

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

PRINTED: 03/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185252</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>03/26/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SHADY LAWN NURSING AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2582 CERULEAN RD. CADIZ, KY 42211</b>
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 03/16/14 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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  SHADY LAWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2682 CERULEAN RD. CADIZ, KY 42211
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F 000	INITIAL COMMENTS  A Recertification Survey was conducted on 02/12/14 through 02/13/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E".	F 000	<b>Plan of Correction disclaimer for Shady Lawn Nursing and Rehabilitation:</b>  <b>The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth or facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because of State and Federal Regulations.</b>	
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH  Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility's resident accounting records and the facility's policy and procedure it was determined the facility failed to ensure personal funds and a final accounting for two unsampled deceased residents (Resident B and Resident C) were conveyed within thirty (30) days to the individuals administering the residents' estates.  The findings include:  Review of an undated facility policy, titled Closing of Resident Trust Fund Accounts, revealed the facility will maintain and close resident trust fund accounts according to the State and Federal guidelines and the Resident Trust fund accounts will be conveyed to the appropriate party within thirty (30) days of the resident's expiration.	F 160	F160 Conveyance of personal funds upon death.  1. Residents B and C's funds have been conveyed to the individuals administering the residents' estates. This was completed by the Business Office Manager by 2/13/2014.  2. The Business Office Manager completed an audit, since last survey date, of all existing resident accounts to ensure all expired or discharged residents' accounts have been closed, and funds have been conveyed, if appropriate. This was completed by February 28, 2014. Any identified concerns were corrected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
Shawn J. Judd Administrator

TITLE \_\_\_\_\_ (X6) DATE 3/21/2014

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 160	<p>Continued From page 1</p> <p>1. Review of facility accounting records revealed Resident B expired on 08/08/13 and had a balance in the resident accounts of \$187.04. Review of the accounting statement revealed the \$187.07 was still in the account and status was "Pending Close on 01/27/14".</p> <p>2. Review of facility accounting records revealed Resident C had expired on 06/25/13 and had a balance in the resident account of \$35.00. Review of the accounting statement revealed the \$35.00 was still in the account and status was "Pending Close on 01/27/14".</p> <p>Interview, on 02/12/14 at 1:00 PM with the Corporate Financial Manager revealed she had identified during an audit, that the facility Business Office Manager had failed to close Resident B's and Resident C's account within the thirty day requirement after the residents had expired. She stated the Business Office Manager had simply over looked the accounts and was provided inservicing on 02/07/14. The cooperate financial manager additionally revealed the accounts still had not been closed.</p> <p>Interview with the Administrator, on 02/13/14 at 3:00 PM, revealed resident accounts were to be closed according to State and Federal regulations.</p>	F 160	<p>3. The Administrator provided training to the Business Office Manager on 2/7/2014 on F160 Conveyance of Funds. One time a month for three months an audit of all residents' accounts will be completed to ensure upon death of a resident with a personal fund deposited with the facility the funds have been conveyed. This will be completed by the Business Office Manager.</p> <p>4. One time a month for three months an audit of all resident accounts will be completed to ensure upon death of a resident with a personal fund deposited with the facility the funds have been conveyed. This will be completed by the Business Office Manager. The Administrator will also review residents' accounts with the Business Office Manager one time a month for 3 months to ensure that funds have been conveyed to the individual or probate jurisdiction administering the residents' estates. The results of these audits will be reviewed with the Quality Assurance Committee</p>	
F 332 SS=D	<p>483.26(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p>	F 332		

