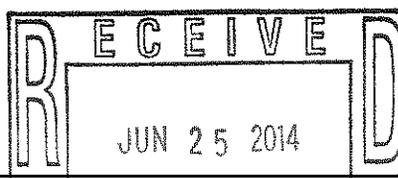


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING: Division of Health Care Southern Enforcement Branch B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2014
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NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
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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
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<p>F 000</p> <p>F 253 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 05/20-22/14. Deficient practice was identified with the highest scope and severity at "D" level.</p> <p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies/procedures, it was determined the facility failed to ensure services were provided to maintain a sanitary and comfortable interior. Observations made on 05/21/14 at 12:18 PM and 12:47 PM revealed tile in one (1) of fifty-five (55) resident rooms was chipped revealing the floor underneath, and one (1) of four (4) fire doors on the East Hall was chipped and splintered.</p> <p>The findings include:</p> <p>Review of facility policy titled, "Facility Maintenance Program," which was undated, revealed the facility would properly maintain all items which were deemed the Maintenance Department's responsibility.</p> <p>1. Observation of resident room 153 on 05/21/14 at 12:18 PM revealed the tile flooring under the resident's bed was observed to be ripped/chipped and revealed the wood floor below the tile.</p>	<p>F 000</p> <p>1.</p> <p>F 253</p> <p>2.</p> <p>3.</p>	<p>Resident room 153 revealed that the tile flooring under resident's bed was chipped and a fire door on East Wing to the right of the nurses's station had a chipped/splintered edge near the bottom of the door indicating that the facility was not being properly maintained per facility maintenance program. Maintenance repaired the fire door the day it was identified and called a floor company about purchasing tile.</p> <p>On 5-27-14 Department Managers conducted environmental rounds throughout the facility to assure the facility was properly implementing the facility's maintenance program.</p> <p>The following areas were identified as not properly being maintained: resident room 126 bathroom floor, flooring needs repaired/replaced; resident room 119 bathroom door needs paint; West Wing fire door needs paint; resident room 128 vent needs repaired or replaced; resident room 146 bathroom wall needs paint, resident room 102 tile flooring under resident bed chipped. These items were put on a maintenance schedule to be repaired. The projected date of completion is 7-8-14.</p> <p>The Executive Director/Maintenance Director in-serviced Department Managers on 5-27-14 to thoroughly check on their daily rounds (M-F) the environment for maintenance concerns and complete a Maintenance Request Form and give to the Maintenance Director. Other staff were in-serviced 5-27 and 5-30-14 to complete Maintenance Request Forms every time they saw an environmental concern and give to the Maintenance Director.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Clara E. Beuss* TITLE: *Type Director* (X6) DATE: *06-23-14*

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 253	Continued From page 1 2. Observations of the East Hall on 05/21/14 at 12:47 PM revealed a fire door on the hallway to the right of the East Hall nurses' station had a chipped/splintered sharp edge near the bottom of the door. Interview with the Maintenance Director on 05/22/14 at 6:20 PM revealed staff completed a maintenance/repair order when an issue was identified. The Maintenance Supervisor stated staff turned the orders into him daily and he also received verbal maintenance/repair orders daily. The Maintenance Supervisor further stated he was not aware the tile or door needed repairs.	F 253	4. Dept Managers will make daily rounds/ audits (M-F) utilizing a check off sheet to assure Housekeeping/Maintenance provides services necessary to maintain a sanitary, orderly, and comfortable interior. Findings are presented to the Executive Director. The ED will follow up with Maintenance and Housekeeping Directors responsible for the findings to assure the findings are corrected. The Department Managers will conduct audits 5 times a week for 4 weeks then 3 times a week for two weeks to assure that there are no environmental concerns. Audits will be presented to the monthly Performance Improvement (PI) Committee meeting. Revisions will be made to the systems as indicated. Audits will continue until the PI Committee determines compliance.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and facility policy review, the facility failed to meet professional standards of quality for two (2) of twenty (20) sampled residents (Residents # 1 and #7). Review of the physician's orders revealed the physician had requested for Resident #1's heels to be up on a pillow and off of the bed. In addition, review of the physician's orders revealed the physician had prescribed thigh-high TED (Thrombo-Embolic-Deterrent) stockings (stockings used to prevent blood clots in the legs) for Resident #7. However, observations conducted on 05/20/14 and 05/21/14 revealed Resident #1's heels were not positioned on a pillow and Resident #7 was not wearing TED	F 281	1. Resident #1 physician was notified on 5-23-14 that resident refuses to keep heels on pillow and off of the bed. New order obtained to d/c order to keep heels on pillow and off of bed. Resident #7 physician was notified on 5-21-14 that resident refuses to wear TED stockings. New order obtained to d/c TED stockings. No adverse effects noted. 2. 100% audit of all physician's orders written in the last 90 days was completed by the DON, ADON and Unit Manager on 5-27-14 and 5-28-14 to ensure all physician's orders were being followed.	6-30-14	

