

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

PRINTED: 08/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 07/22/14 and concluded on 07/24/14. The facility was found not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "E".	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES This was a Nursing Home Initiative Survey with entrance to the facility on Tuesday, 07/22/14 at 7:45 AM. The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	1. Residents #14, #15, and #16, or their responsible parties, were immediately contacted by phone by the Social Services Director and informed of their rights to appeal. The Notice of Medicare Non-coverage was mailed to each of these residents by the Social Services Director by 8/13/14. 2. Social Services Director reviewed all Medicare discharges for the prior 30 days and informed each resident, or responsible party of his or her appeal rights, as necessary. All were notified by phone and letter by 8/13/14.	09/05/14

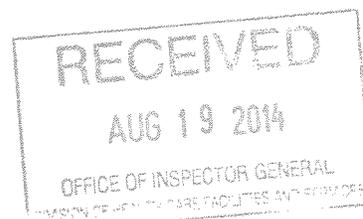
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X [Signature]* TITLE: *X Administrator X* (X6) DATE: *8/18/14*

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 156	<p>Continued From page 1</p> <p>Inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the</p>	F 156	<p>3. Administrator re-educated Social Services Director on proper procedure for the Issuance of Advanced Beneficiary Notices on 8/9/14 using the "SNF Beneficiary Notice Requirements" procedure manual issued by corporate office.</p> <p>4. Quality Assurance Nurse will audit 100% of Medicare discharges monthly for three months beginning August 2014, then 25% quarterly to ensure compliance. Quality Assurance Nurse will present results of audit at QA on 09/04/14 and not less than quarterly thereafter.</p>		



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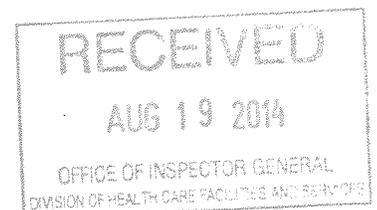
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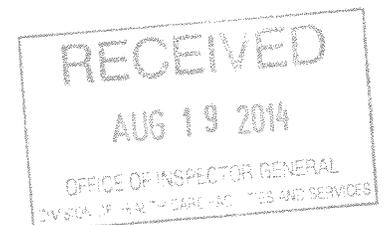
F 156	<p>Continued From page 2 facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and closed record review, it was determined the facility failed to ensure Medicare A residents were issued a "Notice of Medicare Provider Non-coverage" letter upon termination of all Medicare Part A services for three (3) of three (3) closed records reviewed, (Residents #14, #15 and #16). The facility failed to issue a non-coverage letter, with information on beneficiary appeal rights for those residents that were discharged from the facility after Medicare Part A services were terminated. The facility only provided that information to those residents who continued to reside in the facility after Medicare Part A services was terminated.</p> <p>The findings include: The facility did not provided a policy related to liability and appeal notices.</p>	F 156		
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F 156	<p>Continued From page 3</p> <p>Review of the facility's admission agreement revealed the facility provided information on how the resident could apply for benefits under Medicare and Medicaid.</p> <p>1. A closed record review for Resident #14 revealed the facility admitted the resident on 06/18/14 for skilled services under Medicare Part A. The record revealed the resident was discharged to home on 07/04/14 with skilled days remaining. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>2. A closed record review for Resident #15 revealed the facility admitted the resident on 07/02/14 for skilled services under Medicare Part A. The record revealed the resident was discharged to home with home health on 07/11/14 with skilled days remaining. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>3. A closed record review for Resident #16 revealed the facility admitted the resident for skilled services under Medicare Part A on 07/03/14. The record revealed the resident was discharged to home with home health services on 07/12/14 with skilled days remaining. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>Interview with the Bookkeeper, on 07/24/14 at 12:05 PM, revealed she was not responsible for providing the Liability Notices & Beneficiary Appeal letters issued to facility residents at the time of discharge. She stated the Social Worker</p>	F 156			



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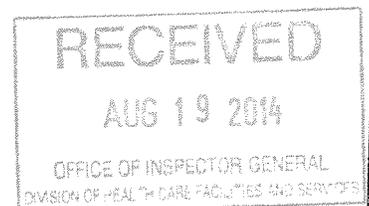
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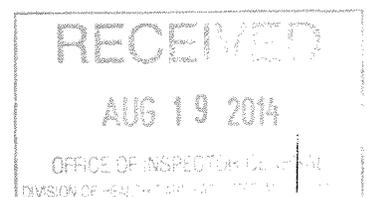
F 156	<p>Continued From page 4 actually issued the letters.</p> <p>Interview with the Social Service Director, on 07/24/14 at 1:47 PM, revealed she was responsible for Liability Notices & Beneficiary Appeal letters after a resident's Medicare Part A skilled services were terminated. She did not issue to residents who were there for rehab and chose to go home. She stated she only issued those letters to residents who would remain in the facility and she would issue the notice when the skilled service would end. She further stated she was not trained to issue the notice to residents that were discharged to home.</p>	F 156		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to implement their abuse policy as it related to</p>	F 226		



