

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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F 000 INITIAL COMMENTS

F 000

A standard health survey was initiated on 08/13/13 and concluded on 08/15/13 and a Life Safety Code survey was conducted on 08/13/13 with deficiencies cited at the highest scope and severity of an "F", with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.

This Plan of Correction is the center's credible allegation of compliance.

In addition, an abbreviated survey was conducted 08/13/13 -08/15/13 in conjunction with the standard survey to investigate KY20567. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law

F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

F 156 F-156

09.25.13

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.

1. Resident #16 and A no longer reside at the center.
2. An audit of all residents was conducted by the Case Manager (CM) on 08.15.13 currently covered by Medicare to ensure timely notice of services if applicable.
3. The Case Manager (CM) was re-educated on 08.19.13 by District Director of Case Management of Facility's procedures to ensure notice is provided, orally or in writing, and documented on a timely basis.

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

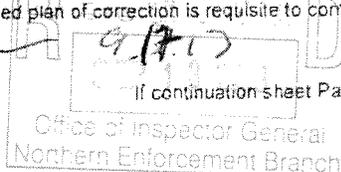
The CM will attempt to provide in-person notice of non-coverage to the resident or representative. If CM is unable to provide in-person notice, the CM will attempt to telephone the resident or representative.

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 the 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 Continued From page 1
and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section

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.

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,

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.

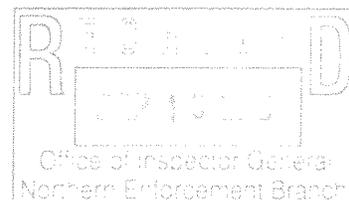
A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit, and a statement that the resident may file a complaint with the State survey and certification

F 156 If the CM provides in-person or telephone notice, CM will document that direct-contact notice in the resident's chart; confirm its occurrence by noting its occurrence (and date of occurrence) on a copy of a written notice to the resident/representative; mailing a copy of the confirming written notice to the resident/representative; maintain a tracking form recording that the notice was mailed that date; retaining a copy of the confirming notice and mailing envelope; placing a dated copy of the confirming notice and tracking information in the resident's financial file.

If the CM is unable to provide direct-contact notice to the resident/representative, CM will document attempts on the resident's chart; note the attempts on a written notice; send the notice to the resident/representative by certified mail, return receipt requested; retain a copy of the dated notice and mailing envelope; maintain a tracking form recording that the notice was mailed that date and if and when the notice was received by addressee or returned by post office; place a dated copy of the written notice and tracking information in the resident's financial file.

4. The CM will present the results of the tracking form to the Performance Improvement Committee for review and actions as indicate for three months or until the Committee determines compliance has been sustained.

Executive Director to monitor for continued compliance.



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F 156

agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

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

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and review of the facility's Notice of Medicare Non-Coverage policy, it was determined the facility failed to notify one (1) of sixteen sampled residents (Resident #16) and one (1) of seven (7) Unsampled Resident, (Unsampled Resident A) prior to the date that Medicare benefits would terminate.

The findings include

Review of the facility's policy regarding Notice of Non-Coverage (NONMC), dated 04/09/12, revealed the form Notice of Medicare Non-Coverage (CMS 10123-NOMNC) stated the notice was issued two-days prior to the discontinuation of Medicare Services for Medicare based insurance coverage. The notice instructed the resident of their appeal rights.



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F 156

Review of Resident #16's Notice of Medicare Non-Coverage letter, during the Demand Bill Review, revealed the resident's current therapy services would end on 08/05/13; however, the letter was not signed until 08/05/13, the same day as the services ended.

In addition, review of Unsample Resident A's Notice of Medicare Non-Coverage letter, revealed the resident was issued a notice that current therapy services would end, on 08/12/13; however, the letter was not signed until 08/13/13, 1 day after the services had ended.

Interview with the Utilization Review Coordinator (URC), on 08/15/13 at 3.30 PM, revealed she was responsible for issuing the Notices of Medicare Non-Coverage. The UR Coordinator stated she notified the family one week prior to when Medicare services would be discontinued. She stated she would leave a phone message requesting the families to come in to sign the notice letter. If they did not come in, she would send a certified letter. The UR Coordinator stated that families were notified verbally, however, she could not provide any evidence that the notices were provided verbally.

F-160

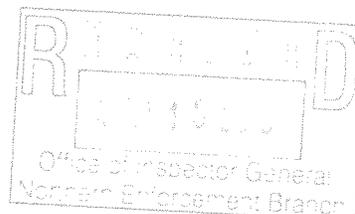
1. It is the practice of this facility to convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate upon the death of a resident with a personal account deposited with the facility. Refunds have been completed on Resident D, E, F and G; and, these residents no longer reside at the facility.

09.25.13

F 160 483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH

F 160

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



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F 160 Continued From page 4

F 160

This REQUIREMENT is not met as evidenced by:

Based on interview, and review of the facility's policy, and trust fund account documentation, it was determined the facility failed to convey funds from resident trust fund accounts in a timely manner upon the death of four (4) of seven (7) unsampled residents (Unsampled Residents D, E, F and G).

