

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

PRINTED: 10/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/10/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW	STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101
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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 000}	INITIAL COMMENTS An onsite revisit was conducted on 10/10/13 and the deficiencies were corrected as of 09/27/13, as alleged in the acceptable PoC.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101		
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F 000	INITIAL COMMENTS A recertification survey was conducted on 08/20/13 through 08/23/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E".	F 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <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>		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide dignity for one (1) resident, in the selected sample of twenty four (24) residents, in a manner that maintained or enhanced dignity and respect in full recognition of his/her individuality. The findings include: Interview with the Director of Nursing, on 08/21/13 at 3:20 PM, revealed there was no policy in place for the maintenance and care of rectal tubes. Observations, on 08/20/13 at 11:10 AM and 4:05 PM and on 08/21/13 at 8:40 AM, revealed Resident #5 to have a rectal tube intact and connected to the bedside drainage bag. The rectal bedside drainage bag contained a large amount of brown fecal material and was	F 241	Rosewood will continue to promote Care for residents in a manner and in an Environment that maintains or enhances each resident's dignity and respect in full Recognition of his or her individuality. On 8/21/13 a dignity cover was placed over the drainage bag of Resident #5 to provide him with dignity. Resident #5 no longer resides at Rosewood. All residents who have catheters, rectal tubes or other devices that drain bodily fluids have the potential to be affected by this practice. There are no residents with rectal tubes in the facility currently. All residents who have catheters with drainage bags have been checked to ensure a dignity cover is in place covering their drainage bags. This was completed by the SRNAs from their assignment sheets. The assignment sheets were updated to indicate residents with catheters that need to have covers over drainage bags. From their assignment sheets, SRNAs will ensure dignity covers are in place every shift. Nursing staff were educated regarding the use of dignity bags by the Staff Development Coordinator and/or DNS on		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Marcella Holops* TITLE: *Executive Director* (X6) DATE: *9/27/13*

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F 241	Continued From page 1 connected to the bed frame facing the hallway without a dignity bag covering Interview with the Licensed Practical Nurse (LPN) on 08/21/13 at 1:20 PM, revealed Resident # 5 had a rectal tube to promote healing of a sacral decubitus. The LPN stated a dignity bag was not covering the rectal drainage bag because "we could not find one" Further interview with the DON, on 08/21/13 at 3:20 PM, revealed this was the first time the facility had provided care to a resident with a rectal tube and the drainage bag should be covered to maintain Resident #5 dignity	F 241	9/13/13 through 9/26/13 After 9/26/13 no nursing staff member will be allowed to work until they receive this education Unit Managers will monitor the residents on their units daily for the use of dignity covers. Any concerns identified will be corrected at that time. The DNS and/or ADNS will observe for the use of dignity covers in their weekly rounds. The result of those rounds will be presented to the Performance Improvement Committee each month for 3 months to ensure continued compliance or until the Committee determines compliance has been sustained.		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible This REQUIREMENT is not met as evidenced by Based on observation, interview and facility policy review it was determined the facility failed to provide a safe, clean and comfortable environment related to cigarette butts observed on the ground in the designated smoking areas. Additionally, bird droppings were observed covering the side walk, residents' outdoor seating and activity equipment in the facility outside courtyard area The findings include	F 252	Date of Compliance: 9/27/13 F 252 Rosewood will continue to provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. On 8/23/13 the smoking area was cleaned by Housekeeping to ensure the cigarette butts were removed and the area was clean. On 8/23/13 the maintenance assistant pressure washed the sidewalks and tables and benches in the courtyard to clean the area and remove bird droppings from the sidewalks and outdoor furnishings. All residents who smoke or who use the courtyard are affected by this practice		

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F 252 Continued From page 2

Review of a facility policy, titled "SMOKING", dated 07/22/11, revealed to educate patients and/or legal representative on smoking policy, smoking locations and smoking times, educate staff on smoking policy, smoking locations and smoking times, plan, schedule and post smoking times and monitor smoking patients, and assign staff to supervise patients smoking in designated smoking areas at the appropriate time frames. Additionally, the policy stated safety ash trays should be used and the ash trays are emptied in covered metal containers.