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F 281	<p>Continued From page 2 hose as ordered.</p> <p>The findings include:</p> <p>A review of the facility's "Physician's Orders/Transcription" policy (revision date October 2004) revealed proper communication would be used to ensure accurate delivery of medications and treatments to all residents. According to the policy, this would be achieved by using the Order Sheet, Telephone Order Form, Medication Administration Record, and Treatment Record. In addition, the policy noted observation, monitoring, and audits would be performed randomly to ensure compliance was met.</p> <p>1. Review of the medical record revealed the facility admitted Resident #1 on 11/09/11 with diagnoses that included Alzheimer's, Coronary Atherosclerosis, Pacemaker, History of (Left) Femur Fracture, and Dysphagia.</p> <p>Review of the significant change Minimum Data Set (MDS) comprehensive assessment dated 04/30/14 revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of 0 (which indicated the resident to have severe cognitive impairment), to require extensive assistance with bed mobility, transfers, bathing, and toileting, and to have one Stage II pressure ulcer.</p> <p>Review of the May 2014 physician's orders revealed the physician requested staff to keep Resident #1's heels off the bed and on a pillow.</p> <p>Observations conducted on 05/20/14, at 3:50 PM, 4:45 PM, and 5:40 PM, revealed Resident #1 was lying on a low bed; however, the resident's</p>	F 281	<p>100% audit was completed on 5-27-14 and 5-28-14 by ADON and Unit Manager for all residents with an order to keep heels on pillow and off of bed to ensure physician's orders were followed. No problems noted.</p> <p>100% audit was completed on 5-28-14 by the Unit Manager for all residents with an order for TED stockings to ensure physician's orders were being followed. No problems noted.</p> <p>3. An in-service was conducted by the Staff Development Coordinator on 5-30-14 for all licensed nursing staff related to following physician's orders. All orders and C.N.A. Care Guides are reviewed daily by DON, ADON, MDS Coordinator, Rehab Manager and Unit Managers Monday through Friday to ensure they are being implemented and proper interventions are being followed by all nursing staff.</p> <p>An in-service was conducted by the Staff Development Coordinator on 5-30-14 for all Certified Nursing Assistants related to reviewing and implementing information on resident's Care Guides.</p>		

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F 281	<p>Continued From page 3</p> <p>feet/heels were not positioned on a pillow. Further observations conducted on 05/21/14, at 9:05 AM, revealed Resident #1 was again in bed; however, the resident's feet/heels were lying on the bed. A skin assessment was conducted on 05/21/14, at 9:15 AM with facility staff. The resident was observed to have a healing Stage II pressure ulcer on the coccyx area. No additional reddened or broken areas were noted. Further observations conducted on 05/21/14, at 9:25 AM, 10:15 AM, 11:00 AM, and 12:30 PM, revealed the resident remained in bed and the feet/heels were still not positioned up on a pillow as ordered by the physician.</p> <p>Interview with Certified Nurse Aide (CNA) #3 on 05/21/14, at 2:45 PM, revealed the CNA was assigned to provide care for Resident #7. The CNA stated the CNAs were responsible to review the CNA care plan guide at the beginning of each shift to identify specific resident needs. CNA #3 stated she had only "glanced" at the care plan guide for Resident #7 and did not realize the resident's feet/heels were supposed to be up on a pillow.</p> <p>2. Review of the medical record revealed the facility admitted Resident #7 on 11/22/13 with diagnoses that included Late Effect Cerebrovascular Accident, Atherosclerosis, Osteoporosis, and Seizures. A new diagnosis of Pelvic Fracture was added on 04/07/14 after the resident sustained a fall at the facility.</p> <p>Review of the physician's orders dated 04/08/14 revealed the physician prescribed thigh-high TED hose for Resident #7 related to Deep Vein Thrombosis (DVT) prophylaxis after the resident sustained a fractured pelvis.</p>	F 281 4.	<p>Audits will be completed by the DON, ADON, and Unit Managers daily Monday through Friday x 4 weeks, weekly x 4 weeks, then monthly x 4 months on all residents with an order for TED stockings and orders for heels to be on a pillow and off of the bed to ensure orders are being followed. The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting. Revisions will be made in the systems as indicated.</p>	6-30-14	

