



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

PRINTED: 07/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/19/2014
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
(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 000	INITIAL COMMENTS	F 000	Disclaimer: Preparation and 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 deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.		
F 164 SS=D	<p>A Recertification Survey was conducted on 06/17/14 through 06/19/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "F".</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>F 164 483.10(e), 483.75(l) (4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the rights to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Criteria #1: Privacy is being provided during care for Resident #11 as determined by: care observation performed by administrative nurses on 6/23/14, 6/27/14, and 7/1/14.</p> <p>Criteria #2: All residents had the potential to be affected by this alleged deficient practice.</p> <p>Criteria #3: Nursing staff members are receiving a nursing skills check-off and in-service education on 7/15/14 and 7/17/14 by the Director of Nursing or her designee on the requirements of F 164, including, but not limited to: providing privacy (closing blinds, pulling privacy curtain, closing door, etc.) when providing personal care that would indicate the need for privacy. Any nursing staff members that have not been in-serviced by target date will be prior to their next shift worked.</p>		

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

Stacey Bullock, RN

TITLE

Administrator

(X6) DATE

7/22/14

Any deficiency statement finding with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Resident's Rights policy, it was determined the facility failed to ensure personal privacy for one (1) resident (Resident #11), in the selected sample of thirteen (13) residents. Findings include: Review of the Resident's Rights, undated, revealed each resident had the right to privacy with regard to personal care. Observation of Resident #11, on 06/17/14 at 4:10 PM, revealed Licensed Practical Nurse (LPN) #1 administered insulin to the resident without pulling the privacy curtain, enabling the resident's roommate to view his/her care. Interview with LPN #1, on 06/17/14 at 4:10 PM, revealed it was difficult to provide privacy as the room was so small. Interview with the Director of Nursing (DON), on 06/19/14 at 12:15 PM, revealed she expected staff to utilize the privacy curtain between residents when providing treatment.	F 164	Criteria #4: The QA indicator tool for the monitoring of privacy as outlined in F 164 shall be utilized weekly X4 weeks, then monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Director of Nursing. Results of the audits will be reported to the QA Committee by the Director of Nursing or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the Director of Nursing or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Audit frequency may be increased or decreased per QA committee findings. Criteria #5: Target Date	7/17/2014	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 281			

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F 281	<p>Continued From page 2</p> <p>and review of the facility's policy/procedure, it was determined the facility failed to ensure services provided met professional standards of quality related to staff following physician's orders for one (1) resident (Resident #1), in the selected sample of thirteen (13) residents, and one (1) resident (Resident A), not in the selected sample.</p> <p>Findings include:</p> <p>1. Record review revealed the facility admitted Resident #1 on 04/25/13 with diagnoses to include Muscular Wasting, Anorexia, and Dementia. Review of a quarterly Minimum Data Set (MDS), dated 05/24/14, revealed the resident was assessed to have a Brief Interview for Mental Status (BIMS) score of six (6).</p> <p>Review of the June 2014 physician's order revealed an order for Resident #1 to have heel protectors to his/her bilateral heels every shift.</p> <p>Review of the Treatment Administration Record (TAR), dated June 2014, revealed documentation by staff that bilateral heel protectors were in place every shift, except for one omission noted on 06/10/14. Further review of the TAR revealed the original order for the heel protectors was written on 12/17/13.</p> <p>Observation of Resident #1, on 06/18/14 at 8:40 AM, revealed the resident was not wearing heel protectors, and the heel protectors were not in view in the resident's room.</p> <p>Further observation of Resident #1, on 06/18/14 at 1:40 PM, revealed the resident was not wearing heel protectors. A review of the Kiosk by State Registered Nurse Aide (SRNA) #2 revealed</p>	F 281	<p>F 281 483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility shall meet professional standards or quality:</p> <p>Criteria #1: Resident #1 – an order to discontinue heel protectors was obtained on 6/18/14. Resident A is receiving medications in accordance with physician orders as determined by: med pass observation and MAR inspection on 6/18/14, 6/25/14, and 7/9/14.</p> <p>Criteria #2: An audit of resident ancillary orders was completed on 6/18/14 by the Assistant Director of Nursing (ADON) to determine that physician orders for items including but not limited to: heel boots were being followed. Medication observations were performed on 7/8/14 by the pharmacy consultant to determine if other residents were not receiving medications per MD order(s).</p> <p>Criteria #3: The facility protocol for discontinuing MD orders when indicated (such as after a wound has healed) has been reviewed and revised as indicated on 7/1/14 by Administrative nurses. Facility nurses and KMA's will receive in-service education on 7/15/14 and 7/17/14 as provided by the Administrative nurses on the regulatory requirements of F 281, including, but not limited to: (1) on verifying order/treatment(s) are in place prior to initialing the Item TAR (such as heel boots), (2) any revisions made to the above mentioned protocol, and (3) administering medications as per MD order. Any nurses or KMA that were not in-serviced by target date will receive in-service education prior to their next scheduled shift.</p>		