Review of a facility policy titled "GENERAL ENVIRONMENTAL CONDITIONS", dated 10/31/10 revealed a safe, functional, sanitary and comfortable environment is provided for patients, staff and the public. The policy stated the physical plant and equipment are monitored through Performance Improvement (Preventative Maintenance Programs) for potential hazards. The policy did not address maintenance of resident activity equipment or seating areas.

An observation, on 08/22/13 at 9:45 AM revealed Activity Staff #1 and one resident was in the designated smoking area. The resident had a smoking apron on and was smoking as Activity Staff #1 was standing by. The resident finished smoking and was assisted back into the building by Activity Staff #1. A tour of the adjoining courtyard area was conducted with the Activity Staff #1 at this time. Observation revealed the sidewalk area covered in bird droppings with one area so thickly covered in the droppings there was a crunching sound when walked on. Resident chairs and a basket ball and basket ball goal were also observed coated with bird

F 252 The smoking area will be cleaned twice daily by the housekeeping department, once in the morning as they begin their shift and once in the afternoon just before they leave for the day. Between times, staff who take residents out to smoke will be responsible for ensuring the smoking area is cleaned up and left clean for the next smoke break. Housekeeping staff will be educated by the Housekeeping Supervisor by 9/13/13 regarding their role in keeping the resident smoking area clean. Facility staff will be educated by the Staff Development Coordinator and/or the Director of Nursing beginning 9/13/13 to 9/26/13 regarding their role in ensuring the cleanliness of the smoking area. After 9/26/13 staff who have not received this education will not be allowed to work until they receive it. The cleanliness of the courtyard is the responsibility of the Maintenance Supervisor and/or Maintenance Assistant. They will pressure wash the outdoor furnishings and sidewalks in the courtyard twice a week in the spring and summer months and weekly in the fall and winter months. When the Activities staff have a planned event in the courtyard, they will ensure the area is clean and suitable for their event. If the courtyard needs to be cleaned, they will notify maintenance that the area needs to be cleaned in time for their event. The Executive Director will educate the maintenance department and the Activity staff as to this process on 9/13/13.

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F 252 Continued From page 3
droppings

An interview with Activity Staff #1, at the time of the observation revealed all smoking material was kept secured and whoever was assigned to supervise and monitor residents smoking was to keep cigarette butts off the ground and in the ash trays. Activity Staff #1 also stated during outside activities she covered the two chairs with sheets so residents could sit on the chairs without getting bird droppings on them when the residents participated in outside activities in the courtyard area.

An observation, on 08/23/13 at 10:00 AM with the Maintenance Director, revealed the smoking area had a large number (14) of cigarette butts on the ground. The Maintenance Director stated at the time the cigarette butts "shouldn't be there and whoever was supervising residents to smoke was responsible to ensure the cigarette butts were put in the proper receptacle".

An interview conducted on 08/23/13 at 10:30 AM with Activities Staff #2, revealed she had supervised the scheduled 9:30 AM smoking activity with residents but had not noticed the cigarette butts on the ground and would normally keep the cigarette butts off the ground in the ash container.

Additional observation of the courtyard area adjoining the designated smoking area revealed a thick covering of bird droppings on the sidewalk and on two resident chairs, a basket ball and basket ball goal. Interview with the Maintenance Director at the time of the observation revealed he does pressure wash the courtyard area at times but had no set schedule to monitor the area.

F 252 As part of her daily rounds, the Executive Director will include looking at the cleanliness of the resident smoking area and the courtyard. Any identified concern will be addressed at that time. The result of these environmental rounds will be taken to the monthly Performance Improvement Committee meeting for 3 months to ensure continued compliance or until the Committee determines that compliance has been sustained.

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F 252 Continued From page 4
for necessity of cleaning. There was no log maintained to verify when the residents' courtyard area was monitored and cleaned.