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F 281	<p>Continued From page 4</p> <p>Review of the significant change MDS assessment dated 04/10/14, revealed staff assessed the resident to have a BIMS score of 4 (which indicated the resident had severely impaired cognition). The resident was further assessed to require extensive assistance with bed mobility, transfers, bathing, ambulation, and toileting, and to be at risk for skin breakdown.</p> <p>Interview with Resident #7 could not be conducted due to the resident's cognitive impairment.</p> <p>Resident #7 was observed on 05/20/14, at 3:50 PM, 4:45 PM, and 6:00 PM to be sitting up in a wheelchair in the doorway of his/her room. The resident was observed to be wearing shoes and socks; however, the resident was not wearing TED hose. The resident verbalized concerns of swelling of his/her legs/ankles. Observation confirmed the resident's lower extremities were swollen. Further observations conducted on 05/21/14, at 9:00 AM, 9:30 AM, 10:15 AM, 11:30 AM, and 2:20 PM, revealed Resident #7 continued to have swelling/edema of both lower extremities; however, TED hose were not in use as ordered by the physician.</p> <p>Interview with CNA #4 on 05/21/14, at 2:35 PM, revealed she had been trained to follow the CNA care plan guide to provide care for the residents. CNA #4 stated she was not familiar with Resident #7 and had not reviewed the care guide and as a result did not know the TED hose were to be worn by Resident #7. CNA #4 confirmed she had not placed the TED hose on Resident #7 as ordered by the physician.</p>	F 281		

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F 281	Continued From page 5 Interview with Licensed Practical Nurse (LPN) #1 on 05/22/14, at 7:25 PM, revealed she was the Unit Manager for the West Wing. The LPN stated she was responsible to add the physician's orders to the CNA care plan guide and confirmed the CNAs were to follow the direction/instruction provided on the CNA care plan guide. LPN #1 stated she conducted daily resident rounds and random audits two times per week to ensure care was provided as ordered by the resident's physician, and had not identified any concerns. Interview with the Director of Nurses (DON) on 05/22/14, at 7:40 PM, also revealed the CNAs should follow the direction/instruction provided on the CNA care plan guide. According to the DON, she conducted resident rounds at least two times per day to ensure care was provided as ordered by the physician and had not identified any concerns related to resident care.	F 281			
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.	F 441	1. Resident #1 was assessed by the Unit Manager on 5-22-14. No adverse effects were noted related to SRNA #1 not washing hands after handling soiled linen and handing clean linen to resident #1. 2. 100% observation audit was completed on 5-28-14 by the DON and ADON at different times to ensure proper hand-washing techniques were being followed per policy. No problems noted.		

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F 441	<p>Continued From page 6</p> <p>(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.</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 and interview it was determined the facility failed to maintain an infection control program that provided a sanitary environment and to ensure personnel handled linens to prevent the spread of infection for one (1) of twenty (20) sampled residents (Resident #1). Observation on 05/22/14 at 3:20 PM revealed State Registered Nurse Aide (SRNA) #1 picked up linen from the floor beside Resident #1's wheelchair and handed the linen to Resident #1; the SRNA then took the linen from the resident, entered an area with the soiled linen, and returned with clean linen that she handed to the resident. SRNA #1 failed to ensure clean linens were provided to the resident when she</p>	F 441	<p>3. All associates were in-serviced on 5-30-14 by the Staff Development Coordinator on infection control and hand washing. Staff Dev. Coordinator performs observation and hand washing competencies on all nursing staff annually, randomly, and upon hire to ensure proper hand washing techniques are being performed.</p> <p>4. The DON, ADON, and Unit Manager will perform audits on 5 associates during linen changes to ensure hand-washing compliance daily Monday through Friday x 2 weeks, then weekly x 2 weeks, then monthly x 2 months. The results of the audits will be reviewed in the monthly Performance Improvement (PI) Committee meeting. Revisions will be made in the systems as indicated.</p>	6-30-14	

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F 441	<p>Continued From page 7</p> <p>obtained the linen from the floor and handed the linen to the resident. In addition, the SRNA acknowledged she failed to sanitize/wash her hands after making contact with the dirty linen or before she obtained the clean linen and delivered the linen to the resident.</p> <p>The findings include:</p> <p>A review of the facility's infection control policy titled, "Infection Control Plan," revised date of 02/06/2006, revealed the facility would "reduce the risk of acquisition and transmission of health-care associated infections, monitor for any occurrences of infection and implement appropriate control measures, identify and correct problems relating to infection control practices, and ensure compliance with State, Federal, and Occupational Safety Health and Administration (OSHA) regulations and Joint Commission on Accreditation of Health Care Organizations (JCAHO) standards."</p> <p>Review of the Centers for Disease Control and Prevention guidelines for Hand Hygiene in Health-Care setting; Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, MMWR 2002; 51 (No. RR-16): [page 32], revealed hands should be decontaminated after contact with inanimate objects in the immediate vicinity of the resident.</p> <p>Observation on 05/22/14 at 3:20 PM revealed Resident #1 sitting in a wheelchair in the hallway of the facility and a piece of linen was lying on the floor beside the resident's wheelchair. State Registered Nurse Aide (SRNA) #1 was observed to pick up the linen from the floor and handed the</p>	F 441			