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F 281	<p>Continued From page 3</p> <p>no entry in the SRNA's care plan for the heel protectors. Interview with the SRNA revealed the resident does not have heel protector booties and his/her feet were floated on pillows.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/18/14 at 3:35 PM, revealed a new order was written on 06/18/14 to discontinue the bilateral heels boots. She reported the boots were discontinued on an unknown date and the heels have been floated since that time. After a review of the June TAR for the resident, the ADON revealed the heel protectors were documented as in place which she revealed was inaccurately documented.</p> <p>Interview with the Director of Nursing (DON), on 06/19/14 at 11:55 AM, revealed she expected staff to follow the physician's orders, and if they cannot, they should contact the physician. An expectation would also be for staff to accurately document the care a resident received.</p> <p>2. Review of the facility's policy/procedure for "Transdermal Drug Delivery System Application", undated, revealed to identify the location on the body for patch placement. Remove the old patch from the body. Document the placement site on the Medication Administration Record (MAR).</p> <p>Review of the "Medication Administration" policy/procedure, revised 12/18/12, revealed medications were administered in accordance with written orders of the attending physician.</p> <p>Record review revealed the facility admitted Resident A on 01/08/14 with diagnoses to include Type II Diabetes Mellitus, Hypertension (HTN), Peripheral Vascular Disease (PVD), Mastitis VS</p>	F 281	<p>Criteria #4: The CQI tool for the monitoring of following MD orders, including, but not limited to: heel boots and medication administration shall be utilized weekly X2 weeks, monthly X2 months, and then quarterly as per established CQI calendar under the supervision of the Director of Nursing. Results of the audits will be reported to the QA Committee by the Director of Nursing or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the Director of Nursing or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Audit frequency may be increased or decreased per QA committee findings.</p> <p>Criteria #5: Target Date</p>	7/17/2014	

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F 281	Continued From page 4 Inflammatory Cancer Right Breast, Lower Extremity Cellulitis, Left Foot Ulcer, Depression, Self Care Deficit, and Anxiety. Review of the physician's orders, dated June 2014, revealed an order for Exelon 4.6 mg/24 hour transdermal patch once daily for cognitive dysfunction. Remove the old patch before applying the new one, rotate sites (do not apply a new patch to the same location for at least fourteen days). Review of the MAR, dated June 2014, revealed staff did not document which site the Exelon patch was applied, from 06/01/14 through 06/17/14. Observation, on 06/18/14 at 7:32 AM, revealed Kentucky Medicaid Aide (KMA) #1 applied an Exelon transdermal patch 4.6 milligrams (mg) to the left upper back on Resident A; however, she did not remove an old patch from the resident. Interview with KMA #1, on 06/18/14 at 7:17 AM, revealed she "always" used the same site when applying the resident's Exelon patch. She revealed the resident's old patch was not on his/her back when she applied the new one. Interview with the Director of Nursing (DON), on 06/19/14 at 12:15 PM, revealed staff were expected to look for the old patch before applying a new one, and notify the nurse if unable to locate the old patch. Staff should document on the MAR which site a transdermal patch was placed. Staff were expected to follow the physician's orders related to medication administration. The standard of practice used by the facility was the "Transdermal Drug Delivery System Application" policy.	F 281			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			

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F 315	<p>Continued From page 5</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is Incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, the facility failed to ensure residents received appropriate treatment and services to prevent urinary tract infections (UTI) for one (1) resident (Resident #1), in the selected sample of thirteen (13) residents, related to improper technique for catheter care.</p> <p>Findings include:</p> <p>Review of the facility's policy/procedure related to Catheter Care, undated, revealed the procedure of catheter care was to hold the catheter near the meatus, clean the catheter from the meatus down the catheter about four (4) inches, using soap, water, and a clean washcloth. Clean downward away from the meatus with one (1) stroke. Repeat as needed with a clean area on the washcloth each time.</p> <p>Record review revealed the facility admitted Resident #1 on 04/25/13 with diagnosis to include Urinary Retention. Review of the quarterly</p>	F 315	<p>F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible;</p> <p>Criteria #1: Resident #1 is receiving catheter care as per facility policy and procedure as determined by; cath care observation done on 6/20/14 by administrative nurses.</p> <p>Criteria #2: All residents with indwelling catheters have the potential to be affected by this alleged deficient practice.</p> <p>Criteria #3: SRNA's received in-service education on the facility's policy and procedure on providing catheter care initiated on 6/20/14 as provided by Director of Nursing or her designee. A posttest was given along with return demonstration to determine staff competency. Re-education and testing was provided as indicated. Any SRNA not in-serviced on 6/20/14 will be on 7/15/14 and 7/17/14 skill check off/in-service session. Any SRNA not in-serviced by target date will receive in-service education prior to their next shift worked.</p> <p>Criteria #4: The QA Cath Care Skills tool shall be utilized randomly with 4 staff members weekly X 2 weeks, then monthly X 2 months and then annually and prn as part of the facility's annual skills review process. All new hire SRNA's will be required to successfully perform this task as part of their orientation process. Results of the audits will be reported to the QA Committee by the DON or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the DON or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Audit frequency may be increased or decreased per QA committee findings.</p> <p>Criteria #5: Target Date</p>	7/17/2014	

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F 315	Continued From page 6 Minimum Data Set (MDS) assessment, dated 05/24/14, revealed the facility assessed Resident #1 to have a Brief Interview Mental Status (BIMS) score of six (6). Observation, on 06/18/14 at 8:49 AM, revealed State Registered Nurse Aide (SRNA) #1 completed Resident #1's catheter care by using the same area of the washcloth, wiping the catheter with a back and forth motion. Review of documentation, received from the Assistant Director of Nursing (ADON), revealed SRNA #1 received a review of peri-care and catheter care procedures/skills by the ADON on 06/18/14. Review of a written inservice training on Catheter Care, dated 05/20/14, revealed when doing catheter care, the staff should always clean from the meatus outward with a clean washcloth. SRNA #1 signed the signature sheet for the inservice training. Interview with the Director of Nursing (DON), on 06/19/14 at 11:55 AM, stated the catheter care policy/procedure revealed to wipe with downward, single swipes. It was reported staff have been educated and received random and yearly competencies for catheter care.	F 315			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371			