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F 332	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the facility's Do not crush list, and the facility's policies it was determined the facility failed to ensure it was free of a medication error rate of five percent or greater. Observation of three (3) medication passes on two (2) different days revealed a total of thirty-three (33) opportunities with two (2) errors which resulted in a six percent (6%) error rate. Observation of a medication pass on 02/13/14 revealed two (2) extended release medications were crushed and administered to one (1) unsampled resident (Resident A).</p> <p>The findings include:</p> <p>Review of the facility's policy guide titled, "Medication Pass Administration", not dated, revealed staff should ensure accurate dosage form and not crush medications that should not be crushed. The guide additionally revealed, "If a drug contains SR (slow release), XL (long acting), or EC (enteric coated) in its name, it should not be crushed or opened.</p> <p>Review of the "Common Oral Dosage Forms That Should Not Be Crushed", dated 2013, revealed medications that were not to be crushed which included Nisoldipine (anti-hypertensive) ER and Potassium Chloride (for low potassium) ER.</p> <p>Record review revealed the facility readmitted Resident A on 02/11/14. Review of the Physician's orders, dated 02/11/14, revealed to administer Nisoldipine ER 8.5 milligrams (mg.) tablet once a day and Potassium chloride 10</p>	F 332	<p>monthly to ensure ongoing compliance. If at any time concerns are identified the Quality Assurance Committee will convene for further recommendations. The Quality Assurance Committee will consist at a minimum the Director of Nursing, Administrator, Business Office Manager, Assistant Director of Nursing, Dietary Services Manager, Maintenance Director, Activities Director, and Social Services Director. The Medical Director will attend at least quarterly.</p> <p>F332 Free of Medication Error rates of 5% or more. : 5. 3/16/2014</p> <p>1. Resident #11's guardian and physician were notified by Licensed Nursing on 2/14/2014 of the medications that were crushed, and the resident was monitored for decreased blood pressure and irritation from crushed Potassium, with no concerns noted. On 2/17/14 LPN #1 was observed by the Director of Nursing administering medications with no concerns identified. On 2/17/2014 an observation for medication for Resident #11 was completed by the Director of Nursing. No medications were crushed and medications were administered as ordered by the physician.</p>	
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F 332	Continued From page 3 millequivalents (mEq.) twice a day. Further review of the Physician's orders revealed the medications were "NOT TO BE CHEWED OR CRUSHED" and "DO NOT CRUSH".  Observation of a medication pass, on 02/13/14 at 8:45 AM, revealed Resident A was administered via a gastrostomy tube (G-Tube) Nisoldipine ER 8.5 mg, and Potassium Chloride ER 10 mEq. that were crushed and mixed with water and instilled into the resident's G-tube.  Interview with Licensed Practical Nurse (LPN) #1, 02/13/14 at 9:00 AM, revealed she knew the Nisoldipine ER and the Potassium Chloride were not supposed to be crushed. The LPN stated the resident had been taking medications whole and by mouth, the G-tube was very recently placed, and the resident was not NPO (nothing by mouth). The LPN gave no other explanation as to why she crushed the two (2) medications.  Interview with the Director of Nursing (DON), on 02/13/14 at 2:45 PM, revealed the Nisoldipine ER and the Potassium Chloride ER should never be crushed. She stated a list was provided to staff that listed the medications that were not to be crushed. She revealed the Nisoldipine ER could cause an acute drop in blood pressure and the Potassium Chloride could cause a resident to feel ill if given crushed.	F 332	2. A one time 100% audit of orders of residents' who are indicated to have medications that are to be crushed will be completed by the Assistant Director of Nursing/Director of Nursing to ensure medications and methods of administration are appropriate for that specific resident. The physician will be contacted for further orders, if needed. This will be completed by March 15, 2014. On 2/17/2014 the Director of Nursing completed Medication Administration observations with no concerns identified.  3. The Director of Nursing will provide training to Licensed Nurses on Medications that do not need to be crushed, and medication administration. Training will also be provided to Licensed Nurse by the Director of Nursing that if a resident is not able to take a medication that is not to be crushed, that the physician should be contacted for further orders. The training will be completed by March 15, 2014.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.	F 333		