The findings include:

Review of the facility's policy regarding Resident Trust Statements/Discharges and Medicaid, revised on 09/01/05, revealed per Federal Regulations, upon the death of a resident with a Resident Trust Fund deposited with the facility, the facility must disburse the resident funds within 30 days, and a final accounting of those funds, to the responsibility party, state agency or probate jurisdiction administering the estate.

1. Review of Unsampled Resident D's Trust Account revealed the resident had deceased on 06/09/13; however, the facility failed to convey funds to the responsible party until 07/18/13, or 9 days past the 30 day period.

2. Review of Unsampled Resident E's Trust Account, revealed the resident expired on 06/03/13, however, the funds were not dispensed until 07/18/13, or 15 days late.

3. Review of Unsampled Resident F's Trust Account, revealed the resident expired on 02/19/13; however, the resident's trust account was not dispensed until 05/08/13, or 48 days late.

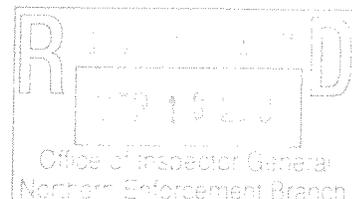
2. The Business Office Manager conducted an audit on all resident accounts on 09.05.13 and completed refunds as applicable.

3. The Business Office Manager was re-educated regarding resident funds, resource limits, surety bond and appropriate disbursement of funds by the Regional Manger of Field accounting on 08.16.13.

The Business Office Manager will audit Resident Trust Fund and discharge records at monthly closeout to determine disbursement needs and validate compliance.

4. The results of this audit will be discussed at the monthly Performance Improvement Committee Meetings for three months or until the Committee determines compliance has been sustained.

Executive Director to monitor for continued compliance.



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F 160 Continued From page 5 F 160

4. Review of Unsamped Resident G's Trust Account, revealed the resident expired on 01/09/13; however, the trust account was not conveyed until 02/28/13, or 20 days late.

Interview with the Business Office Manager, responsible for reconciling accounts, on 08/15/13 at 2:00 PM, revealed she knew resident trust fund accounts were to be closed within 30 days of a resident's death; however, stated that since May 2013, she had been doing the payroll for the facility, due to an employee leaving. The Accountant stated she had been doing two jobs, and just didn't have the time. The Manager stated there was no one else to do her job, and acknowledged the accounts should have been closed within 30 days.

F 248 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES

The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to provide ongoing activities to meet the residents' interests and psychosocial well-being for three (3) of seventeen (17) sampled residents (Residents # 4, 5, and 9) and two (2) of seven (7) unsampled residents (Unsampled Residents A and B). The facility after assessing Resident #4, #5, and #9 as enjoying

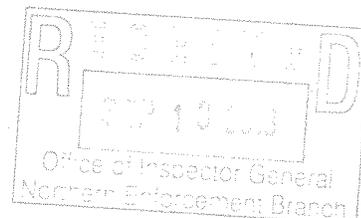
F-248

09.25.13

Resident #4, #5, #9, and unsampled resident A and B had their activity preferences reviewed by the Activity Director and/or Social Services Director with their care plans updated to reflect their interests regarding outdoor activities. The interventions for Resident #4, #5, #9, and unsampled A and B were added to the SRNA assignment sheets to communicate their interests to the direct care staff.

The center's activity calendar has been revised by the Activity Director to allow at least one outing a quarter for residents with input from the Resident Council as to outing locations.

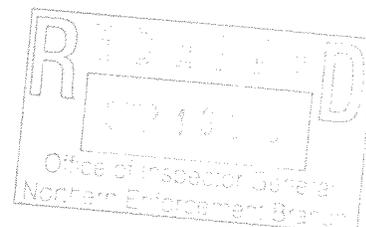
All current interviewable residents were interviewed by the Activity Director and/or Social Services Director on activity preferences with outside activities. Any residents expressing a desire for increased outdoor activities will have their care plan updated by the Activity Director and/or Social Services Director with interventions that allow their wishes to be honored.