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F 371	<p>Continued From page 7 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was stored and served under sanitary conditions related to the appropriate storage of food in the refrigerator and freezer, the appropriate use of hair nets, handwashing/glove use while serving food, and water temperatures below recommendation for the facility's dishwasher. The facility's census was forty-nine (49) residents with four (4) residents receiving tube feeding. There were eight (8) residents on thickened liquids.</p> <p>Findings include:</p> <p>1. Review of the facility's "Refrigerated Storage" policy/procedure, undated, revealed foods would be dated with the "arrival date" and an "opened date". Food would be discarded within appropriate shelf life.</p> <p>Review of the manufacturer's guidelines for honey thickened orange juice, honey thickened lemon flavored water, nectar thickened cranberry cocktail, and nectar thickened sweetened tea with lemon, undated, revealed to refrigerate up to five (5) days.</p> <p>Observation of the refrigerator, on 06/17/14 at 8:55 AM, revealed the following: 1. One (1) honey thickened orange juice, opened</p>	F 371	<p>F 371 483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility shall procure food from sources approved or considered satisfactory by Federal, State or local authorities; store, prepare, distribute, and serve food under sanitary conditions.</p> <p>Criteria #1: The undated opened thickened liquids identified by the OIG inspector were discarded on 6/17/14 by dietary staff. The maintenance director repaired the walk-in freezer on 6/19/14, and it is maintaining proper temp as determined by review of daily temp log for 6/19/14 - 7/9/14. Dietary staff are utilizing hairnets and gloves as per policy as determined by observations performed on 6/20/14, 6/24/14, and 7/9/14 by the Administrator. The dish washing machine was inspected on 6/19/14 by the maintenance director. It is running at the proper temperature. The dish machine is monitored for proper water temp with each load. Staff have been educated to monitor each load to ensure the temperature reaches 120 degrees for wash and rinse, not use the dishwasher or items ran through at a temperature below 120 degrees, and report to the maintenance director immediately any problems with maintaining temperatures at acceptable levels. Findings are documented as per facility protocol.</p> <p>A new hot water booster was ordered on 7/9/14 and will be installed immediately upon arrival to the facility.</p> <p>Criteria #2: All residents have the potential to be affected by this alleged deficient practice.</p>		

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 US HWY 231 S. BEAVER DAM, KY 42320		
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F 371	<p>Continued From page 8 with no date.</p> <p>2. One (1) honey thickened lemon flavored water, opened with no date.</p> <p>3. One (1) nectar thickened cranberry cocktail, opened with no date.</p> <p>4. One (1) nectar thickened sweetened tea with lemon, opened with no date.</p> <p>Interview with Dietary Aide (#1) and the Dietician, on 06/17/14 at 2:55 PM and 3:00 PM, respectively, revealed items in the refrigerator should be dated when opened.</p> <p>2. Review of the facility's "Proper Food Storage" policy/procedure, dated 08/21/95, revealed all foods and supplies would be stored appropriately upon receipt to protect them from contamination. Refrigerators and freezers were kept at optimum temperatures for the specific products to be stored.</p> <p>Observation of the freezer, on 06/17/14 at 8:55 AM, revealed Maintenance staff was working on the freezer door. The freezer temperature was twenty (20) degrees Fahrenheit (F). Observation, on 06/17/14 at 10:30 AM, revealed the door to the freezer would not latch and the temperature remained twenty (20) degrees F. Observation, on 06/17/14 at 2:45 PM, revealed several ice cream/sherbet cups on a tray in the freezer that were not frozen solid. The freezer temperature was five (5) degrees F.</p> <p>Review of the "AM Readings" for the freezer, dated 06/14/14, revealed the following temperatures: 06/05/14- two (2) degrees F 06/06/14- four (4) degrees F 06/14/14- ten (10) degrees F</p>	F 371	<p>Criteria #3: Dietary staff received in-service education on 6/17/14 by the Dietary Manager on requirements of regulatory requirements of F 371, including but not limited to: (1) proper water temps during dish machine use, that machine is not to be used when proper temp cannot be maintained, (2) facility P&P on walk-in freezer temp monitoring and documentation, (3) facility P&P on glove and hairnet use in the dietary department, and (4) dating of food items per facility P&P.</p> <p>The maintenance staff received in-service education on 6/17/2014 by the facility Administrator on routine maintenance and checking of all essential mechanical, electrical, and patient care equipment in safe operating condition, including, but not limited to the dish machine and walk-in freezer.</p> <p>Criteria #4: The CQI indicator tool for the monitoring of dietary sanitary conditions shall be utilized weekly X 4 weeks and then monthly under the supervision of the Dietary Manager. Results of the audits will be reported to the QA Committee by the Dietary Manager or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the Dietary Manager or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Audit frequency may be increased or decreased per QA committee findings.</p> <p>Criteria #5: Target Date</p>	7/17/2014	