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F 333	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, review of the Do Not Crush List and the facility's policy it was determined the facility failed to ensure one (1) unsampled resident ( Resident A), was free of any significant medication errors. Observation of a medication pass revealed the nurse crushed Nisoldipine ER (extended release) (anti-hypertensive) and administered it mixed with water to Resident A per gastrostomy tube (g-tube). The Pharmacist revealed crushing Nisoldipine ER would cause the medication to act more quickly and could cause the resident's blood pressure to drop to much.</p> <p>The findings include:</p> <p>Review of the facility's policy guide titled, "Medication Pass Administration", not dated, revealed to ensure medication was in accurate dosage form and to not crush medications that should not be crushed. The guide additionally revealed; If a drug contains SR (slow release), XL (long acting), or EC (enteric coated) in it's name, it should not be crushed or opened.</p> <p>Review of the "Common Oral Dosage Forms That Should Not Be Crushed", dated 2013, revealed a list of medications that were not to be crushed which included Nisoldipine ER.</p> <p>Record review revealed the facility readmitted Resident A on 02/11/14 with diagnoses which included Diabetes Mellitus, Hypertension, Dysphagia and Anemia.</p> <p>Review of the Physician's orders, dated 02/11/14, revealed staff should administer Nisoldipine ER</p>	F 333	<p>4. The Director of Nursing or Assistant Director of Nursing will complete medication administration five (5) per week for four (4) weeks, then weekly for eight (8) weeks to assure on going compliance with medication administration regulations. The results of these audits will be reviewed with the Quality Assurance Committee monthly to assure ongoing compliance. If at any time concerns are identified the Quality Assurance Committee will convene for review and further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Business Office Manager, Assistant Director of Nursing, Dietary Services Manager, Maintenance Director, Activities Director, and Social Services Director. The Medical Director will attend at least quarterly.</p>	5. 3/16/2014
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F 333	Continued From page 5 8.5 milligrams (mg.) once a day. The Physician's Orders also revealed "NOT TO BE CHEWED OR CRUSHED".  Observation of a medication pass, on 02/13/14 at 8:45 AM, revealed Licensed Practical Nurse (LPN) #1 crushed the Nisoldipine ER 8.5 mg. and mixed the medication with water. She then administered the medication to Resident A via G-tube.  Interview with LPN #1, on 02/13/14 at 9:00 AM, revealed she knew the Nisoldipine ER was not supposed to be crushed. She stated the resident had been taking medications whole and by mouth but recently had a G-tube placed and the resident was not NPO (nothing by mouth). The LPN gave no other explanation as to why she crushed the medication.  Interview with the Director of Nursing (DON), on 02/13/14 at 2:45 PM, revealed the Nisoldipine ER should never be crushed. She stated a list was provided to staff that listed the medications that were not to be crushed. She revealed the Nisoldipine ER could cause an acute drop in blood pressure.  Interview with Pharmacist #1, on 02/13/14 at 3:00 PM, revealed Nisoldipine ER should never be crushed. He stated administering the medication after crushing it would cause the medication to act more quickly and the medication was to be released over a twenty four hour period. He stated it could cause a person's blood pressure to drop too much.	F 333	F333 Residents free of significant Medication Errors  1. Resident #11's guardian and physician were notified by Licensed Nursing on 2/14/2014 of the medications that were crushed, and the resident was monitored for decreased blood pressure and irritation from crushed Potassium, with no concerns noted. On 2/17/14 LPN #1 was observed by the Director of Nursing administering medications with no concerns identified. On 2/17/2014 an observation for medication for Resident #11 was completed by the Director of Nursing. No medications were crushed and medications were administered as ordered by the physician.	
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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		
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F 371	<p>Continued From page 6</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy it was determined the facility failed to prepare and distribute food under sanitary conditions. Observation of a lunch meal service revealed kitchen staff hair restraints were not adequately restraining hair and hand washing/glove changing was not conducted. Additionally, beverages were left uncovered in the dining room during the meal.</p> <p>The findings include: Review of facility policy titled, "Food Service/Distribution", dated 2010, revealed Food service staff, including nursing services personnel, will wash their hands before serving food to residents. The policy also stated bare hand contact with food is prohibited. Gloves must be worn when handling food directly. However, gloves can also become contaminated and/or soiled and must be changed between tasks. Additionally, Dietary staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.</p>	F 371	<p>2. A one time 100% audit of orders of residents' who are indicated to have medications that are to be crushed will be completed by the Assistant Director of Nursing/Director of Nursing to ensure medications and methods of administration are appropriate for that specific resident. The physician will be completed for further orders, if needed. This will be completed by March 15, 2014. On 2/17/2014 the Director of Nursing completed Medication Administration observations with no concerns identified.</p> <p>3. The Director of Nursing will provide training to Licensed Nurses on Medications that do not need to be crushed, and medication administration. Training will also be provided to Licensed Nurse by the Director of Nursing that if a resident is not able to take a medication that is not to be crushed, that the physician should be contacted for further orders. The training will be completed by March 15, 2014.</p>	
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F 371

Continued From page 7

1. Observation of food tray preparation, on 02/12/14 at 12:20 PM, revealed Kitchen Staff #1 left the steam table where she was preparing resident food trays and went through a door to the dry storage area by opening the door with her gloved hand using the door knob. She returned to the kitchen through the same door using the door knob. She then opened the four compartment refrigerator and obtained sandwich meat in a plastic bag. She then reached into the bag, retrieved a piece of sandwich meat with the same gloved hand she had touched the door knobs and refrigerator handles with and made a sandwich for a resident. The sandwich was then served to a resident.

