No problems were identified.</p> <p>* 8/21/14, the Administrator and Director of Maintenance were re-educated by the Regional Property Manager regarding NFPA Life Safety Code K027. The Fire Drill procedures have been revised to include a staff member, assisting in the drill to observe</p>	
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42361		
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K 027	<p>Continued From page 4</p> <p>potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for forty-five (45) beds and the census was forty-one (41) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/21/14 at 2:04 PM, with the Maintenance Director revealed the cross-corridor doors located at the Dining Room would not completely close when tested, leaving a gap of approximately half an inch (1/2 ") between the doors in the closed position. The pair of doors could not close completely and resist the passage of smoke in the event of an emergency.</p> <p>Interview, on 08/21/14 at 2:05 PM, with the Maintenance Director revealed he was not aware the pair of 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 forty-one (41) was verified by the Administrator on 08/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/21/14.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition)</p>	K 027	<p>each fire door for appropriate closure.</p> <p>* The Maintenance Director will audit the fire doors for appropriate closure with each fire drill. The audit results will be presented in the Performance Improvement Committee meeting monthly for six months and as needed for further recommendations. The meeting is attended by the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Maintenance, Social Services Director, Food Service Director and Activity and Environmental Services Director.</p>	9/15/14

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K 027 Continued From page 5
Standard for Fire Doors 2-3.1.7
The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.

K 038 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure egress was maintained at exit doors in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for forty-five (45) beds and at the time of the survey, the census was forty-one (41).

The findings include:

Observation, on 08/21/14 at 2:06 PM with the Maintenance Director, revealed the Therapy Room door had locking arrangements located five (5) feet from the floor.

K 027

K 038 *8/26/14, parts were obtained to lower the lock located on the therapy door. The lock was lowered to less than 48 inches from the floor per Life Safety Code K038. The remaining latch was ordered and will be installed upon arrival. Estimated time of delivery Monday 9/15/14.

*8/21/14, all door locks were audited to ensure no other locks were greater than 48 inches from the floor. No other problems were identified.

*8/21/14, the Administrator and Director of Maintenance were re-educated by the Regional Property Manager regarding NFPA Life Safety Code K038.

* The Maintenance Director will audit locks going forward with any new installation/ construction to ensure all locks meet the life safety requirement. Findings will be reported in the Performance Improvement Meeting, monthly for six months and as needed for further recommendations. The meeting is attended by the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Maintenance, Social Services Director, Food Service Director and Activity and Environmental Services Director.

9/15/14

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K 038	<p>Continued From page 6</p> <p>Interview, on 08/21/14 at 2:07 PM with the Maintenance Director, revealed they were unaware locking arrangements could not be located over four (4) feet from the floor.</p> <p>The census of forty-one (41) was verified by the Administrator on 08/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/21/14.</p> <p>Actual NFPA Standard:</p> <p>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.</p> <p>Exception No. 1*: Egress doors from individual living units and guest rooms of residential occupancies shall be permitted to be provided with devices that require not more than one additional releasing operation, provided that such device is operable from the inside without the use of a key or tool and is mounted at a height not exceeding 48 in. (122 cm) above the finished floor. Existing security devices shall be permitted to have two additional releasing operations. Existing security devices other than automatic latching devices shall not be located more than 60 in. (152 cm) above the finished floor. Automatic latching devices shall not be located more than 48 in. (122 cm) above the finished</p>	K 038		
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K 038	Continued From page 7 floor. Exception No. 2: The minimum mounting height for the releasing mechanism shall not be applicable to existing installations.	K 038		
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 interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of three (3) smoke compartments, forty-five (45) residents, staff and visitors. The facility has the capacity for forty-five (45) beds and at the time of the survey, the census was forty-one (41). The findings include: Review of the facility's Fire Drill documentation, on 08/21/14 at 12:00 PM, with the Maintenance Director, revealed the fire drills were not being conducted at random times on all shifts	K 050	*9/9/14, a random fire drill was completed at 1:30 PM by the Administrator. * 8/21/14 the 2014 Fire Drill Schedule was reviewed by the Administrator to ensure it met Life Safety Code K050 requirements. When executed as scheduled there are no regulatory concerns. *8/21/14, the Administrator and Director of Maintenance were re-educated by the Regional Property Manager regarding NFPA Life Safety Code K050. * The Administrator will audit the time that drills are conducted and compare it to the drill schedule. Any discrepancies will be corrected immediately. Results will be discussed in the Performance Improvement Committee meeting monthly for six months and as needed for further recommendations. The meeting is attended by the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Maintenance, Social Services Director, Food Service Director and Activity and Environmental Services Director.	9/15/14

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K 050 Continued From page 8

K 050

Interview, on 08/21/14 at 12:01 PM, with the Maintenance Director, revealed he was unaware the fire drills were not being conducted as required.

The census of forty-one (41) was verified by the Administrator on 08/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/21/14.

Actual NFPA Standard:

Reference: NFPA 101 (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 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

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 sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for forty-five (45) beds and at the time of the survey, the census was forty-one (41).

K 062 * 9/9/14 the five year internal pipe inspection was completed by Federal Fire and Security. No problems were identified.

* 8/21/14 all inspection reports related to the fire sprinkler system were reviewed by the Administrator and no other inspections were out of compliance.

**8/21/14, the Administrator and Director of Maintenance were re-educated by the Regional Property Manager regarding NFPA Life Safety Code K062.

9/9/14, the internal pipe inspection was added to the electronic Total Equipment Life System (T.E.L.S.) This will prompt the Maintenance Director to ensure the inspection is completed.