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1695 US HWY 231 S. BEAVER DAM, KY 42320		
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F 371	<p>Continued From page 9</p> <p>06/15/14- four (4) degrees F 06/17/14- four (4) degrees F</p> <p>Interview with Dietary Aide #1, on 06/17/14 at 2:55 PM, revealed there have been issues with the freezer door for a couple of months.</p> <p>Interview with the Dietician, on 06/19/14 at 7:30 AM, revealed the freezer temperature should be at zero (0) degrees F, or below.</p> <p>Interview with the Maintenance Director, on 06/19/14 at 10:45 AM, revealed the freezer door heater and seals have been replaced twice by a different company. He revealed the facility was in the process of receiving "bids" for a new freezer; however, it had not been purchased at this time.</p> <p>Review of the Invoices, dated 02/28/14 and 05/31/14, revealed the freezer had been serviced on both dates.</p> <p>Interview with the Administrator, on 06/19/14 at 12:25 PM, revealed the facility's policy does not specify what degree the freezer temperature should be; however, it was usually zero (0) degrees or below. She revealed staff were expected to monitor the temperature and check for "softness" of food, reporting any issues to maintenance immediately.</p> <p>3. Review of the facility's "Dress Code" policy/procedure, undated, revealed hair must be appropriately restrained or completely covered.</p> <p>Observation of the tray line, on 06/17/14 at 11:15 AM, revealed the Cook, Dishwasher, and Dietary Aide #2 were wearing hair restraints which did not completely cover their hair. Hair was noted</p>	F 371			

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F 371	<p>Continued From page 10</p> <p>uncovered in the back and on the sides of the hair restraints for all three employees.</p> <p>Interview with the Administrator, on 06/17/14 at 3:05 PM, revealed dietary staff should ensure all hair was covered when wearing hair restraints.</p> <p>4. Review of the facility's "Handwashing and Glove Use" policy/procedure, undated, revealed guidelines for handwashing and glove use to promote safe and sanitary conditions throughout the dietary department must be followed. Hands must be washed following contact with any unsanitary surface. Gloves must be changed as often as hands need to be washed.</p> <p>Observation, on 06/17/14 11:30 AM, revealed the Cook served food during the tray line while wearing gloves. The Cook left the tray line, obtained potato chips from a bag for a resident tray using her soiled gloved hand, then returned to the tray line without washing her hands and changing gloves.</p> <p>Interview with the Dietician, on 06/19/14 at 7:30 AM, revealed staff should not touch food items with soiled gloves. If they leave the tray line, they should remove their gloves and wash their hands before returning.</p> <p>Interview with the Administrator, on 06/17/14 at 12:25 PM, revealed she expected the dietary staff to follow the policy related to handwashing and glove use.</p> <p>5. Review of the facility's "Dishmachine" policy/procedure, undated, revealed to check water temperature gauges. Follow manufacturer's instructions for proper temperatures according to</p>	F 371			

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 US HWY 231 S. BEAVER DAM, KY 42320		
(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 371	<p>Continued From page 11</p> <p>low temperature or high temperature machines. To reach proper temperatures upon startup, several empty racks should be sent through the machine. If the machine failed to reach the proper temperature, turn off the machine and report to the supervisor.</p> <p>Review of the Manufacturer's Guidelines, undated, revealed operating temperatures of the Dishmachine was 120 degrees (minimum) wash and 120 degrees (minimum) sanitizing rinse.</p> <p>Observation of the dishwasher, on 06/17/14 at 8:55 AM, revealed the wash cycle at 100 degrees with 120 degrees rinse. On 06/17/14 at 2:45 AM, the wash cycle was 100 degrees with 115 degrees rinse. At that time, staff pushed in the "booster" button on the machine. Rewash was 100 degrees with 120 degrees rinse.</p> <p>Interview with Dietary Aide #1, on 06/17/14 at 2:55 PM, revealed the "booster" button on the dishwasher was suppose to stay pushed in; however, it had not worked properly for "a couple of weeks."</p> <p>Interview with the Route Sales Manager for the dishwasher leasing company, on 06/19/14 at 9:25 AM, revealed the manufacturer recommended a wash and rinse cycle for the low temperature dishwasher at 120 degrees. The booster heater should stay on at all times, making the temperature of the water well above 100 degrees. He revealed the facility notified him last week of the concern related to the booster heater; however, it was their responsibility to maintain the equipment.</p> <p>Interview with the Maintenance Director, on</p>	F 371			

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1699 US HWY 231 S, BEAVER DAM, KY 42320		
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F 371	Continued From page 12 06/19/14 at 10:45 AM, revealed he was not aware of any concerns related to the dishwasher prior to 06/17/14. It was determined today there was a "hole" in the booster heater. Interview with the Administrator, on 06/19/14 at 12:25 PM, revealed she would have expected staff to notify her of issues involving the dishwasher; however, she was unaware prior to 06/17/14.	F 371			
F 456 SS-F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the Manufacturer's Guidelines, and review of the facility's policy/procedure, it was determined the facility failed to maintain all essential mechanical and electrical equipment in safe operating condition. The census of the facility was forty-nine (49) residents with four (4) residents requiring tube feeding. Findings include: 1. Review of the facility's "Proper Food Storage" policy/procedure, dated 08/21/95, revealed refrigerators and freezers were kept at optimum temperatures for the specific products to be stored. Observation of the freezer, on 06/17/14 at 8:55	F 456	F 456 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION Maintain all essential mechanical, electrical, and patient care equipment in safe operating condition: Criteria #1: The dish washing machine was repaired on 6/19/14. It is running at the proper temperature. The dish machine is monitored for proper water temp with each load and findings are documented as per facility protocol. Staff have been educated to monitor each load to ensure the temperature reaches 120 degrees for wash and rinse, not to use the dishwasher or items ran through at a temperature below 120 degrees, and to report to the maintenance director immediately any problems with maintaining temperatures at acceptable levels. A new hot water booster was ordered on 7/9/14 and will be installed immediately upon arrival to the facility. The maintenance director repaired the walk-in freezer on 6/19/14, and it is maintaining proper temp as determined by review of daily temp log for 6/19/14-7/9/14. Criteria #2: All residents have the potential to be affected by this alleged deficient practice.		