Further observation revealed there were three (3) staff in the kitchen that had hair restraints on but a large amount of hair was not covered on the top, sides and backs of their heads. One staff's restraint had slipped off exposing most of her hair as she circulated about the preparation area.

Interview with the Kitchen Staff #1, on 02/12/14 at 12:30 PM, revealed she should have changed her gloves after touching the door knobs and again after touching the refrigerator handles and had failed to do so.

2. Observation during the noon meal, on 02/12/14 at 12:40 PM, revealed four (4) pitchers of beverages on a rolling serving cart that were not appropriately covered leaving them exposed to contamination.

Interview with the Dietary Manager on 02/12/14 at 12:40 PM and 12:45 PM, revealed hair restraints often slip and the staff try to fix them. She stated the staff's hair was supposed to be completely

F 371

4. The Director of Nursing or Assistant Director of Nursing will complete medication administration five (5) per week for four (4) weeks, then weekly for eight (8) weeks to assure on going compliance with medication administration regulations. The results of these audits will be reviewed with the Quality Assurance Committee monthly to assure ongoing compliance. If at any time concerns are identified the Quality Assurance Committee will convene for review and further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Business Office Manager, Assistant Director of Nursing, Dietary Services Manager, Maintenance Director, Activities Director, and Social Services Director. The Medical Director will attend at least quarterly.

5. 3/16/2014

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F 371	Continued From page 8 restrained. The Dietary Manager revealed there was a concern with staff preparing food for residents with contaminated gloves and Kitchen Staff #1 should have stopped and changed gloves after touching the door knobs and refrigerator handles. In addition, she revealed it had not been the facility's practice to cover the beverage pitchers.	F 371	F371 Food Procure, store/prepare/serve-sanitary  1. On 2/18/2014, 2/25/2014, and 3/7/2014 observations were completed by the Dietary Services Manager that noted that all dietary employees had on hair restraints that were restraining all of their hair and the dietary staff were washing hands and changing gloves properly, per guidelines. On 3/7/2014 beverage pitchers were ordered by the Dietary Service Manager to ensure that the pitchers of beverages in the dining room would be appropriately covered at all times and to meet sanitation guidelines. The new pictures will be in place by 3/15/2014  2. On 2/12/2014, 2/25/2014, and 3/7/2014 observations were completed by the Dietary Services Manager that noted that all dietary employees had on hair restraints that were restraining all of their hair and the dietary staff were washing hands and changing gloves properly, per guidelines. On 3/7/2014 beverage pitchers were ordered by the Dietary Service Manager to ensure	

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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2682 CERULEAN RD. CADIZ, KY 42211		
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F371 Continued  
Lawn Leader  
Administrator  
3/21/14

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F 371	Continued From page 8 restrained. The Dietary Manager revealed there was a concern with staff preparing food for residents with contaminated gloves and Kitchen Staff #1 should have stopped and changed gloves after touching the door knobs and refrigerator handles. In addition, she revealed it had not been the facility's practice to cover the beverage pitchers.	F 371 Cont'd	ensure ongoing compliance. If at any time concerns are noted the Quality Assurance Committee will re-convene for review and further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Business Office Manager, Assistant Director of Nursing, Administrator, Business Office Manager, Assistant Director of Nursing, Dietary Services Manager, Maintenance Director, Activities Director, and the Social Services Director with the Medical Director attending at least quarterly.	5. 3/16/2014	

*Dawn Jeddler*  
*Adm.*  
*3/21/14*

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{K 000}	<p><b>INITIAL COMMENTS</b></p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 03/16/14 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(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	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1982, 1993</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: Three (3) smoke compartments.</p> <p><del>FIRE ALARM</del>: Complete fire alarm system with twenty-two (22) smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 02/12/2014. Shady Lawn Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty (50) beds and the census was thirty-eight (38) 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 \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*Ylawn Jeddler, Administrator* 3/21/14