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F 226	<p>Continued From page 5</p> <p>misappropriation of resident property for one (1) of sixteen (16) sampled residents (Resident #10). The facility failed to complete an investigation or make a report to the state agencies per their policy when Resident #10 reported seventy (\$70.00) dollars missing from his/her purse/wallet.</p> <p>The findings include:</p> <p>Review of the facility's Abuse Policy, undated, revealed the facility had a zero tolerance for any acts of abuse. The policy was devised to prohibit mistreatment, neglect, abuse of residents and misappropriation of resident property. Events that should be reported and investigated included misappropriation of funds/property.</p> <p>Review of the facility's supplement to the Abuse policy, titled Reporting any Reasonable Suspicion of a Crime, dated 05/17/11, revealed reasonable suspicion of a crime must be immediately reported to the Manager on Duty. The Manager on Duty would conduct an investigation and would report the event to the appropriate agencies. Under the heading Procedure: Investigating the initial report of a reasonable suspicion of a crime, the Manager on Duty shall make a written report of the findings of the investigation.</p> <p>Interview with Resident #10, on 07/22/14 at 1:30 PM, during the Quality of Life Assessment Group Interview, revealed he/she had seventy (\$70.00) dollars missing from his/her room back in April 2014. He/she stated the money was in his/her purse/wallet in the closet of his/her room. He/she stated the missing money was reported to the facility and replaced by the facility.</p>	F 226	<ol style="list-style-type: none"> 1. Resident had already been reimbursed lost money and given a personal lock box for her room on 4/26/14. 2. Administrator met with Social Services Director on 8/9/14 to ensure there were no current reports of missing money, and reported information to the appropriate agencies, as necessary. 3. The Vice President for Clinical Services re-educated Administrator on the proper procedures for investigating and reporting missing money on 8/9/14. The Social Services Director will report all missing items to the Administrator for appropriate action. The Administrator will notify State agencies, as appropriate. 4. Administrator will audit "missing items" reports weekly for three months, then monthly for three months, then quarterly until compliance is sustained. Administrator will report results of audit at QA on 9/04/14 and not less than quarterly thereafter. 	09/05/14	



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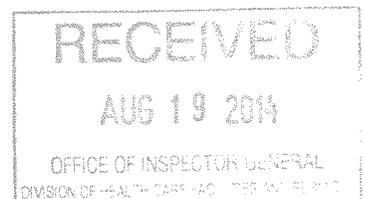
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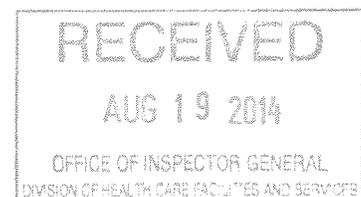
F 226	Continued From page 6 Clinical record review for Resident #10 revealed the facility admitted the resident on 06/28/13 with diagnoses of Parkinsons Disease, Dementia, Hypertension, Osteoarthritis, and Peripheral Vascular Disease. The facility completed an Annual Minimum Data Set (MDS), on 03/15/14 and assessed Resident #10's cognition status using the Brief Interview for Mental Status (BIMS). The resident scored fifteen (15) of fifteen (15) on the BIMS test meaning the resident was cognitively intact. The facility completed a Quarterly MDS, on 06/15/14 and reassessed Resident #10's cognition status as still intact with a score of thirteen (13) out of fifteen (15) on the BIMS test. Review of the Missing Item Report, dated 04/22/14, completed by the Social Services Director revealed \$73.00 cash was missing from Resident #10's purse/wallet. However, the resident in interview stated it was \$70.00. The money was reported as last seen on 04/19/14 and identified as missing on 04/21/14 per Resident #10. The document stated the resident felt another resident's family member (took the money) and that was all he/she felt comfortable saying. The document stated the room was searched by the Activities Director and the Social Services Director without money being found. The money was replaced by the facility. Review of the Social Services Progress Notes, dated 04/22/14, revealed Resident #10 reported money missing that morning. The notes stated the room was searched and the money was not found. The resident believed the money was taken by another resident's family member. The notes revealed the Administrator was aware and the money would be replaced.	F 226		
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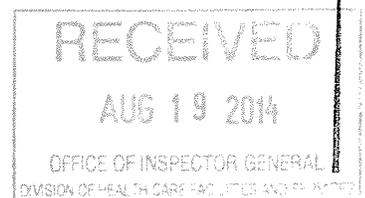
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F 226	Continued From page 7 Interview with the Director of Social Services, on 07/23/14 at 12:30 PM, revealed she did get a report during a morning meeting of Resident #10's missing money a few months back. She reported, she and the Activities Director did search the resident's room for the missing money, which was not found. She stated, she made the Administrator aware of the missing money and knew the money was replaced. She stated her only involvement was searching the room with the Activities Director. She stated she documented everything in the chart. Interview with the Administrator, on 07/24/14 at 5:10 PM, revealed he was made aware of the money Resident #10 had missing. He stated Social Services assisted with the investigation. He stated they did investigate the missing money; however, did not have the interviews written down. He stated since it did not involve the facility staff, he just didn't report the missing money to the outside agencies. The resident told him he/she may have misplaced the money. He stated he gave the resident \$72.00 because of the discrepancy in the amount reported, the resident reported \$70.00 and the incident report stated \$73.00, so he knew the \$70.00 was covered. He stated, according to the regulation, he should have reported the misappropriations of the resident's property.	F 226			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253			