Additionally, Federal Fire and Security has

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K 062	<p>Continued From page 9</p> <p>The findings include:</p> <p>Sprinkler testing record review, on 08/21/14 at 12:05 PM with the Maintenance Director, revealed the five (5) year internal pipe inspection for the sprinkler system was past due. The last internal pipe inspection was performed on 05/19/09.</p> <p>Interview, on 08/21/14 at 12:05 PM with the Maintenance Director, revealed he relied on his Sprinkler Company to ensure the system was inspected properly as required.</p> <p>The census of forty-one (41) was verified by the Administrator on 08/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/21/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition), 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p>	K 062	<p>scheduled the inspection for August 29, 2019.</p> <p>*The Maintenance Director will audit the T.E.L.S. program monthly for routine fire sprinkler inspections and report in the Performance Improvement Meeting monthly for six months and as needed for further recommendations. The meeting is attended by the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Maintenance, Social Services Director, Food Service Director and Activity and Environmental Services Director.</p> <p>9/15/14</p>

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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8006 US HWY 60 WEST LEWISPORT, KY 42351
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K 062	<p>Continued From page 10</p> <p>Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance</p>	K 062		
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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42361	
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K 062	Continued From page 11 Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies	K 062	

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NAME OF PROVIDER OR SUPPLIER HEARTLAND VILLA CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 8005 US HWY 60 WEST LEWISPORT, KY 42351	
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K 062	Continued From page 12 Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		
K 066	NFPA 101 LIFE SAFETY CODE STANDARD	K 066		

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K 066 SS=D	<p>Continued From page 13</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(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 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 residents was properly equipped for safe smoking, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect residents using the smoking areas and staff. The facility has the capacity for forty-five (45) beds and at the time of the survey, the census was forty-one (41).</p>	K 066	<p>* 9/02/14 a stainless steel self extinguishing step can was obtained and placed in the designated smoking area with a flip top, stainless steel table top ashtray. A fire extinguisher and enclosure cabinet was installed in the designated smoking area on 8/28/14.</p> <p>* No other areas are designated for smoking.</p> <p>*8/21/14, the Administrator and Director of Maintenance were re-educated by the Regional Property Manager regarding NFPA Life Safety Code K066.</p> <p>* The Maintenance and Environmental Services Director will audit the use and presence of the stainless steel smoking implements on weekly rounds. Audit results will be presented in the monthly Performance Improvement Committee Meeting for the next six months and as needed for further recommendations. The meeting is attended by the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Maintenance, Social Services Director, Food Service Director and Activity and Environmental Services Director.</p>	9/15/14
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K 066	<p>Continued From page 14</p> <p>The findings include:</p> <p>Observation, on 08/21/14 at 2:15 PM, with the Maintenance Director revealed the designated outdoor smoking area for residents and staff did not have an approved metal container with a self-closing lid to empty ashtrays into for disposal.</p> <p>Interview, on 08/21/14 at 2:16 PM, with the Maintenance Director revealed he was not aware of the requirement that the designated outdoor smoking area for residents was to be equipped with an approved metal container with a self-closing lid to empty ash trays into for disposal.</p> <p>The census of forty-one (41) was verified by the Administrator on 08/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/21/14.</p> <p>Actual NFPA Standard:</p> <p>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:</p> <p>(1) Smoking shall be 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 areas shall be posted with signs that read NO SMOKING or shall be posted with the international</p>	K 066		
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K 066	Continued From page 15 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	K 066	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	*The generator is set up on an automatic schedule to exercise weekly. The documentation for May 2014 weekly cycles was not available for inspection nor was the 30 minute monthly load test. There is no way to produce the documentation to support the automatic weekly exercises or load test. 8/21/14 the generator was tested under load with no problems identified. 8/22/14, Vanguard Sales rewired the battery charger to the prime mover and calculated the

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K 144	<p>Continued From page 16</p> <p>This STANDARD is not met as evidenced by: Based on Generator testing record review, observation, and interview, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, forty-five (45) residents, staff and visitors. The facility has the capacity for forty-five (45) beds with a census of forty-one (41) on the day of the survey.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Generator testing record review, on 08/21/14 at 12:17 PM with the Maintenance Director, revealed the generator had not been checked weekly or tested during the month of May 2014. <p>Interview, on 08/21/14 at 12:18 PM with the Maintenance Director, revealed the facility did not have a Maintenance Director during that time.</p> <ol style="list-style-type: none"> 2. Observation, on 08/21/14 at 2:13 PM with the Maintenance Director, revealed the battery charger located inside the generator enclosure to keep the battery charged for the emergency generator was connected directly to the battery terminals instead of through the prime mover starter. <p>Interview, on 08/21/14 at 2:14 PM with the Maintenance Director, revealed he was not aware the battery charger could not be connected directly to the battery terminals.</p> <p>The census of forty-one (41) was verified by the</p>	K 144	<p>percent load used by the generator.</p> <ul style="list-style-type: none"> * 8/22/14 All generator systems were audited by the Vanguard representative and found in compliance. * 8/21/14, the Administrator and Director of Maintenance were re-educated by the Regional Property Manager regarding NFPA Life Safety Code K144. * The Maintenance Director will audit T.E.L.S. program monthly for routine documentation of the generator exercises both weekly and monthly. The maintenance Director will report audit findings in the Performance Improvement Meeting monthly. The meeting is attended by the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Director of Maintenance, Social Services Director, Food Service Director and Activity and Environmental Services Director. 	9/15/14

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K 144	<p>Continued From page 17</p> <p>Administrator on 08/21/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/21/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 110 (1999 Edition) 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices.</p> <p>Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.</p> <p>Reference: NFPA 99 (1999 Edition) 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p>	K 144	