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F 441	<p>Continued From page 8</p> <p>linen to Resident #1. SRNA #1 was then observed to enter an area through a doorway with the soiled linen and return with clean linen that she handed to the resident.</p> <p>An interview conducted with SRNA #1 on 05/22/14 at 3:21 PM revealed she had attended an in-service training related to infection control provided by the facility. SRNA #1 stated she should not have given the linen that had touched the floor to Resident #1. SRNA #1 stated she had been nervous during the observation and also acknowledged she failed to sanitize/wash her hands after making contact with the dirty linen and before she obtained the clean linen and delivered the linen to the resident.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #2 on 05/22/14 at 3:23 PM revealed staff should replace linens that have touched the floor and should wash their hands after contact with soiled objects.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on 05/22/14 at 4:07 PM, revealed the facility reviewed infection control concerns at the monthly performance improvement meetings. LPN #1 further revealed the facility retrained staff on infection control precaution procedures if a resident was admitted to the facility with an infection. According to the LPN, if linen fell to the floor it would be considered dirty and staff should place the linen in the dirty linen container and wash their hands.</p> <p>An interview was conducted with the Director of Nursing (DON), who is also the facility's Infection Control Nurse, and the facility's Nurse Consultant on 05/22/14 at 7:45 PM. The facility's Nurse</p>	F 441			

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F 441	Continued From page 9 Consultant stated the facility did not have policies related to specific infection control actions. The DON stated the facility followed the Centers for Disease Control and Prevention (CDC) guidelines related to infection control and provided staff with infection control in-services at the time they are hired and on an annual basis. In addition, the interviews revealed nurses, administrative staff, and the infection control nurse conducted observations on a random basis of staff when they provided resident care in an effort to ensure staff maintained infection control practices. The DON acknowledged staff should not have handed the resident the soiled linen and should have washed her hands before she obtained the clean linen and returned the linen to the resident.	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/21/2014
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NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11, Division of Health Care MANCHESTER, KY 40962, Police Enforcement Branch
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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
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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: 1976</p> <p>SURVEY UNDER: 2000 Existing (Short Form)</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V(000)</p> <p>SMOKE COMPARTMENTS: Five</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 05/21/14. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p>	K 000		
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 038	<p>1. Once Maintenance Director was made aware that facility Mechanical Room and West Housekeeping Clean Linen Closet required a door closing device. He immediately called Shamrock Glass to assure they could install the door closing devices identified as needed.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Diana Benz* TITLE: *Exec Dir* (X6) DATE: 06-13-14

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.

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

PRINTED: 06/06/2014
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962	
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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor exit ways were maintained according to National Fire Protection Agency standards. This deficient practice affected three (3) of five (5) smoke compartments, staff, and approximately sixty (60) residents. The facility has the capacity for 107 beds with a census of 93 on the day of the survey. The findings include: During the Life Safety Code survey on 05/21/14 at 11:15 AM with the Director of Maintenance (DOM), a door to the mechanical room was observed to open and project more than seven (7) inches into the corridor in the fully opened position. This condition could impede egress in an emergency and requires a door-closing device to remedy the situation. An interview with the DOM on 05/21/14 at 11:15 AM revealed he was unaware the door needed a door closing device. During the survey corridor doors to the East and West housekeeping clean linen closet were observed to open and project more than seven (7) inches into the corridor. The Administrator was not available at exit. The DOM will notify the Administrator of these	K 038 2.	Maintenance Director checked all doors in the facility and identified the following as needing the door closure device: HIM Office, West Wing, Housekeeping Closet, Storage Closet, Shower Door, Nourishment, Crash Cart Room, Clean Linen Room, Middle Housekeeping Closet, Cafe, Activities, East Solid Waste, Housekeeping Closet and Nourishment. 3. On 5-21-14 the Maintenance Director in-serviced staff relative to the above list of doors requiring a door closing device. Staff was instructed to report any identified problems immediately to a supervisor, Dept. Manager, Maintenance Director and/or Executive Director. Shamrock Glass installed door closures on all of the above doors on 6-2-14. 4. During daily rounds/audits Dept Managers will audit doors to assure newly installed closures are in place and functioning properly. Audits will be done 5 x a week Monday through Friday for 3 weeks, then 3 x per week for 2 weeks. Any closure not functioning properly will be reported to the Maintenance Director immediately.	

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K 038	Continued From page 2 findings. Reference: NFPA 101 (2000 Edition). 7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.) Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open.	K 038	Audits will be presented to the monthly Performance Improvement (PI) Committee meeting. Revisions will be made to the system as indicated and audits will continue until PI Committee determines compliance.	6-30-14