F 252

An interview with Resident #28, not in the selected sample of twenty four (24) residents, on 08/23/13 at 10:20 AM, revealed he/she had participated in activities in the courtyard area on multiple occasions and did see the bird droppings on the chairs, equipment and sidewalk. Resident #28 stated the bird droppings were dried and he/she "just sat on it".

Interviews with Residents #29 and #30 also not the selected sample of 24 residents, on 08/23/13 at 10:25 AM, revealed they had utilized the courtyard area in the past when the weather was good and had seen a large amount of bird droppings. Residents #29 and #30 both stated residents that did not sit in a wheelchair did sit on the chairs.

An interview with the Director of Nursing (DON), on 08/23/13 at 11:AM, revealed the thick covering of bird droppings on the residents' courtyard area including the chairs and activity equipment was a concern. She was unaware if there was a monitoring and cleaning schedule in place and that it would be the responsibility of the Maintenance Department. The DON additionally stated there was a smoking policy and staff were to ensure cigarette butts were not be left on the ground.

An interview with the Staff Development Coordinator (SDC), on 08/23/13 11:15 AM, revealed she was responsible for the facility Infection Control Program. The SDC stated bird droppings were a health risk to anyone and

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F 252 Continued From page 5
especially any resident with any respiratory issues and that Histoplasmosis was a concern.

F 441 483 65 INFECTION CONTROL, PREVENT
SS=D SPREAD LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection

- (a) Infection Control Program
The facility must establish an Infection Control Program under which it -
- (1) Investigates controls, and prevents infections in the facility.
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident, and
 - (3) Maintains a record of incidents and corrective actions related to infections

- (b) Preventing Spread of Infection
- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident
 - (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease
 - (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice

- (c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of

F 252

F 441 F 441

Rosewood has established and will 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

Residents #25 and #26 were not adversely affected by improper hand hygiene techniques.

All residents in the facility have the potential of being affected by this practice

LPN #1 was reeducated regarding infection control and hand hygiene during medication administration on 9/13/13 by the DNS. All licensed staff have been inserviced regarding infection control practices during medication administration, including hand hygiene. Other staff have been inserviced regarding hand hygiene and other infection control practices. This education was completed by the Staff Development Coordinator on 9/13/13 through 9/26/13. After 9/26/13, staff will not be allowed to work until they receive this education

Unit Managers will randomly observe daily to ensure infection control practices, such as

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F 441 Continued From page 6
infection

This REQUIREMENT is not met as evidenced by
Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure an infection control program was maintained related to improper hand sanitation between residents during a medication pass. The Nurse administering medications did not sanitize her hands between the administration of medications for two unsampled residents (#25 and #26).
The findings include
An observation of a medication pass, on 08/20/13 at 12:15 PM, revealed Licensed Practical Nurse (LPN) #1 failed to sanitizer her hands between two unsampled residents (#25 and #26).
A review of the facility policy titled, "INFECTION CONTROL WORK PRACTICES", dated 04/28/10 revealed employees at risk for occupational exposure to blood-borne pathogens are expected to follow work practice controls in order to reduce the likelihood of exposure. The work practice controls included at the minimum hand-washing practices. Employee should wash their hands with soap and water immediately or as soon as feasible after removal of gloves or other personal protective equipment and after using antiseptic hand cleansers or towelettes.
An interview with LPN #2, on 08/21/13 at 1:25 PM, revealed she usually sanitized her hands in between medication administration and washed her hands on every third medication pass. She stated she must have forgotten to sanitize her hands in between Resident #25 and #26.
An interview with the Director of Nursing (DON),

F 441 hand hygiene, are in place on their units. The Staff Development Coordinator and the Director of Nursing and/or the Assistant Director of Nursing will randomly observe during medication administration and general care of the residents to ensure infection control practices such as hand hygiene are practiced. These observations will take place at least twice weekly and will be documented on a round sheet. The weekend supervisor will be responsible for at least one round on the weekend to observe for infection control practices such as hand hygiene. The result of these rounds observations will be taken to the monthly Performance Improvement Committee meeting by the DNS for a period of 3 months to ensure continued compliance or until the Committee determines compliance has been sustained.