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F 456	<p>Continued From page 13</p> <p>AM, revealed Maintenance staff was working on the freezer door. The freezer temperature was twenty (20) degrees Fahrenheit (F). Observation, on 06/17/14 at 10:30 AM, revealed the door to the freezer would not latch and the temperature remained twenty (20) degrees F. Observation, on 06/17/14 at 2:45 PM, revealed several ice cream/sherbet cups on a tray in the freezer which were not frozen solid. The freezer temperature was five (5) degrees F.</p> <p>Review of the "AM Readings" for the freezer, dated 06/14/14, revealed the following temperatures: 06/06/14- two (2) degrees F 06/06/14- four (4) degrees F 06/14/14- ten (10) degrees F 06/15/14- four (4) degrees F 06/17/14- four (4) degrees F</p> <p>Interview with Dietary Aide #1, on 06/17/14 at 2:55 PM, revealed there have been issues with the freezer door for a couple of months.</p> <p>Interview with the Maintenance Director, on 06/19/14 at 10:45 AM, revealed the freezer door heater and seals have been replaced twice by a different company. He revealed the facility was in the process of receiving "bids" for a new freezer; however, it had not been purchased at this time.</p> <p>Review of the Invoices, dated 02/28/14 and 05/31/14, revealed the freezer had been serviced on both dates.</p> <p>Interview with the Administrator, on 06/19/14 at 12:25 PM, revealed the facility's policy does not specify what degree the freezer temperature should be; however, it was usually zero (0)</p>	F 456	<p>Criteria #3: Dietary staff received in-service education on 6/17/14 by the Dietary Manager on requirements of regulatory requirements of F 456, including but not limited to: (1) proper water temps during dish machine use, that machine is not to be used when proper temp cannot be maintained, (2) facility P&P on walk-in freezer temp monitoring and documentation.</p> <p>The maintenance staff received in-service education on 6/17/14 by the facility Administrator on routine maintenance and checking of all essential mechanical, electrical, and patient care equipment in safe operating condition, including, but not limited to the dish machine and walk-in freezer.</p> <p>Criteria #4: The QA indicator tool for the monitoring of the safe operating conditions of essential equipment shall be utilized monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Results of the audits will be reported to the QA Committee by the Maintenance Director or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the Maintenance or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Audit frequency may be increased or decreased per QA committee findings.</p> <p>Criteria #5: Target Date</p>	7/17/2014	

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1695 US HWY 231 S. BEAVER DAM, KY 42320		
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F 456	<p>Continued From page 14</p> <p>degrees or below. She revealed staff were expected to monitor the temperature and check for "softness" of food, reporting any issues to maintenance immediately.</p> <p>2. Review of the facility's "Dishmachine" policy, undated, revealed to check water temperature gauges. Follow manufacturer's instructions for proper temperatures according to low temperature or high temperature machines. To reach proper temperatures upon startup, several empty racks should be sent through the machine. If the machine fails to reach proper temperature, turn off the machine and report to the supervisor.</p> <p>Review of the Manufacturer's Guidelines, undated, revealed operating temperatures of the Dishmachine was 120 degrees (minimum) wash and 120 degrees (minimum) sanitizing rinse.</p> <p>Observation of the dishwasher, on 06/17/14 at 8:55 AM revealed the wash cycle at 100 degrees with 120 degrees rinse. On 06/17/14 at 2:45 AM, the wash cycle was 100 degrees with 115 degrees rinse. At that time, staff pushed in the "booster" button on the machine. Rewash was 100 degrees with 120 degrees rinse.</p> <p>Interview with Dietary Aide #1, on 06/17/14 at 2:55 PM, revealed the "booster" button on the dishwasher was suppose to stay pushed in; however, it had not worked properly for "a couple of weeks."</p> <p>Interview with the Route Sales Manager for the dishwasher leasing company, on 06/19/14 at 9:25 AM, revealed the manufacturer recommended a wash and rinse cycle for the low temperature dishwasher at 120 degrees. The booster heater</p>	F 456			

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F 456	Continued From page 15 should stay on at all times, making the temperature of the water well above 100 degrees. He revealed the facility notified him last week of the concern related to the booster heater; however, it was their responsibility to maintain the equipment. Interview with the Maintenance Director, on 06/19/14 at 10:45 AM, revealed he was unaware of any concerns related to the dishwasher prior to 06/17/14. It was determined today there was a "hole" in the booster heater. Interview with the Administrator, on 06/19/14 at 12:25 PM, revealed she would have expected staff to notify her of issues involving the dishwasher; however, she was not aware prior to 06/17/14.	F 456			
F 460 SS-D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Resident's Rights policy/procedure, it was determined the facility failed to ensure each resident bed was provided total visual privacy for one resident (Resident E), not in the selected sample.	F 460	F 460 483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident: In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. Criteria #1: The privacy curtain in Resident E's room has been repaired by the housekeeping department on 7/8/14. Criteria #2: An audit of all resident room privacy curtains was completed 7/8/14 by the housekeeping supervisor to determine that all were in correct working order.		