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	K 000		
K 025 SS=E	<p>Deficiencies were cited with the highest deficiency identified at an "E" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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 observations 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 NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, all residents, staff and visitors. The facility is certified for fifty (50) beds and the census was thirty-eight (38) on the day of the survey. The facility failed to ensure one (1) smoke barrier was sealed around pipes, wires and complete to the roof to resist the passage of smoke.</p> <p>The findings include:</p> <p>Observations, on 02/13/14 at 10:01 AM with the</p>	K 025	<p><b>K025 Life Safety Code Standard</b></p> <ol style="list-style-type: none"> <li>The smoke barrier that was found to not be sealed around pipes, wires, and complete to the roof, to resist the passage of smoke, will be repaired according to the Life Safety Code Standards by the Maintenance Director by March 15, 2014.</li> </ol>	

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K 025	<p>Continued From page 2</p> <p>Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at the utility/electrical room was penetrated by pipes and wires and not sealed to prevent the transfer of smoke. Further observation revealed the wall was not complete at the bottom and top.</p> <p>Interview, on 02/13/14 at 10:01 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barriers as they have been inspected several times since the last survey. Further interview revealed he was unaware the wall was not complete at the top and bottom to be properly rated at the 30 minute fire resistive rating.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <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"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration</p>	K 025	<ol style="list-style-type: none"> <li>2. The Maintenance Director will complete a one time inspection of smoke barriers to ensure that there are no further smoke barriers that do not meet NFPA standards. The Maintenance Director will also inspect all walls to ensure that they are complete from bottom to top. Any identified concerns will be corrected by 3/15/2014 by the Maintenance Director.</li> <li>3. The Maintenance Director will be educated on the requirements for smoke barriers per NFPA regulations by the Administrator by 3/12/2014. One time a quarter the Maintenance Director will complete an inspection of smoke barriers to ensure that smoke barriers are meeting the NFPA standards. The results of these audits will be reviewed with the Quality Assurance Committee monthly to assure ongoing compliance. If at any time concerns are identified the Quality Assurance Committee will convene for review and further recommendations. The Quality Assurance Committee will consist of at a</li> </ol>	
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K 025	Continued From page 3 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  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: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025	minimum the Director of Nursing, Administrator, Business Office Manager, Assistant Director of Nursing, Dietary Services Manager, Maintenance Director, Activities Director, and Social Services Director. The Medical Director will be attending at least quarterly.	
K 029 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  One hour fire rated construction (with ¼ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 029	4. One time a quarter the Maintenance Director will complete an inspection of smoke barriers to ensure that smoke barriers are meeting the NFPA standards. The results of these audits will be reviewed with the Quality Assurance Committee monthly to assure ongoing compliance. If at any time concerns are identified the Quality Assurance Committee will convene for further recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Business Office Manager, Assistance Director of Nursing, Dietary Services Manager, Maintenance Director, Activities Director, and Social Services Director. The Medical Director will attend at least Quarterly.  5. 3/16/2014	

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K 029	<p>Continued From page 4</p> <p>determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twenty-four (24) residents, staff and visitors. The facility is certified for fifty (50) beds and the census was thirty-eight (38) on the day of the survey. The facility failed to ensure two (2) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 02/13/14 at 10:57 AM with the Maintenance Supervisor, revealed the Director of Nursing office and the dry storage room in the kitchen were not properly protected due to the storage located in the rooms. This requirement is due to the storage of combustible items inside the areas. The dry storage door in the kitchen had a string that was used to tie the door open not allowing the closer to work. The Director of Nursing office was not equipped with a door closer for protection.</p> <p>Interview, on 02/13/14 at 10:57 AM with the Maintenance Supervisor, revealed he was unaware of the amount of storage in the Director of Nursing office. Further interview revealed he was unaware of the string being used to hold the dry storage room opened.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas</p>	K 029	<p>K029 NFPA 101 Life Standard Safety Code</p> <ol style="list-style-type: none"> <li>The Maintenance Director has been completing observations of the kitchen supply/storage door on 2/13/2014, 2/14/2014, 2/17/2014, 2/18/2014, 2/19/2014, 2/20/2014, and 2/21/2014 to ensure that this door has not been propped open in any way. No problems have been noted and the kitchen/supply/storage door has not been propped open in any way. On 3/7/2014 the Administrator inserviced the Director of Nursing that her door is to remain closed until office space is cleared to meet NFPA standards. Office Space/all identified concerns will be cleared by the Maintenance Director and Director of Nursing by 3/12/2014.</li> <li>The Maintenance Director will do a one time inspection of offices/storage spaces within the facility to ensure any areas with combustible material will have a door closure installed. Identified concerns will be corrected by 3/15/2014.</li> </ol>	