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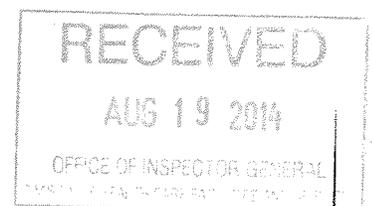
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F 253	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's work orders, it was determined the facility failed to ensure repairs to walls, base boards, and doors were completed on two (2) of two (2) units by maintenance. The findings include: Interview with the Maintenance Director, on 07/24/14 at 2:30 PM, revealed there were no policies for the Maintenance Department. He stated the facility practice was for employees to document any request for repairs in the maintenance book and he checked off the requests as he completed the jobs. Observations of the facility, on 07/22/14 at 7:45 AM, revealed the finish on the head board of Room 2 Bed 1, had worn away in areas. There were multiple rusty looking areas on the bedside commode, the closet doors were off the track, and a dark brown substance was on the base board in the bathroom. The finishes on the foot board and bedside chest were coming off in Room 8. In addition, there was no pull cord on the overbed light. The walls in Rooms 11, 13, 14, 15, 16, 21, 22, 24, 32, and 41 were scuffed, marked and pieces of wall board were missing. In Rooms 18, 20 and 21 there were numerous nails in the wall along with foam stickers and nail holes. Observations of the facility, on 07/24/14 at 10:20 AM, revealed the baseboards were off the wall in Room 21. Rooms 22 and 17 had cracked caulking and holes around the air conditioning	F 253	<ol style="list-style-type: none"> All cited areas repaired by the Maintenance Director by 8/15/14. Bedside commodes with surface rust near the bottom were discarded. Maintenance Director inspected all headboards, commodes, closet doors, chests, caulking, walls, and floor tile in the building and made repairs as necessary by 8/15/14. Maintenance Director re-educated by Administrator on 7/22/14 regarding need to keep up on minor repairs. Maintenance Director or assistant will perform, and document, formal daily rounds to identify any new areas in need of repair beginning 8/15/14. Administrator will audit daily maintenance rounds monthly to ensure work performed, and will present results of monthly audits at QA on 9/4/14 not less than quarterly thereafter. 	09/05/14	



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F 253	<p>Continued From page 9</p> <p>units. The caulk around the sink in Room 18 did not make a seal. Room 27 had a hole in the wall by the paper towel dispenser. Floor tile was missing in the bathroom of Room 24. A sprinkler pipe suspended from the ceiling in Room 22 above Bed 1 had been painted white; however, the pipe over Bed 2 had not been painted. The walls and baseboard in the South dining room were covered with a dried substances. The doors to Rooms 14 and 18 were covered with tape residue.</p> <p>Observation of the South Hall, on 07/24/14 at 10:45 AM, revealed torn and missing wall paper in the hallway outside Rooms 32, 34, 35, 37, 38, 39, 41, and 42.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 07/23/14 at 2:20 PM, revealed when something was broken she completed a work request in the maintenance book and the problem was fixed. She stated she never entered a work request for scuffed walls or holes in walls. She indicated the residents should live in a nice room.</p> <p>Interview with CNA #5, on 07/23/14 at 2:42 PM, revealed some rooms looked worn out. She stated she entered a work request in the book if something was broken. She indicated she did not write work requests for holes in walls. She stated the resident's room was their home.</p> <p>Interview with the Maintenance Director, on 07/24/14 at 2:30 PM, revealed he was free to purchase supplies and whatever else was needed when they were needed. He stated he requested permission from the Administrator for purchases over five hundred (500) dollars. He stated he had a maintenance assistant that</p>	F 253			



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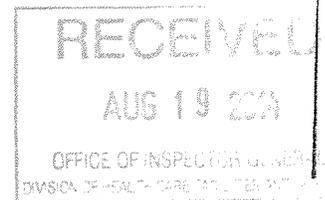
PRINTED: 08/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2014
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NAME OF PROVIDER OR SUPPLIER GREEN VALLEY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1206 ELEVENTH STREET CARROLLTON, KY 41045
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F 253	Continued From page 10 worked five (5) days a week. He indicated that formal rounds of the facility were not made; however, he was up and down the halls all day every day. He revealed no cause for the disrepair of the facility.	F 253		09/05/14
F 280 SS=D	Interview with the Administrator, on 07/24/14 at 3:40 PM, revealed no information regarding the disrepair the facility was in. He and the corporate office were aware of the need for repairs and had discussed a potential redo for 2016 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280	<ol style="list-style-type: none"> Care Plan Coordinator reviewed and updated care plans for residents #3 and #8 ensuring appropriate assessments and interventions on 07/24/14. MDS Coordinator and IDT reviewed all current care plans to ensure all specific needs were identified and care planned appropriately. This was completed on 08/13/14. MDS Coordinator and IDT re-educated on the MDS process and care plan process by Director of Nursing on 08/13/14. Quality Assurance Nurse will audit all completed care plans each week for 4 weeks, then will audit 25% of all assessments completed monthly for 2 months, then 25% quarterly to ensure that specific needs are identified and care planned. Results of the audits will be reported at QA on 09/04/14, and not less than quarterly thereafter. 	