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F 460	Continued From page 16 Findings include: Review of the Resident's Rights, undated, revealed each resident shall be assured of at least visual privacy in multi-bed rooms. Observation, on 06/19/14 at 11:55 AM, revealed the privacy curtain dividing Resident E from his/her roommate was not long enough to provide full visual privacy when pulled. Interview with the Director of Nursing (DON), on 06/19/14 at 12:15 PM, revealed she expected staff to follow the "Resident Rights" related to privacy.	F 460	Criteria #3: All staff are being in-serviced on the facility's P&P for reporting of maintenance and housekeeping needs which began on 6/20/14 by the Administrator and will be completed by 7/17/14. Any staff member that did not received in-service education by target date will receive education prior to their next shift worked. This education included by was not limited to: proper functioning of privacy curtains to assure full visual privacy in each resident room, and reporting maintenance and housekeeping issues per facility procedures. Criteria #4: The QA indicator tool for the monitoring of full visual privacy in resident rooms shall be utilized weekly X 4 weeks, then monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Results of the audits will be reported to the QA Committee by the Housekeeping Supervisor each month it is completed. If an accepted threshold of compliance is not achieved, the Administrator or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Audit frequency may be increased or decreased per QA committee findings.		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's Pest Control Agreement and policy/procedure, it was determined the facility failed to maintain an effective pest control program so that the facility was free of pests related to multiple observations of flies in the facility. The facility census was forty-nine (49) residents. Findings include:	F 469	Criteria #5: Target Date	7/17/2014	

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F 469	Continued From page 17 Review of the facility's "Pest Control Service" policy/procedure, undated, revealed the pest management program should be implemented which would allow staff to document any sightings and provide the pest control vendor documentation of noted concerns. Review of the Pest Elimination Services Agreement, dated 03/20/14, revealed the facility purchased the Large Fly Program; however, the Small Fly Program was not included in their coverage. Observation in the kitchen, on 06/17/14 at 11:15 AM, revealed one fly in the kitchen area during tray line. Observation, on 06/17/14 at 11:20 AM, revealed the presence of small flies in the dining room during a meal observation. There were several small flies flying around residents' tables during their meal time. Observation of a medication pass, on 06/17/14 at 4:30 PM, revealed one fly on an unsampled resident's sheet while receiving medications in bed. Observation, on 06/17/14 at 5:10 PM, revealed the presence of several small flies in Resident #1's room during meal time. Additionally, an observation, on 06/18/14 at 8:49 AM, revealed the presence of several small flies in Resident #1's room during catheter care. Flies were noted to be around the room near the resident during the procedure. Interview with the Service Specialist for the	F 469	F 469 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility shall maintain an effective pest control program to that the facility is free of pests and rodents; Criteria #1: New UV lights have been ordered and will be placed at the front entrance, rear entrance, resident smoking area and the dietary entrance door immediately upon arrival to the facility by pest control contractor. The automatic sprays are functioning properly. Fly strips and bate have been placed in appropriate locations. Outside areas around dumpster are being sprayed regularly. Criteria #2: All residents had the potential to be affected by this alleged deficiency. Criteria #3: The Maintenance Director shall monitor the above interventions weekly during summer months and then as needed throughout the year under the supervision of the administrator. Staff members will receive in-service education on the facility's protocol for reporting flies/pests and on not keeping the doors open any longer than absolutely necessary to help prevent fly access to the building on 7/15/14 and 7/17/14 by the Administrative Nursing team during skill and in-service check off sessions. Any staff member that did not receive in-service by target date will receive in-service prior to their next shift worked.		

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1685 US HWY 231 S, BEAVER DAM, KY 42320		
(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 469	Continued From page 18 facility's pest control company, on 06/19/14 at 10:20 AM, revealed the facility had three "fly lights" in the facility with another one added on 06/18/14; however, these lights were used for large flies. He further revealed they "do not work well." He revealed small flies breed in different areas and were treated differently than large flies. Interview with the Administrator, on 06/19/14 at 12:25 PM, revealed flies had been a problem in the facility for approximately a week. She was under the impression the services provided by the pest control company covered both large and small flies.	F 489	Criteria #4: The presence/absence of flies and/or pests shall be monitored through use of the Pest Sighting Log. This shall also be discussed at the next resident council meeting to assure resident satisfaction with the facility's corrective actions. The QA indicator tool for the monitoring of pests/flies shall be utilized weekly X 4 weeks, then monthly X 2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Results of the audits will be reported to the QA Committee by the Maintenance Director or Designee each month it is completed. If an accepted threshold of compliance is not achieved, the Maintenance Director or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Audit frequency may be increased or decreased per QA committee findings.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain clinical records in accordance	F 514	Criteria #5: Target Date	7/20/2014	