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F 248	Continued From page 6 multiple different outdoor activities, failed to afford the residents the opportunity to enjoy outdoor activities without the supervision of staff or family. In addition, interview with Unsampled residents A and B revealed they also liked sitting on the porch, however, review of the activity calendar for June, July, and August 2013 revealed outdoor activities were only offered one time a week on Wednesday. The findings include: Review of the Activity Program policy, revised 06/30/06, revealed a resident's interests and needs would be identified and a recreational activity program would be designed to appeal to his or her interests and enhance the residents highest practicable level of physical, mental and psychosocial wellbeing. The recreation program occurs within the context of each resident's comprehensive assessment and care plan and reflects each individual resident's needs and preferences. During the Group interview meeting, on 08/13/13 at 2:00 PM, revealed Unsampled residents A and B voiced a concern regarding no planned outing or outside activities were offered this summer. The residents stated they were not allowed to go outside without staff. On Wednesdays, the activity department would take the residents outside to the Gazebo for about an hour. The other five residents in attendance validated the residents' concerns. Review of the facility's activity calendar for June, July, and August 2013 revealed no outings from the nursing facility were scheduled. In addition, the only outdoor activity planned for those three	F 248	Inservices will be conducted by the Staff Development Coordinator RN and Activity Director with all nursing staff regarding the posted calendars and SRNA assignment sheets identifying resident activity preferences and requesting assistance ensuring all residents receive adequate help to get them to the activities of their choice beginning 09.09.13. No nursing staff member will be allowed to work if they have not received the education by 09.24.13 until they have received the education. Resident attendance sheets will be checked by the Activity Director against the calendar and individual residents' interests when they are filed in the medical records at the end of each month to ensure residents are attending those events of interest to them and are being afforded the opportunity to enjoy outdoor activities routinely if applicable. The Activity Director will monitor resident attendance and participation in activities of interest on a monthly basis as well as residents' satisfaction with activities based on the Resident Council monthly meeting. A report on the findings will be brought to the monthly Performance Improvement Committee for three months or until the Committee determines compliance has been sustained. Executive Director to monitor for continued compliance.		



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F 248 Continued From page 7

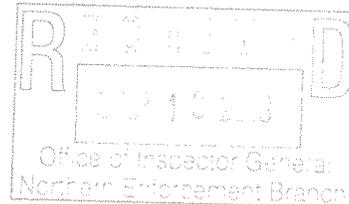
F 248

months was an hour each Wednesday at the Gazebo. A watermelon social was provided on July 29 th, however, that event was held inside in the facility's dining room. A sundae social was provided on June 14th, again it was held in the dining room. A search of the activity calendar revealed no outside activities were provided excluding the one hour each Wednesday

1. Review of Resident #5's medical record revealed the facility admitted the resident on 08/22/12 with diagnoses of a history of Stroke, Diabetes, Depressive Disorder, and Seizure Disorder. Review of the most recent Minimum Data Set (MDS) assessment, dated 07/31/13, revealed the facility assessed the resident to have no cognitive loss with a Brief Interview of Mental Status (BIMS) score of 15 correct answers out of 15. The MDS assessment revealed the resident required extensive assistance with transfers and locomotion. The record revealed the resident made his/her own healthcare decisions.

Review of the activity care plan, revised 11/26/12, revealed the resident's activity interest included sitting outdoors, bird watching, and eating out. The care plan revealed some of the past activities the resident enjoyed were hiking, walking, and photography.

Interview with Resident #5, on 08/14/13 at 2:15 PM, revealed the resident was satisfied with the activity program except for not being able to go sit on the front porch. The resident stated it was a facility rule that staff or family had to be present whenever a resident went outside. The resident continued to say the facility staff was too busy to stop and take the resident outside. The resident attended the outside activity offered each



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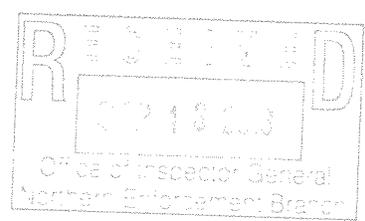
F 248 Continued From page 8 F 248

Wednesday, but would like to go outside more often. The resident stated she/he was an outdoor person and loved to watch the birds.

Review of the activity participation log for Resident #5 revealed the resident was assisted outdoors on June 5, 12, 24, and 26th, July 13, 24, and 31 th, and August 7th with most of those days being on Wednesdays.

Interview with the Activity Director, on 08/15/13 at 2:00 PM, revealed she was new to this position but had assisted the previous activity director. She revealed there used to be more outings scheduled for the residents, mostly restaurants, but the activity budget was small and transportation was costly. She revealed there were no outings scheduled for June, July, or August. She had been told the corporation was looking into purchasing a van for outings; however, that had not occurred to date. She revealed the only outside activity planned was the weekly outside trip to the Gazebo located at the back of the facility. She indicated she had been informed all residents were required to be supervised when outdoors. She stated multiple residents had complained to her about wanting to go outdoors and sit on the front porch. The staff tried to take the residents outside time permitting and those with families can sit on the porch with them. She indicated she had spoken with the Administrator regarding the residents' request to go outside and she was concerned about resident rights.

During an interview with the Administrator, on 08/15/13 at 2:25 PM, he confirmed residents were not allowed to go outside unsupervised. This included all residents. He stated the front



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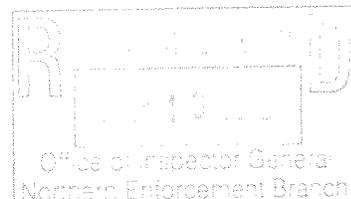
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 248 Continued From page 9 F 248

porch was very close to a busy street and he feared the residents would take off into the street and get hit by a car. He stated that was a decision he made regarding residents' safety. He stated a resident could go outside with family onto the front porch, but the family must sign the resident out. The Administrator stated the residents could sign them selves out and leave the facility. However, no resident could walk onto the front porch and sit without staff or family to supervise. That included those like Resident #5 who had no cognition loss. When asked about the outside activities, the administrator stated there were times the activity department took residents outside, but all outside activities must be supervised by staff. He was aware that some residents wanted to sit on the front porch without supervision, and whenever they wanted. He restated the rule was for every resident to be supervised for safety.