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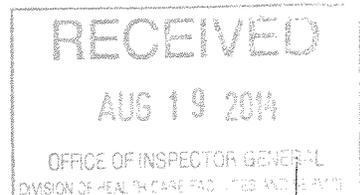
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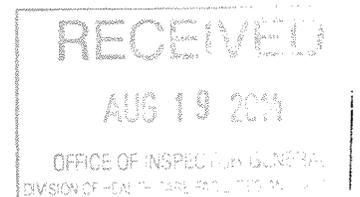
F 280	<p>Continued From page 11</p> <p>by: Based on observation, interview, record review, and review of the facility's Infection Control policies, it was determined the facility failed to revise the care plan for two (2) of sixteen (16) sampled residents (Residents #3 and #8) to address Resident #3 in Contact Precautions, was noncompliant, and refused care. The facility further failed to address Resident #8 on palliative care and was declining.</p> <p>The findings include:</p> <p>Review of the facility's policy for Care Planning, dated 04/08/13, revealed the care plan was reviewed and revised with resident status changes. Interventions were specifically what you would do for the resident: devices, treatments, adaptive equipment, special preferences, modifications to Standards of Care, and techniques used to modify behaviors. The care plan would be realistic, individualized, specific, measurable, and attainable. Care plans were revised with changes as they occurred and not days and weeks later. Care plans were dated and initialed with each entry.</p> <p>1. Observation of Resident #3, on 07/22/14 at 7:52 AM, and at 8:35 AM, revealed the presence of two (2) red hazardous containers next to the resident's bed.</p> <p>Observation of Resident #3, on 07/22/14 at 10:30 AM, revealed the resident now had an overbed table sitting outside the room with a box of gloves and a package of disposable gowns on top.</p> <p>Review of the clinical record for Resident #3, revealed the facility admitted the resident with</p>	F 280		
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F 280	<p>Continued From page 12</p> <p>diagnoses of Diabetes, Hypothyroidism, Anxiety, and Depression. The facility completed a Quarterly Minimum Data Set (MDS) assessment on 05/04/14 which revealed the resident was cognitively intact, was verbally abusive to others, required extensive assistance with activities of daily living and received anti-depressants, anti-anxiety, and hypnotics.</p> <p>Continued review of the clinical record revealed the resident tested positive for C. Diff and received treatment on 04/09/14, 04/29/14 and on 05/26/14.</p> <p>The resident was on a Vancomycin (antibiotic) Protocol for Clostridium Difficile (C. Diff) infection discovered on 07/08/14.</p> <p>Review of the care plan for Resident #3, revealed Resident #3 had a C.Diff infection in the stool. Interventions included: Vancomycin, monitor for healing of infection, treatments as ordered and assess for isolation precautions if indicated. Specific interventions for completion of contact isolation were not located. The resident refused to use a bedside commode, a bedpan or get out of bed to use the bathroom and refused care frequently. In addition, the care plan revealed the resident went to church and outside to visit with other residents on the porch.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on 07/23/14 at 12:01 PM, revealed Resident #3 refused to use the bedside commode, bedpan or bathroom and was incontinent of stool and urine all the time.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/24/14 at 3:00 PM, revealed the care plan for Resident #3 did not contain specific</p>	F 280			



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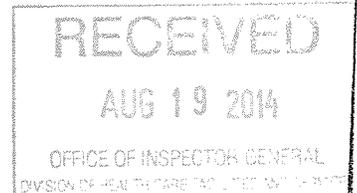
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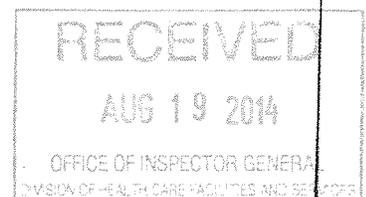
F 280	<p>Continued From page 13</p> <p>interventions for the resident's isolation or noncompliance with care. She stated the care plan goals were not measurable and interventions were not labeled as to which discipline was accountable for completing the interventions to prevent the spread of infection to other residents. She stated the resident required isolation and therefore, would not go to church or to a gathering on the front porch.</p> <p>2. Observation of Resident #8, on 07/22/14 at 11:25 AM, revealed a frail looking thin resident propelling self around the common area and picking at a lap buddy.</p> <p>Review of the clinical record for Resident #8, revealed the facility admitted the resident with diagnoses of Alzheimer's Disease, Anxiety, and Congestive Heart Failure. The facility completed a Quarterly MDS Assessment on 06/04/14 which revealed the resident had a severe cognitive impairment, required extensive assistance with all activities of daily living and was incontinent of bowel and bladder. The resident received an anti-anxiety medication.</p> <p>Review of the care plan for Resident #8, revealed the resident received palliative care. Interventions were not located for palliative care as ordered by the physician and included: Do Not Resuscitate, comfort measures, no hospital, no intravenous fluids or drugs, no feeding tube, no labs, no consults and no tests.</p> <p>Interview with LPN #1, on 07/24/14 at 2:45 PM, revealed there were no interventions to address Resident #8's palliative care and the resident needed more services to ensure the resident's needs were met especially with sons living out of</p>	F 280		
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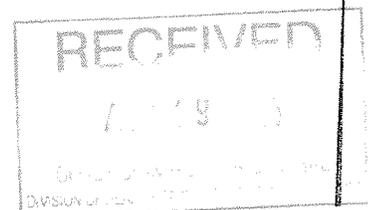
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F 280	Continued From page 14 town.	F 280			
F 281 SS=D	<p>Interview with the Director of Nursing, on 07/24/14 at 2:50 PM, revealed her expectations were for the care plan to be complete.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy for care planning, it was determined the facility failed to develop an initial admission care plan to meet the needs of one (1) of sixteen (16) sampled residents (Resident #11). The care plan did not address pain and constipation for Resident #11.</p> <p>The findings include: Review of the facility's policy for Initial Care Plans, dated 04/08/13, revealed a standard template was used on admission to direct the care of the resident until a comprehensive care plan was developed. A standard template was used to serve as the initial care plan and nurse aide care plan. There were no other directives for admission care plans; however, further review of the facility's Care Plan policy revealed the components of a care plan included problems, goals and interventions.</p> <p>Review of the clinical record for Resident #11, revealed the facility admitted the resident with</p>	F 281	<ol style="list-style-type: none"> Care Plan Coordinator reviewed and updated care plans for resident #11 ensuring appropriate assessments and interventions on 07/24/14. MDS Coordinator and IDT reviewed all current care plans to ensure all specific needs were identified and care planned appropriately. This was completed on 08/13/14. MDS Coordinator and IDT re-educated on the care plan process by Director of Nursing on 08/13/14. The IDT will review each new admission care plan weekly for three weeks to ensure all needs are identified and care planned appropriately. 	09/05/14	