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1695 US HWY 231 S. BEAVER DAM, KY 42320		
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F 514	<p>Continued From page 19</p> <p>with accepted professional standards and practices for one (1) resident (Resident #1), in the selected sample of thirteen (13) residents, related to inaccurate documentation in the medical record.</p> <p>Findings include:</p> <p>The facility was unable to provide a policy related to documentation.</p> <p>Record review revealed the facility admitted Resident #1 on 04/25/13 with diagnoses to include Muscular Wasting, Anorexia, Dementia, and Urinary Retention. Review of a quarterly Minimum Data Set (MDS) assessment, dated 05/25/14, revealed the facility assessed the resident to have a Brief Interview Mental Status (BIMS) score of six (6).</p> <p>Review of the Treatment Administration Record (TAR), dated June 2014, revealed documentation that staff signed the TAR for the presence of Resident #1's heel protectors.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 06/18/14 at 3:35 PM, revealed Resident #1's heel protectors were discontinued at an unknown date; however, staff continued to document the presence of the heel boots on the TAR. The ADON reviewed the documentation and revealed it to be inaccurate.</p> <p>Interview with the Director of Nursing (DON), on 06/19/14 at 11:55 AM, revealed staff should be following current Nursing Standards of Practice by the Kentucky Board of Nursing (KBN). It was further revealed by the DON all documentation by the staff should be accurate.</p>	F 514	<p>F 514 489.75(d)(1) RES RECORDS- COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>Criteria #1: Resident #1- an order to discontinue heel protectors was obtained on 6/18/14 by the Assistant Director of Nursing.</p> <p>Criteria #2: The monthly orders for all residents have been audited to verify that ancillary orders are accurate and reflect the current physician orders. Resident #1 physician was notified that the resident's TAR had been initialed when care was not provided. Resident #1 physician gave an order to discontinue the treatment 6/18/2014.</p> <p>Criteria #3: The facility protocol for discontinuing MD orders when indicated (such as after a wound has healed) has been reviewed and revised as indicated on 7/1/14 by Administrative nurses.</p> <p>Facility nurses and KMA's will receive in-service education on 7/15/14 and 7/17/14 as provided by the administrative nurses on the regulatory requirements of F 281, including, but not limited to: (1) on verifying order/treatment(s) are in place prior to initialing the item TAR (such as heel boots), and (2) any revisions made to the above mentioned protocol. Any nurses or KMA that did not receive in-service by the target date will receive in-service prior to their next shift worked.</p>		

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1588 US HWY 231 S. BEAVER DAM, KY 42320		
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			<p>Criteria #4: The CQI tool for the monitoring of following MD orders and monitoring to ensure MARs and TARs are not initialed when care is not provided shall be utilized weekly X 2 weeks, monthly X 2 months, and then quarterly as per established CQI calendar under the supervision of the DON. Results of the audits will be reported to the QA Committee by the DON or Designee each month It is completed. If an accepted threshold of compliance is not achieved, the DON or Designee shall immediately develop and oversee a corrective plan. The details of the corrective plan will be reported to the QA Committee, with updated audit results, at the next monthly meeting. Audit frequency may be increased or decreased per QA committee findings.</p> <p>Criteria #5: Target Date</p>	7/18/2014	

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1585 US HWY 231 S. BEAVER DAM, KY 42320	
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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: 1964, 1975, 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Type V (000)</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 wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 06/17/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty eight (58) beds with a census of forty nine (49) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p>	K 000		



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

Stacy Sultana

TITLE

Administrator

7/22/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000 K 025 SS=D	Continued From page 1 deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation 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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of five (5) smoke compartments, fifteen (15) residents, staff and visitors. The facility has the capacity for fifty eight (58) beds and at the time of the survey, the census was forty nine (49). The findings include: Observation, on 06/17/14 at 11:40 AM with the Maintenance Director, revealed the smoke partition, extending above the ceiling located in the North Lobby on the backside of room #101 was penetrated the length of room #101 where	K 000 K 025	Disclaimer: Preparation and 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 deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. K 025 NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating 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 Criteria #1: The smoke partition, extending above the ceiling located in the North Lobby on the backside of room #101 was filled with a material rated equal to the partition and can resist the passage of smoke, the length of room #101 where the wall meets the roof. Criteria #2: An audit of all smoke barrier partitions was completed by the Maintenance Director of 6/17/14 to determine that no other smoke partitions were penetrated and can resist the passage of smoke. Criteria #3: The Maintenance Director has received in-service education on 6/17/14 by the Administrator on Life Safety Code Standards including, but not limited to: penetrations in smoke compartments must be filled with a material rated equal to the partition and resists the passage of smoke. The Maintenance	

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1695 US HWY 231 S. BEAVER DAM, KY 42320	
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K 025	Continued From page 2 the wall meets the roof. Interview, on 06/17/14 at 11:41 AM with the Maintenance Director, revealed he was unaware of the penetration at the top of the wall. The census of forty nine (49) was verified by the Administrator on 06/17/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/17/14. Actual NFPA Standard: 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	K 025	director will inspect smoke compartments after any outside vendors have performed any work that might hinder the smoke compartment and make the necessary repairs in a timely manner. Criteria #4: The QA monitoring tool for the monitoring of Life Safety Code Standards and National Fire Protection Association Standards in regards to smoke barriers shall be utilized monthly X2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Criteria #5: Target Date	7/17/14

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K 025	Continued From page 3 the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025			
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 1 3/4-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 cross-corridor doors, located in a smoke barrier, would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the	K 027	K 027 NFPA 101 LIFE SAFETY CODE STANDARD Door Openings in smoke barriers have at least a 20-minute fire protection rating or are at least a 1 3/4-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 Criteria #1: The roll down service door located in the kitchen wall to the egress path will be closed by staff in the event the fire alarm is activated, if there is a fire, and prior to leaving the kitchen unattended until the new fire shutter arrives to the facility, has been installed, and tests as compliant per NFPA standards and Life Safety Code K 027. A new roll down door that will be wired into the fire alarm system to		