2. Review of Resident #4's medical record revealed the resident had resided at the nursing facility since March 2009. Review of the most current MDS assessment, dated 07/24/13, revealed the facility assessed the resident to have severe cognitive deficit with a BIMS score of a six (6). Review of the activity care plan, revised 06/04/12, revealed the resident enjoyed country music, watching television, and talking/conversing

Observation of Resident #4, on 08/13/13 at 11:15 AM, revealed the resident laying in bed with no radio or television on. Later that day at 4:06 PM the resident was observed to be sitting in a wheelchair in the room with no radio or television playing. On 08/14/13, observations at 8:17 AM, 9:35 AM revealed the resident sitting in the room.



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/15/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42761
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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)	LSC COMPLETION DATE
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F 248 Continued From page 10 F 248

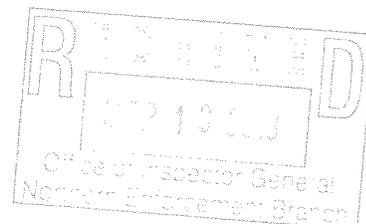
At 10:00 AM, the resident wheeled self to the nurses' station, but was not engaged in conversation with staff or other residents. At 11:08 AM, the resident was observed to be back in his/her room. No radio or television provided. At 2:40 PM through 3:10 PM, the resident was observed to be sitting in a wheelchair leaning forward with head resting on the bed with eyes closed. No music or television was playing.

Review of the activity participation log for June and July 2013 revealed the only activity charted for participation was talking/conversing/telephone and relaxation. On 08/14/13 a pet visit was provided and trips/shopping/outdoors was documented.

Interview with the Activity Assistant, on 08/14/13 at approximately 3:30 PM, revealed the resident was out of the room most of the time, but the television should be on whenever the resident was in the room. She stated the resident used to visit with the spouse, but the spouse died this year.

3. Review of Resident #9's Admission MDS, dated 09/17/12, revealed Resident #9's activity assessment stated Resident #9 enjoyed playing cards, church services, dancing, eating out, exercise, family time/visitors, fishing, keeping up with news/politics, listening to music, outdoor time, reading, running/walking, telling stories and watching movies/sports.

Observation of Resident #9, on 08/13/13 at 11:47 AM, 12:52 PM, 1:19 PM, 1:40 PM, 4:00 PM, 5:36 PM and 6:00 PM, revealed Resident #9 laying in the bed. Observation of Resident #9, on 08/14/13 at 8:30 AM, 10:00 AM, 11:00 AM, 2:00 PM, 3:00

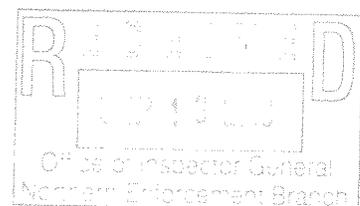


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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248	Continued From page 11 PM, revealed Resident #9 was in bed. Observation of Resident #9 on 08/15/13 at 2:15 PM revealed Resident #9 laying in bed. Review of the Activity Calendar, dated 08/14/13, revealed the outdoor activity was starting at 2:00 PM. Review of the Activity Calendar, dated 08/15/13 revealed Bingo was being played at 2:30 PM. Interview with Certified Nursing Assistant (CNA #3), on 08/15/13 at 2:27 PM, revealed she had offered Resident #9 to go to activities, but Resident #9 complains about his/her legs hurting. CNA #3 revealed the resident stayed in his/her room a lot and she thought it was the activity department's responsibility to ask the residents if they want to attend an activity. Interview with Licensed Practical Nurse (LPN #1), on 08/15/13 at 2:07 PM, revealed she had never seen anyone ask Resident #9 if he/she wanted to go to an activity. LPN #1 stated for the most part Resident #9 was very compliant with care. Review of the activity participation log, dated 08/02/13 at 2:59 PM, revealed the activity was talking/conversing/telephone and TV/radio/movies. On 08/03/13 at 10:28 AM, revealed the activity was TV/radio/movies and talking/conversing/telephone. Continued review of the activity participation log revealed TV/radio/movie or talking/conversing/telephone was the only activity documented as the resident participated in the whole month of August. Interview with the Activity Director, on 08/15/13 at 10:09 AM, revealed she documented twice a day what type of activities were completed for each	F 248		



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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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F 248 Continued From page 12
resident. The Activity Director stated she was educated to make sure to follow through with the plan of care. The Activity Director stated there was no documentation that Resident #9 was offered an activity and refused the activity. The Activity Director stated she was trying to review all the residents plan of care and was going to training the following week to make her job more efficient. The Activity Director stated she had not identified that Resident #9 was not being offered activities

F 248

F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES
SS=E

F 253

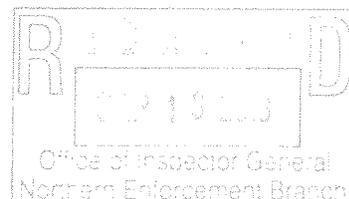
The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

F-253

09.25.13

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's maintenance system (work orders) revealed the facility failed to provide appropriate maintenance services to ensure eight (8) of sixty-four (64) wheelchairs utilized by residents were maintained in a sanitary and comfortable manner. Unsampled Resident C was observed sitting in a wheelchair with both wheelchair arms missing the plastic covering and soiled cotton padding exposed. In addition, further observation revealed seven (7) other wheelchairs with the plastic covering on the arms of the wheelchairs frayed, torn, and missing. Review of the work orders and interview with the Maintenance Director revealed he had not received any reports of wheelchairs in need of repair for torn fabric.