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F 441 Continued From page 7
on 08/23/13 at 11.40 AM, revealed she would have expected a nurse who was passing medications to sanitize their hands in between medication passes for each resident.

F 441

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{K 000}	INITIAL COMMENTS A onsite revisit was conducted on 10/10/13 and the facility was deemed back in compliance on 09/30/13, as alleged in the acceptable PoC.	{K 000}		

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

TITLE

(X6) DATE

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1968</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200)</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke and heat detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/22/13. Kindred Transitional Care & Rehab - Rosewood was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred seventy-six (176) beds with a census of one-hundred thirty three (133) 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</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Marcella Hodges* TITLE: *Executive Director* (X6) DATE: *9/27/13*

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185089	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION ROSEW			STREET ADDRESS, CITY, STATE, ZIP CODE 550 HIGH ST. BOWLING GREEN, KY 42101	
(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 000	Continued From page 1 Fire) Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. 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 two (2) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for one hundred seventy six (176) beds with a census of one hundred thirty three (133) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would resist the passage of smoke. The findings include: Observation, on 08/22/13 at 1:15 PM, with the Maintenance Supervisor revealed the cross	K 027	<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> K027 Rosewood will continue to ensure doors intended to be smoke barriers will resist the passage of smoke in accordance with NFPA standards. The smoke barrier door located in D hall (#2) was repaired by Western Kentucky Door on 9/17/13. On 8/22/13 the Maintenance Director inspected all other smoke barrier doors along with Life Safety Surveyor Robert Welch and no other concerns were identified. As a routine part of the weekly preventative maintenance program, the Maintenance Supervisor and/or the Maintenance Assistant will examine all doors intended to be smoke barriers to ensure they perform according to code. The Executive Director will take the result of these findings to the monthly Performance Improvement Committee meeting for three months to ensure future compliance or until the Committee determines compliance has been sustained. Date of Compliance: 9/30/13	

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K 027	<p>Continued From page 2</p> <p>corridor doors located in D Hall had a gap larger than an eighth of an inch and would not resist the passage of smoke when closed.</p> <p>Interview, on 08/22/13 at 1:15 PM, with the Maintenance Supervisor revealed he was not aware the doors had too large of a gap to resist smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. Reference: NFPA 80 (1999 Edition)</p> <p>2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be</p>	K 027	

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K 027	Continued From page 3 required where each door closes and latches independently of the other.	K 027		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, residents, staff and visitors. The facility is certified for one hundred seventy six (176) beds with a census of one hundred thirty three (133) on the day of the survey. The facility failed to ensure the fire drills were conducted quarterly at unexpected times. The findings include: Fire Drill record review, on 08/22/13 at 12:00 PM, with Maintenance Supervisor revealed the facility failed to conduct fire drills at unexpected times	K 050	K 50 It is the practice of this facility to assure fire drills are conducted at random times to educate staff regarding proper fire response procedures to maintain compliance at all times to include: fire drills held at unexpected times at least quarterly on each shift. The Maintenance Supervisor will schedule and document Fire Drills at unexpected, random times and 2 hours apart from previous quarter's drills. An annual inservice will be conducted regarding Fire Response Procedures. The Maintenance Supervisor's Fire Drill reports will be reviewed monthly for three months and then quarterly by the Performance Improvement Committee to ensure future compliance or until the Committee determines compliance has been sustained. The Executive Director will monitor for continued compliance. Date of compliance: 9/30/13	

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K 050	Continued From page 4 under varied conditions on all three shifts. Interview, on 08/22/13 at 12:00 PM, with the Maintenance Supervisor revealed he was unaware the fire drills were not being conducted as required. Reference: NFPA 101 Life Safety Code (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to	K 050			

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K 050	Continued From page 5 familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
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