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K 029	<p>Continued From page 5</p> <p>shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.6.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> <li>(1) Boiler and fuel-fired heater rooms</li> <li>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</li> <li>(3) Paint shops</li> <li>(4) Repair shops</li> <li>(5) Soiled linen rooms</li> <li>(6) Trash collection rooms</li> <li>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</li> <li>(8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard.</li> </ul> <p>Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or</p>	K 029	<p>3. The Maintenance Director will provide training to the facility's Management Staff on storage within their offices by 3/15/2014. The Administrator will re-educate the Maintenance Director on the requirement of door closures for areas that contain combustible material. This will be completed by March 15, 2014.</p> <p>4. One time a quarter, the Maintenance Director will do an inspection of offices/storage areas to ensure that the facility is meeting NFPA standards. The results of the inspection will be reviewed by Quality Assurance Committee monthly to assure ongoing compliance. If at any time concerns are identified the Quality Assurance Committee will convene for review and recommendations. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, Administrator, Business Office Manager, Assistant Director of Nursing, Dietary Services Manager, Maintenance Director, Activities Director, and Social Services Director. The Medical Director will be attending at least quarterly.</p> <p>5. 3/16/2014</p>	
K 143 SS=D		K 143		

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NAME OF PROVIDER OR SUPPLIER  SHADY LAWN NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2582 CERULEAN RD. CADIZ, KY 42211		
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K 143	<p>Continued From page 6 treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) In an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) In an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect one (1) of three (3) smoke compartments, twenty-four (24) residents, staff and visitors. The facility is certified for fifty (50) beds and the census was thirty-eight (38) on the day of the survey. The facility failed to ensure the oxygen transferring room was mechanically ventilated and had proper signage indicating trans-filling was occurring.</p> <p>The findings include:</p> <p>Observation, on 02/13/14 at 10:57 AM with the Maintenance Supervisor, revealed the room in which oxygen was being transferred did not have proper ventilation. The room was equipped with</p>	K 143	<p>K143 Life Safety Code Standard</p> <ol style="list-style-type: none"> <li>1. The mechanical vent in the room where oxygen is being filled and stored will be repaired by the Maintenance Director by March 15, 2014. Proper signage was placed door of room on February 12, 2014 by the Maintenance Director.</li> <li>2. This is the only room utilized for filling/storing of oxygen tanks/materials. The mechanical vent in the room where oxygen is being filled and stored will be repaired by the Maintenance Director by March 15, 2014. Proper signage was placed door of room on February 12, 2014 by the Maintenance Director.</li> <li>3. The Administrator will inservice the Maintenance Director for the need of signage on oxygen room and to ensure that the ventilation fan is checked one time a month (1) for proper functioning. This will be completed by March 15, 2014.</li> </ol>		

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:  185252	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  02/12/2014
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K 143	<p>Continued From page 7</p> <p>a mechanical vent but it was not functioning. Further observation revealed the oxygen trans-filling room did not have proper signage indicating trans-filling was occurring in the room.</p> <p>Interview, on 02/13/14 at 10:57 AM with the Maintenance Supervisor, revealed the room had the proper signage on it but was unsure of who removed the signage. Further interview revealed he was unaware of when the electrical fan had stopped working in the room.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.6.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</p> <p>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</p> <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.</p> <p>The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for</p>	K 143	<p>4. One time a quarter the Maintenance Director will inspect the room to ensure that the vent is functioning and signage remains in place. Licensed Nursing staff will be provided training by the Director of Nursing to immediately notify the Maintenance Director if the vent is not working. This will be completed by March 15, 2014.</p> <p>5. 3/16/2014</p>	
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K 143	Continued From page 8 the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143		