1. Resident C, #7, Residents in Rooms 4B, 9, 19A, 20B, 30A, and 42C wheelchairs will be repaired by 09.24.13 by Facility's Maintenance Supervisor and/or Maintenance Assistant.
2. An audit of all wheelchairs in use at the facility was conducted on 08.19.13 by Restorative CNAs; and all in need of repairs will be repaired as needed by 09.24.13.
3. The Maintenance Supervisor will add wheelchair appearance and condition to his weekly rounds to identify maintenance needs and develop a schedule to repair items noted during the rounds.



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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(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)

F 253 Continued From page 13
The findings include:

The facility did not provide a policy specific for maintaining wheelchairs. The facility utilized an intra-facility request for repairs or alterations forms (work order forms) to inform the maintenance department whenever a wheelchair was in need of repair.

Review of the work orders for the dates of the survey (August 13-15, 2013) revealed no work order form had been completed regarding the torn and frayed wheelchair arms.

Observation of the North Unit sitting area, on 08/15/13 at 3:00 PM, revealed Unsampled Resident C was sitting up in a wheelchair in the sitting area. Closer observation revealed the resident's wheelchair arms were missing the plastic covering on the majority of the arms with cotton fabric exposed that was soiled. Interview with the resident revealed the wheelchair had been in need of repair for some time.

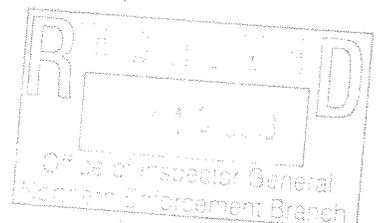
Continued observation revealed a broda chair (Room 19-A) with a large chunk missing from the left arm. Room 9's wheelchair had frayed and torn plastic covering to both arms. The resident in Room 20-B was sitting in a wheelchair with the left arm missing part of the plastic covering and the rest was frayed and cracked.

Observation of the South Unit, on 08/15/13 at 3:15 PM, revealed Resident #7's wheelchair had a frayed and cracked plastic covering to the right arm. The resident in Room 42-C was sitting in a wheelchair with the right and left arm plastic covering cracked and torn. The residents in Room 30-A and 4-B were sitting in wheelchairs

F 253 The Staff Development Coordinator and Maintenance Supervisor will in-service all staff on identifying and reporting maintenance needs including on wheelchairs. The Staff Development Coordinator will include information on identifying and reporting maintenance needs in the orientation of new employees. The Executive Director and Maintenance Supervisor will conduct weekly environmental rounds and cause the repair of items identified on these rounds.

4. The Maintenance Supervisor will present results of weekly environmental rounds to the Performance Improvement Committee for three months or until the Committee determines compliance has been sustained.

Executive Director to monitor for continued compliance.



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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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F 253 Continued From page 14
with the plastic covering torn and parts of the plastic covering was missing.

Interview with the Maintenance Director, on 08/15/13 at 3:20 PM, revealed he had not received any work orders to repair wheelchairs with torn or frayed plastic covering. He stated he had worked on Resident #7's wheelchair that morning for a mechanical problem, but had not noticed the frayed wheelchair arm. He stated most of the requests he received from nursing or the therapy department was for a mechanical problem and not fabric torn or frayed. He stated he would work on problems that involved safety of the resident first and then fix other problems. He revealed there were several spare wheelchair armrest in storage and he could have replaced the torn and frayed armrests. He indicated he made rounds of the building at the beginning of his work shift; however, he did not include looking at torn or frayed wheelchair armrest. He depended on nursing and therapy to inform him when a wheelchair was in need of repair.

F 253

Interview with the North Unit Manager, on 08/15/13 at 3:30 PM, revealed the nursing staff are supposed to inspect each resident's wheelchair daily whenever they place the resident into the chair. If the nursing staff found a wheelchair in need of repair, they are suppose to fill out a work order request for the maintenance department. She stated the wheelchairs were washed on a routine schedule each week. She indicated the above wheelchairs in need of repair would have been washed last week and the staff should have notified someone of the condition of the wheelchair armrests.

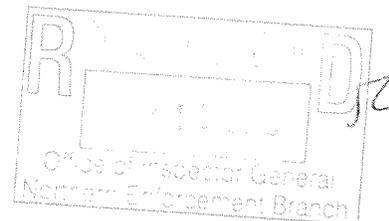
F 319 483.25(f)(1) TX/SVC FOR

F-319

09.25.13

1. Resident #8 was sent out for a psychiatric evaluation on 08.18.13 and returned on 08.29.13 and has continued to be followed by the psychiatric consulting group on 09.03.13.