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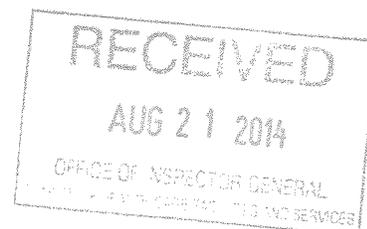
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F 281	Continued From page 15 diagnoses of Cerebral Vascular Accident, Hypertension, Constipation, Left Side Weakness and Peptic Ulcer. The facility admitted the resident on 07/07/14 and the Admission Minimum Data Set (MDS) Assessment had not yet produced a comprehensive care plan. New orders to change medications for constipation were obtained from the physician on 07/16/14. In addition, new orders were obtained from the physician on 07/18/14 for pain medication. Review of the admission care plan for Resident #11, revealed a check off sheet listing care to be provided by the nurse aide. These items included glasses, contact guard of one (1) when ambulating, turn every two (2) hours, assist with toileting, and incontinence of bladder not frequent. There was no evidence the facility identified constipation or pain as problems that required the attention of the physician. In addition, the care plan contained no evidence of goals for the interventions listed. Interview with Licensed Practical Nurse (LPN) #1, on 07/24/14 at 2:45 PM, revealed the admitting nurse did the admission initial care plan and any updates. She stated the care plan was a standardized template plan that turned into a nurse aide care plan after the comprehensive care plan was completed. She stated this was the corporation's policy for the facility. Interview with Director of Nursing, on 07/24/14 at 2:45 PM, revealed her expectation was for residents' care plans to be thorough and meet the residents' needs.	F 281	4. Quality Assurance nurse will audit all new admission care plans weekly for 4 weeks, then will audit 25% of all new admissions monthly for 3 months, then 25% of new admission care plans quarterly to ensure all care plans are in place and updated with appropriate interventions. Results of the audits will be reported at QA on 09/04/14, and not less than quarterly thereafter.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			



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F 441	Continued From page 16 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 infection.	F 441	1. Director of Nursing ensured PPE was available for all staff to use on 7/22/14. Staff cited as non-compliant were re-educated by Director of Nursing and Staff Development Coordinator on 7/22/14. All mini nebulizer and oxygen tubing was cleaned and properly stored on 7/22/14. The procedure for passing ice amended to include sanitizing hands prior to touching each pitcher on 7/25/14. 2. Director of Nursing audited all residents with contact isolation to ensure proper PPE is in place on 7/22/14. The Director of Nursing audited all respiratory equipment to ensure proper cleaning and storage on 7/22/14. Ice pass procedure amended to include sanitizing hands prior to touching each pitcher on 7/25/14. 3. The Staff Development Director will re-educate all staff on 8/19/14 and 8/21/14 on contact precautions, donning PPE, hand washing, cleaning and storing oxygen tubing, and the change in facility procedure for passing ice.	09/05/14	



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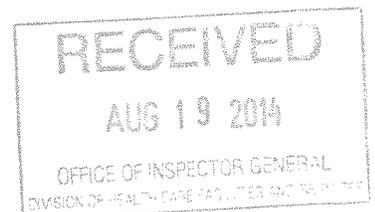
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F 441	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's policies regarding Infection Control, it was determined the facility failed to follow contact isolation precautions for one (1) of sixteen (16) sampled residents, (Resident #3). The facility failed to ensure Personal Protective Equipment (PPE) were available for staff use in the isolation room for Resident #3. The staff failed to follow handwashing policies while passing ice to multiple residents on the North and South halls. In addition, the facility failed to ensure oxygen supplies were stored in a clean manner.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's Transmission Based Precautions policy, undated, revealed contact precautions were taken to reduce the spread of infection through direct and indirect contact. Clostridium Difficile (C. Diff) caused contact precautions to be used. These precautions included the use of equipment dedicated solely for the resident's use, and protecting the removal of infected waste. The policy did not include work practice guidelines for staff to use in contact isolation involving C. Diff. <p>Observation during tour of Resident #3, on 07/22/14 at 7:48 AM, revealed the resident was in bed with the call light in reach. There were two (2) red trash cans against the wall. In addition, a sign asking visitors to see the nurse before entering the room was propped up on the handrail outside the room. There was no evidence of personal protective equipment (PPE) in the area.</p>	F 441	<ol style="list-style-type: none"> Quality Assurance nurse will audit 100% of residents in contact isolation for appropriate infection control procedures weekly for four weeks, monthly for three months, then quarterly. The Quality Assurance nurse will audit all oxygen and mini nebulizer equipment for proper storage weekly for four weeks, then monthly for three months, then quarterly. The Quality Assurance nurse will audit ice pass weekly for four weeks, then monthly for three months, then quarterly. The Quality Assurance nurse will report results of audits at 9/4/14 QA meeting then not less than quarterly thereafter. 		