F 319



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER
KINDRED NURSING AND REHABILITATION-WOODLAND

STREET ADDRESS, CITY, STATE, ZIP CODE
1117 WOODLAND DRIVE
ELIZABETHTOWN, KY 42701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 319 Continued From page 15
SS=D MENTAL/PSYCHOSOCIAL DIFFICULTIES F 319

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to obtain psychiatric services for one (1) of seventeen (17) sampled residents. The facility failed to ensure Resident #8 received a physician ordered psychiatric evaluation.

The findings include:

Review of the facility's Physician Orders Policy, dated 11/21/12, revealed the facility was to review the Performance Improvement Report to validate that orders were completed. No other policy concerning orders for psychiatric evaluations to evaluate or treat was provided.

Review of Resident #8's medical record revealed the facility admitted the resident on 08/15/12 with diagnoses of Dementia with Aggression and Anxiety. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/17/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating the resident was cognitively intact.

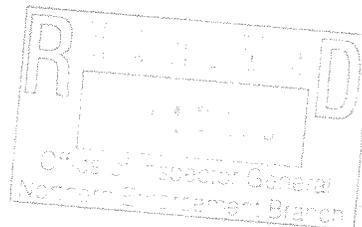
Review of the physician orders and nursing

2. Director of Nursing-RN will review physician orders from previous 60 days to validate any resident with orders for a psychiatric evaluation have been carried out in a timely manner. Any concerns will be immediately addressed.

3. The Licensed Nurses will be responsible for notifying Psychiatric Services via telephone and/or fax for any resident that receives a physician order for a psychiatric service consult.

All Licensed Nurses will be educated of their responsibility for notifying Psychiatric Services via telephone and/or fax when a physician order is received for a psychiatric service consult, beginning 09.06.13 by Director of Nursing-RN, Staff Development Coordinator-RN, and Unit Manager-LPN by the means of presentation.

Education will be on going until all licensed nurses has attended. No licensed nurse will be allowed to work after 09.24.13 without having been in serviced. This same education will be added to general orientation for all new licensed nurses that should be hired.



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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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F 319 Continued From page 16

progress notes for 07/02/13 revealed the physician saw the resident and gave a new order for a psychiatric consult related to increased anxiety and agitation. Continued review of the medical record revealed the psych consult had not been completed by 08/15/13.

Observation of Resident #8, on 08/13/13 at 8:45 AM, 10:30 AM, and 12:30 PM, revealed he/she was sitting up in bed unshaven, with long finger nails, and hair that was long and not groomed. The privacy curtain was pulled around the resident and the door to the resident's room was closed. Continued observation during the survey revealed the resident did not leave the room.

Interview with Resident #8, on 08/13/13 at 12:30 PM, revealed the resident wanted more Ativan (drug for anxiety), wanted to smoke, wanted the privacy curtain and the door to his/her room closed, and wanted to be left alone.

Interview, on 08/13/13 at 4:00 PM, with the Social Service Director (SSD), revealed the Nurse Practitioner from the the psychiatric consultant group saw the residents on every third Tuesday of the month. When an order for a Psych evaluation is received, it is placed in a binder for the Psychiatric Group to review upon their visits. She continued to state Resident #8 should have been seen on 07/16/13, the third Tuesday of the month and was uncertain of the reason the resident was not seen. The SSD revealed it was her responsibility to follow up to ensure Psych evaluations had been completed; however, she did not check the binder to see which residents are to be seen. She revealed the facility did not have a system in place to make sure psych evaluations were completed as ordered.

F 319

4. The Social Services Director, Weekend Supervisor-RN and/or Unit Manager-LPN will review all physician orders daily to identify any resident that receives an order for a psychiatric service consult and will at that time validate notification and will track this order daily until the resident receives the psychiatric services as ordered. The Social Services Director will conduct a monthly audit on any resident that receives an order for a psychiatric service consult to ensure notification and provision of Mental Health Services was delivered as ordered. Results of this monthly audit will be reported by the Social Services Director at least monthly for 3 months to the Performance Improvement Committee Meeting or until the Committee determines compliance has been sustained.

Executive Director to monitor for continued compliance.



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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND	STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701
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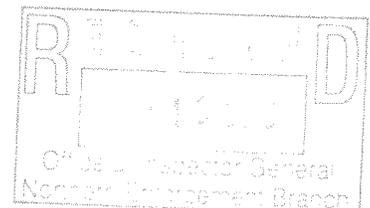
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F 319 Continued From page 17

F 319

Interview with the Nurse Practitioner from the psychiatric consultant group, on 08/14/13 at 11:40 PM revealed she had not received the referral to see the resident until 08/11/13.

Interview with the Director of Nursing, on 08/15/13 at 11:50 AM, revealed when a nurse receives an order for a Psych evaluation, the nurse would place a copy of the order in the Psychiatric binder and forward a copy to SSW. The DON indicated she was aware of the Psych order, but was uncertain who checked the binder to ensure those evaluations were completed.



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NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
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<p>K 000 INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected</p> <p>SMOKE COMPARTMENTS: Five (5) 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 (installed in 2009).</p> <p>A standard Life Safety Code survey was conducted on 08/13/13. Woodland Terrace Health Care Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid.</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> <p>Deficiencies were cited with the highest</p>	<p>K 000</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p style="text-align: right;">09.25.13</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ED/OHA DATE 09.01.13

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.

RW

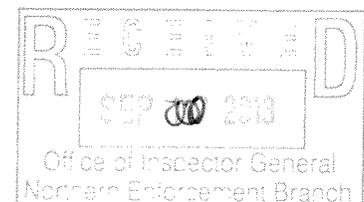
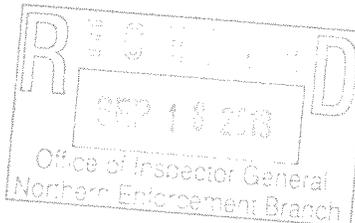


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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185118	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION-WOODLAND		STREET ADDRESS, CITY, STATE, ZIP CODE 1117 WOODLAND DRIVE ELIZABETHTOWN, KY 42701	
(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)

<p>K 000 Continued From page 1 deficiency identified at F level CFR: 42 CFR 483.70(a)</p> <p>K 025 NFPA 101 LIFE SAFETY CODE STANDARD SS=D 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 five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twelve (112) beds with a census of eighty three (83) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 08/13/13 at 10:20 AM, with the Maintenance Supervisor revealed the smoke barrier extending above the ceiling located in the North Hall next to room #16 to be penetrated by two (2) pipes. The penetrations were filled with</p>	<p>K 000 This Plan of Correction is the center's credible allegation of compliance.</p> <p>K 025 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>K25 9.25.13</p> <p>It is the practice of this facility to assure that all fire/smoke cubicles remain within compliance at all times to include: smoke barrier located in North hall next to room 16.</p> <p>The North hall smoke barrier was repaired on 08.13.13 using materials designed specifically for this purpose.</p> <p>Maintenance Supervisor or, if absent, the Maintenance Assistant will check work of contractors, working on or about smoke barriers, to confirm and document that barriers are intact or repaired.</p> <p>All smoke barrier walls will be inspected/ and/or sealed by 09.24.13 to ensure compliance throughout facility.</p> <p>All smoke/fire barrier walls will be inspected monthly for 3 months and quarterly thereafter.</p> <p>These inspections will be documented in the center Preventive Maintenance Log</p>
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K 025 Continued From page 2
unrated expandable foam.

Interview, on 08/13/13 at 10:20 AM, with the Maintenance Supervisor revealed he was not aware of the use of expandable foam

Reference: NFPA 101 (2000 Edition).

8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:

(a) The space between the penetrating item and the smoke barrier shall

1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or
2. Be protected by an approved device designed for the specific purpose.

(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

1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or
2. Be protected by an approved device designed for the specific purpose.

(c) Where designs take transmission of vibration 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.

K 027 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1½-inch thick solid bonded wood core. Non-rated

K 025

The Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance or until the Committee determines compliance has been sustained.

Executive Director to monitor for continued compliance.

K-27

K 027 It is the practice of this facility to assure that all door openings in smoke barrier walls are within compliance at all times to include: door to Therapy room.

09.25.13

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SEP 18 2013
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Northern Enforcement Branch

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SEP 17 2013
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Northern Enforcement Branch

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K 027 Continued From page 3
protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twelve (112) beds with a census of eighty three (83) on the day of the survey. The facility failed to ensure doors located in a smoke barrier had a self-closing device.

The findings include:

Observation, on 08/13/13 at 10:19 AM, with the Maintenance Supervisor revealed the door to the Therapy Room was part of the smoke partition and was not self-closing.

Interview, on 08/13/13 at 10:19 AM, with the Maintenance Supervisor revealed he was not aware the door to the Therapy Room was part of the smoke partition and required to be self-closing.

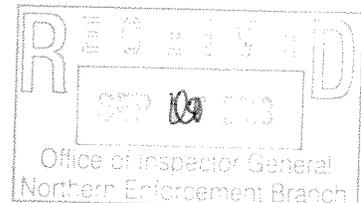
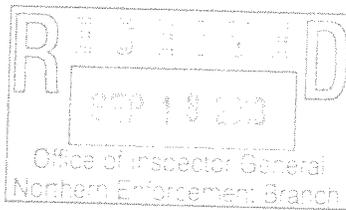
K 027
A Self closing device was installed on the therapy room door on 08.23.13. .

All other doors in this facility will be inspected and corrected as needed by 9.24.13.

All doors will be inspected and documented monthly during the Facility's routine Preventative Maintenance Room checks by the Maintenance Supervisor.

Life Safety Preventive Maintenance Logs will be reviewed by the PI Committee quarterly to ensure continued compliance or until the Committee determines compliance has been sustained.

Executive Director to monitor for continued compliance.