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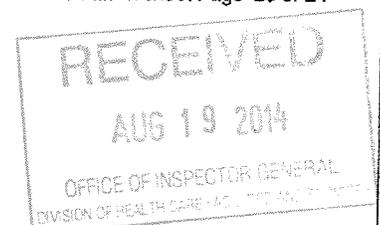
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F 441	<p>Continued From page 18</p> <p>Observation of Resident #3, on 07/22/14 at 8:52 AM, revealed no PPE was found in the area.</p> <p>Observation of Resident #3, on 07/22/14 at 10:35 AM, revealed an overbed table with gloves and gowns had been placed in the hallway outside the door of Resident #3's room.</p> <p>Review of the clinical record for Resident #3, revealed the facility admitted the resident with diagnoses of Diabetes, Hypothyroidism and Anxiety. The facility completed a Quarterly Minimum Data Set (MDS) Assessment on 05/04/14 which revealed the resident was cognitively intact, required extensive assistance with dressing and bathing, was nonambulatory, and incontinent of bowel and bladder. Laboratory reports revealed the resident had positive C. Diff cultures and required treatment with a series of antibiotics on 04/09/14, 04/29/14, 05/26/14 and 07/08/14.</p> <p>Review of the care plan for Resident #3, revealed the resident had a C.Diff stool infection and staff was to assess the resident for isolation precautions if indicated.</p> <p>Interview with Registered Nurse (RN) #2, on 07/22/14 at 11:05 AM, revealed Resident #3 tested positive for the C. Diff toxins and was on a Vancomycin (antibiotic) regimen. She stated staff was required to use a gown and gloves prior to entering the resident's room and to wash hands with soap and water before leaving the room to prevent the other residents from becoming sick.</p> <p>Observation of Licensed Practical Nurse (LPN) #4, on 07/22/14 at 3:33 PM, revealed she entered</p>	F 441			



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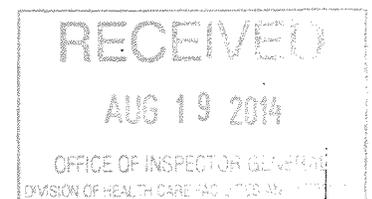
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F 441	<p>Continued From page 19</p> <p>Resident #3's room without PPE. She reappeared at the door and asked Certified Nurse Aide (CNA) #4 to help her. They both entered the room without PPE. They repositioned the resident then used Alcohol sanitizer on their hands and left the room.</p> <p>Interview with CNA #4, on 07/22/14 at 3:38 PM, revealed she did not see the sign or the PPE. She stated she did not know the reason Resident #4 required isolation and no gloves were needed to reposition a resident. She stated she had been educated on isolation sometime in the past; however, she was not sure of when that occurred. She used alcohol sanitizer to clean her hands. She stated she should have used a gown and gloves to prevent the spread of germs to the other residents.</p> <p>Interview with LPN #4, on 07/22/14 at 3:43 PM, revealed she did not use PPE when entering Resident #3's room as she planned to not make contact with the resident. She stated she did pull the resident up in bed using a draw sheet and her clothing was in contact with the resident's bed linen. She stated she did not use soap and water to clean her hands after assisting the resident. She stated she had been educated on isolation and infection control; however, she was not aware that C. Diff was not killed by alcohol sanitizer. She stated she should have followed isolation policies to prevent the spread of infection to others.</p> <p>2. Observation of the Dietary Aide passing fluids to residents, on 07/23/14 at 10:17 AM, revealed she entered Resident #3's room after she dressed in PPE. When finished, she placed the gown and gloves in the red trash and walked</p>	F 441			



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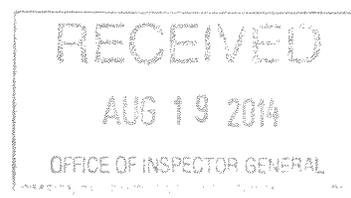
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2014
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F 441	<p>Continued From page 20</p> <p>across the hallway and entered Room 115 where she washed her hands and turned the faucet off with her bare hand. She then continued with the fluid pass.</p> <p>Interview with the Dietary Aide, on 07/23/14 at 10:17 AM, revealed she left Resident #3's room to wash her hands because that sink was in the room with the germs. She stated she forgot and turned off the faucet with her bare hand. She stated she had been educated regarding infection control and handwashing.</p> <p>3. Observation of Maintenance, on 07/23/14 at 11:34 PM, revealed he dressed in PPE before entering Resident #3's room. When finished, he walked out of the room into the hallway in the PPE and used the sleeve of the gown to wipe his forehead. He did not wash his hands before leaving the room.</p> <p>Interview with Maintenance, on 07/23/14 at 10:17 AM, revealed he had been educated regarding isolation; however, he could not remember when that occurred. He stated he was not comfortable with isolation procedures.</p> <p>Interview with the Advanced Practice Registered Nurse (APRN), on 07/23/14 at 11:45 AM, revealed Resident #3 continued to require Contact Isolation until the antibiotics were completed to be considered safe. She stated the antibiotic protocol was new and since the resident had multiple C. Diff infections, completion of the protocol was important.</p> <p>Interview with the Director of Nursing, on 07/24/14 at 3:30 PM, revealed she had no</p>	F 441			



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F 441	<p>Continued From page 21</p> <p>information regarding the staff not following Contact Precautions. She stated there were policies for Contact Isolation and staff were educated on these policies. She stated the policy did not include specifics on C. Diff.</p> <p>4. Observation of Room 14-1, on 07/22/14 at 8:15 AM, revealed the minineb oxygen tubing was in direct contact with the floor. In Room 27, the oxygen equipment bag was resting on the floor.</p> <p>Observation of Room 27, on 07/22/14 at 9:05 AM, revealed the resident's oxygen tubing directly on the floor. In Room 26, A minineb mask and mouth piece were stored on top of a cabinet uncovered.</p> <p>Interview with LPN #3, on 07/23/14 at 3:10 PM, revealed the staff had been educated to ensure oxygen supplies and tubing were covered when not in use to prevent contamination of the supplies with other organisms that might make the resident sick.</p> <p>5. Review of the facility's Standard Precautions policy, effective date 08/01/12, revealed Standard Precautions would be used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presumed that all blood, body, secretions, excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Standard precautions would apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases.</p>	F 441		



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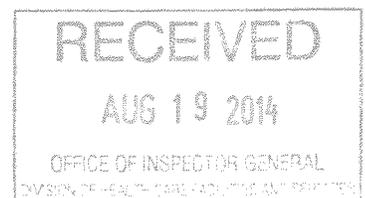
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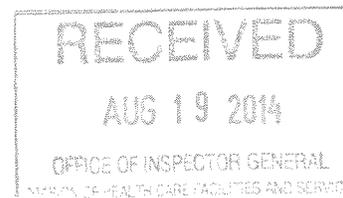
F 441	<p>Continued From page 22</p> <p>Hands would be washed with soap and water whenever visibly soiled with dirt, blood, body fluids or after direct or indirect contact with such, and eating and after using the restroom. Wash hands after removing gloves. Wear gloves when handling or touching resident-care equipment that is visibly soiled or potentially contaminated with blood, body fluids or infectious organisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another resident. Wash hands immediately to avoid transfer of microorganisms to other residents or environments.</p> <p>Review of A Patient's Guide, Hand Hygiene Saves Lives pamphlet provided by the facility, undated; however, identified as a pamphlet from the Center for Disease Control (CDC) revealed hand hygiene was the #1 way to prevent the spread of infections. The pamphlet further stated the healthcare provider should practice hand hygiene every time they enter the resident's room.</p> <p>Observation of the Nurse Aide Educator, on 07/22/14 at 9:30 AM, revealed her passing ice and water to the individual resident rooms on the South Hall. The resident rooms on South Hall were semi-private living arrangements. She pushed an ice cart down the corridor. She wore gloves as she entered into resident room 41 and obtained the resident's ice and water containers. Upon completing ice and water delivery in resident room 41, she then proceeded to resident room 32, wearing the same gloves. She poured out the water in the water pitchers, added water and proceeded to the ice cart in the corridor. She added ice to the water pitchers and proceeded to resident room 33, wearing the same gloves and</p>	F 441		
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F 441	<p>Continued From page 23 without hand hygiene.</p> <p>Informal interview with the Nurse Aide Educator, on 07/22/14 at 9:40 AM, revealed she did not routinely pass the ice and fill the water pitcher. She stated she was helping the unit out and making sure everyone had fresh ice and water.</p> <p>Observation of the Nurse Aide Educator, on 07/22/14 at 10:40 AM, revealed her passing ice and water to the individual resident rooms on the North Hall. She wore gloves during ice and water pass. She was observed in resident room 14 wearing gloves. She approached the ice cart, obtained ice and returned to resident room 14. Upon exit of resident room 14, she continued to wear the same gloves and did not practice hand hygiene. She proceeded into resident room 15 wearing the same gloves and tended the ice/water pitcher without hand hygiene.</p> <p>Interview with the Nurse Aide Educator, on 07/24/14 at 4:40 PM, revealed she used gloves during the ice and water pass as that was the practice of the facility. She stated she was not touching the resident and that was not a problem to wear the same gloves while passing ice and water. She stated she did instruct the aides to wear the gloves during water pass.</p> <p>Interview with the Director of Nurses, on 07/24/14 at 5:00 PM, revealed the practice of the facility was to wear gloves while completing water and ice distribution. She stated she knew they had been cited in the past for not wearing gloves during the process, so they wear the gloves. She reported the staff was not touching the resident so it was not a problem to wear the same gloves.</p>	F 441		



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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: 1977, 1989, 2007</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V Unprotected.</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator installed in 2005. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 07/22/14. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility had seventy-eight (78) certified beds and the census was seventy-four (74) 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			

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

TITLE

(X8) DATE

X Alan M. Wade

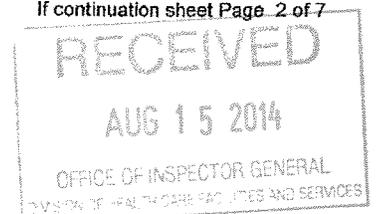
X Administrator X 8/15/14

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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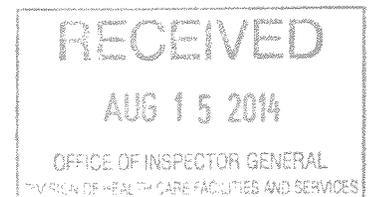
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K 000	Continued From page 1	K 000			
K 029 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved 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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of (4) smoke compartments, residents, staff and visitors. The facility had seventy-eight (78) certified beds and the census was seventy-four (74) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/22/14 at 8:04 AM, with the Director of Maintenance revealed the door to the Janitor Closet located on the Laundry Room, did</p>	K 029	<ol style="list-style-type: none"> Maintenance Director installed automatic closers on janitor closet in laundry area and on the two mechanical rooms in the Activities area by 8/13/14. Maintenance Director removed all items from mechanical closet in Activities room on 7/22/14. Maintenance Director removed wooden wedge from dry storage room in kitchen on 7/22/14. All doors in facility leading to potentially hazardous areas checked to ensure automatic door closers in place and functioning properly by Maintenance Director on 7/24/14. All mechanical rooms inspected for inappropriately stored items and, remedied as necessary, on 7/24/14. All doors with self-closing devices inspected to ensure none were chocked open by Maintenance Director on 7/24/14. 	09/05/14	