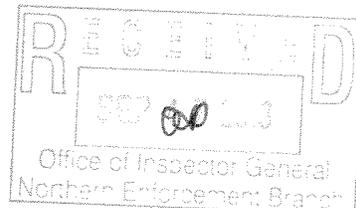
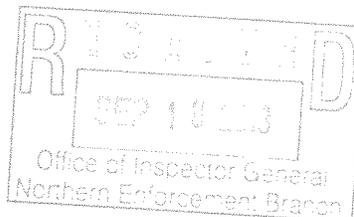
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K 027	Continued From page 4 Reference: NFPA 101 (2000 edition) 19.3.7.6* Requires doors in smoke barriers to be self-closing and resist the passage of smoke Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027		
K 029 SS-D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The	K 029	It is the practice of this center to assure that all hazardous locations are within compliance at all times to include: door separating soiled utility room from laundry room and door to South Unit Manager's office. Maintenance Supervisor educated by Executive Director, by 09.17.13, about K-29 requirements, cited deficiency, corrective actions, and preventative measures by their review of the SOD, facility's POC, and facility's preventative maintenance program and practices to assure that all hazardous locations are within compliance at all times to include: door separating soiled utility room from laundry room and door to South Unit Manager's office.	09.25.13

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K 029 Continued From page 5
deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twelve (112) beds with a census of eighty three (83) on the day of the survey. The facility failed to maintain self-closing doors protecting hazardous areas.

The findings include:

Observation, on 08/13/13 between 9:30 AM and 3:00 PM, with the Maintenance Supervisor revealed the door separating the soiled linen room from the laundry room had been removed. Further observation revealed the door the South Unit Managers Office did not have a self-closing device and the office had hazardous amounts of combustible storage.

Interview, on 08/13/13 between 9:30 AM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware of the requirements for protection from hazards.

8.4.1.3
Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.

Reference:
NFPA 101 (2000 Edition).

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

K 029 A Fire Rated self closing door to Soiled Linen room will be replaced with rated unit by 9.24.13.

A Self closing device will be installed on South Unit Manager's door by 09.24.13.

All doors will be inspected by Maintenance Supervisor by 09.06.13.

Any other doors found inadequate will be repaired or replaced by 09.24.13.

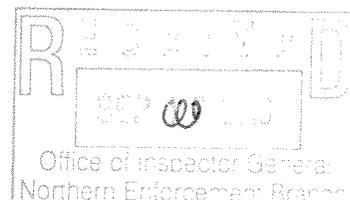
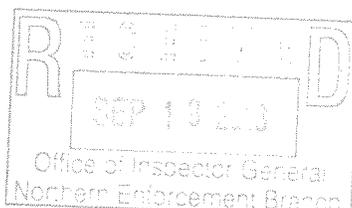
All doors will be inspected monthly during routine Preventive Maintenance Room checks by Maintenance Supervisor.

These room checks will be documented in the centers Life Safety Preventive Maintenance Log.

Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance or until Committee determines compliance has been sustained.

Executive Director to monitor for continued compliance.

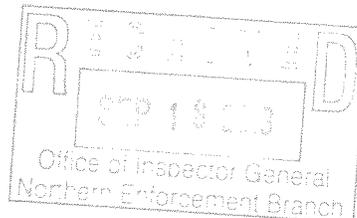
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K 029	Continued From page 6 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other 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 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (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 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. 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.	K 029			
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	K-38 It is the practice of this facility to assure that all exits remain accessible and discharge to an area of safe refuge at all times to include: Maintaining proper signage with contrasting background that reads "PUSH UNTIL ALARM SOUNDS" "DOOR CAN BE OPENED IN 15 SECONDS".	09.25.13	



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K 038 Continued From page 7

K 038

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twelve (112) beds with a census of eighty three (83) on the day of the survey. The facility failed to maintain signage for doors equipped with delayed egress locks.

The findings include:

Observation, on 08/13/13 between 9:30 AM and 3:00 PM, with the Maintenance Supervisor revealed the Main Entrance, North East Wing Entrance, and the North Lobby Entrance were equipped with delayed egress locks, and did not have proper signage with a contrasting background to make the signs easily recognizable.

Interview, on 08/13/13 between 9:30 AM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware the delayed egress signage was required to have a contrasting background.

Reference:

NFPA 101 (2000 edition)

Maintenance Supervisor educated by Executive Director, by 09.17.13, about K-38 requirements, cited deficiency, corrective actions, and preventative measures by their review of the SOD, facility's POC, and facility's preventative maintenance program and practices to assure that all exits remain accessible and discharge to an area of safe refuge at all times to include: Maintaining proper signage with contrasting background that reads "PUSH UNTIL ALARM SOUNDS" "DOOR CAN BE OPENED IN 15 SECONDS".

Proper signage was installed on all exit doors on 08.24.13 and 08.25.13.

The Maintenance Supervisor will inspect exit access weekly and document in Preventive Maintenance Log.

Preventive Maintenance Log will be reviewed by the PI committee quarterly to ensure continued compliance or until the Committee determines compliance has been sustained.

Executive Director to monitor for continued compliance.

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