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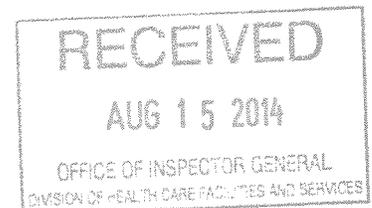
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K 029	<p>Continued From page 2</p> <p>not have a self-closing device installed on the door and had two (2), one (1) inch diameter holes on each side of the interior walls.</p> <p>Interview, on 07/22/14 at 8:06 AM, with the Director of Maintenance revealed he was not aware the door to the Janitor Closet was not equipped with a self-closing device and indicated that a rod previously used to hang mop heads had been removed approximately one (1) month ago and had not been sealed with a fire rated sealant. He acknowledged the room was not capable of resisting the passage of smoke in the event of an emergency.</p> <p>Observation, on 07/22/14 at 8:53 AM, with the Director of Maintenance revealed the door to the Dry Storage Room, located within the Kitchen, was propped open with a wood wedge and the door could not be closed because of carts being placed in the door swing area.</p> <p>Interview, on 07/22/14 at 8:55 AM, with the Director of Maintenance and the Dietary Manager revealed the door was being held open with a wood wedge to stock supplies delivered earlier that morning. The carts are routinely moved in and out of the storage room throughout the work day and should have been placed back in the storage room, allowing the self-closing device to close and latch the door as required in hazardous storage rooms.</p> <p>Observation, on 07/22/14 at 9:03 AM, with the Director of Maintenance revealed the door to the Mechanical Closet located in the Activities Room, contained two (2) gas-fired air handling units that did not have a self-closing device installed on the</p>	K 029	<p>3. Maintenance Director re-educated on regulation by Regional Maintenance Director on 08/14/14 and will add inspection of automatic door closers to his monthly preventative Maintenance checklist. Dietary staff re-educated by Administrator on 7/22/14 regarding chocking open doors in rooms with self-closing devices. Formal daily rounds will be conducted, and documented, by the Maintenance team.</p> <p>4. Administrator will audit daily maintenance rounds monthly to ensure work performed, and will present results of audit at QA on 9/4/14 and not less than quarterly thereafter.</p>		



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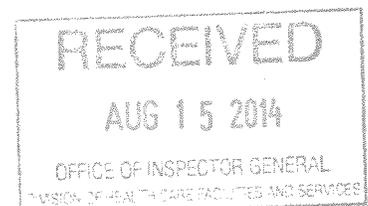
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K 029	<p>Continued From page 3</p> <p>door and the systems electrical disconnect switch was obstructed by boxes of combustible materials stored within the room.</p> <p>Interview, on 07/22/14 at 9:05 AM, with the Director of Maintenance revealed he was not aware the door to the Mechanical Room was not equipped with a self-closing device and acknowledged that three (3) feet of clearance was required for access to the disconnect switch. He was not aware the Activities Staff had stored boxes of materials within the Closet and acknowledged the potential hazard of improperly stored materials.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas 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 19.3.5.4. 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: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops</p>	K 029			



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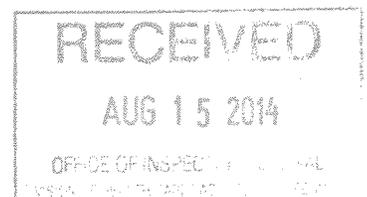
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K 029	Continued From page 4 (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of NFPA 101 LIFE SAFETY CODE STANDARD	K 029	<ol style="list-style-type: none"> Late fire system inspection was due to a change in contractors. The 3/5/14 quarterly inspection revealed no issues. Quarterly fire system inspections audited back 12 months by Maintenance Director on 7/22/14, and no other instances of being late were found. Administrator re-educated Maintenance Director on 7/22/14 on regulations regarding sprinkler system inspections. Maintenance Director will use TELS preventative maintenance tools to track the due dates of inspections to ensure inspections are timely. Administrator will audit quarterly fire system inspections quarterly and report results at QA on 9/4/14 and not less than quarterly thereafter. 	09/05/14
K 062 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 interview and record review, it was determined the facility failed to have quarterly inspections and testing performed on the automatic sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the four (4) smoke compartments, residents, staff, and visitors. The facility had seventy-eight (78) certified beds and the census was seventy-four (74) on the day of the survey. The findings include: Review of the automatic sprinkler system, on 07/22/14 at 10:57 AM, with the Director of Maintenance revealed the facility had not conducted quarterly inspections and testing in a timely manner and had exceeded the time frame to have quarterly inspections performed on the automatic sprinkler system. The fourth quarter inspection for 2013 was performed on 10/17/13 and the first quarter inspection of 2014 was performed on 03/05/14 by a new contractor, an	K 062		



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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
K 062	<p>Continued From page 5 approximate five (5) month period had elapsed between quarterly inspections.</p> <p>Interview, on 07/22/14 at 10:59 AM, with the Director of Maintenance revealed the five (5) month period between quarterly inspections was a result of the facility's decision to hire a new contractor to maintain the automatic sprinkler system and perform quarterly inspections and testing.</p> <p>The census of seventy-four (74) was verified by the Administrator on 07/22/14. The findings were acknowledged by the Administrator and the Director of Maintenance during the Exit Conference on 07/22/14</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>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. 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 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</p>	K 062		



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

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

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K 062	Continued From page 6 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	K 062			