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K 027	<p>Continued From page 4</p> <p>potential to affect two (2) of five (5) smoke compartments, twelve (12) residents, staff and visitors. The facility has the capacity for fifty eight (58) beds and the census was forty nine (49) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/17/14 at 12:32 PM, with the Maintenance Director revealed the roll down service door located in the Kitchen wall to the egress path was not self-closing or connected to the fire alarm to close in the event of an emergency.</p> <p>Interview, on 06/17/14 at 12:33 PM, with the Maintenance Director revealed he was not aware the roll down door was to be self-closing.</p> <p>Observation, on 06/17/14 at 1:01 PM, with the Maintenance Director revealed the cross-corridor doors located at the South Nurses' Station would not completely close when tested, leaving a gap of approximately half an inch (1/2 ") between the doors in the closed position. The pair of doors could not close completely and resist the passage of smoke in the event of an emergency.</p> <p>Interview, on 06/17/14 at 1:02 PM, with the Maintenance Director revealed he was not aware the pair of doors would not completely close and would not be capable of resisting the passage of smoke in the event of an emergency.</p> <p>The census of forty nine (49) was verified by the Administrator on 06/17/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview</p>	K 027	<p>automatically close with the fire alarms activation has been ordered and will be installed immediately upon its arrival to the facility. Estimated arrival date is 7/31/14. The cross-corridor doors located at the South Nurses' Station have been repaired so that they closed completely and resisted the passage of smoke in the event of an emergency by the Maintenance Director.</p> <p>Criteria #2: All residents had the potential to be affected by this alleged deficient practice.</p> <p>Criteria #3: All dietary staff have been educated on kitchen roll down service door procedures. All facility smoke barrier doors were inspected to ensure proper closure in order to resist the passage of smoke in the event of an emergency by the Maintenance Director on 6/17/14. The Maintenance Director received in-service education on Life Safety Code Standard including but not limited to: there is to be no impediment to the closing of doors protecting corridor openings and self-closing requirements for roll down service doors. In-service conducted by the Administrator on 6/17/14.</p> <p>Criteria #4: The QA monitoring tool for the monitoring of Life Safety Code Standards in regards to doors protecting corridor openings and roll down service doors shall be utilized monthly X2 months and then quarterly as per established QA calendar under the supervision of the Administrator.</p> <p>Criteria #5: Target Date</p>	8/15/14

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K 027	Continued From page 5 on 06/17/14. Reference: NFFA 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. Reference: NFFA 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. NFFA 101 LIFE SAFETY CODE STANDARD	K 027		
K 046 SS=F	Emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain emergency lighting in accordance with the National Fire Protection Association (NFFA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, fifty eight (58) residents, staff and visitors. The facility has the capacity for fifty eight (58) beds and the census was forty nine (49) on the day of the survey. The findings include:	K 046	K 046 NFFA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9 19.2.9.1. Criteria #1: All battery powered emergency lighting was tested for the required 1 1/2 hour duration on 6/23/14 by the Maintenance Director. All emergency lighting passed the 1 1/2 hour required test at that time. Criteria #2: All residents had the potential to be affected by this alleged deficient practice. Criteria #3: The Maintenance Director received in-service education on Life Safety Code Standards including but not limited to the requirements of K 046 to test all emergency lighting of at least 1 1/2 hour duration annually. In-service education conducted by the Administrator on 6/17/14.	

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K 046	<p>Continued From page 6</p> <p>Observation, on 06/17/14 at 12:16 PM, with the Maintenance Director revealed the facility failed to document the annual ninety (90) minute test for battery powered emergency lighting.</p> <p>Interview, on 06/17/14 at 12:17 PM, with the Maintenance Director revealed he was not aware that documentation was to be provided for the ninety (90) minute test.</p> <p>The census of forty nine (49) was verified by the Administrator on 06/17/14. The survey findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/17/14.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An</p>	K 046	<p>Criteria #4: The QA monitoring tool for the monitoring of Life Safety Code Standards in regards to Emergency Lighting shall be utilized monthly X2 months and then quarterly as per established QA calendar under the supervision of the Administrator.</p> <p>Criteria #5: Target Date</p>	7/17/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/17/2014
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320	
(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 046	Continued From page 7 annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD	K 046		
K 047 SS=D	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, and Kitchen Staff. The facility has the capacity for fifty eight (58) beds and at the time of the survey, the census was forty nine (49). The findings include:	K 047	K 047 NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 Criteria #1: An Exit sign with continuous illumination also served by the emergency lighting system was ordered for the kitchen to clearly mark the path of egress by the Maintenance Director on 6/24/14. Installation will occur immediately upon its arrival to the facility. Criteria #2: All kitchen staff and approximately 10 residents had the potential to be affected by this alleged deficient practice. All other paths of egress were audited on 6/17/14 by the Maintenance Director and noted to have the path of egress clearly marked with proper exit signage as required by National Fire Protection Association (NFPA) Standard.	

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K 047	Continued From page 8 Observation, on 06/17/14 at 12:38 PM with the Maintenance Director, revealed the Kitchen did not have the path of egress clearly marked with proper exit signage. Interview, on 06/17/14 at 12:39 PM with the Maintenance Director, revealed he was unaware the Kitchen did not have proper exit signage. The census of forty nine (49) was verified by the Administrator on 06/17/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/17/14. Actual NFPA Standard: Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible	K 047	Criteria #3: The Maintenance Director received in-service education on Life Safety Code Standards and NFPA standards including but not limited to the requirements of K 047, Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. In-service education conducted by the Administrator on 6/17/14. Criteria #4: The QA monitoring tool for the monitoring of Life Safety Code Standards in regards to Exit and directional signs shall be utilized monthly X2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Criteria #5: Target Date	7/17/14

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K 047 K 052 SS=F	Continued From page 9 in both the normal and emergency lighting mode. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on fire alarm testing record review and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for fifty eight (58) beds and at the time of the survey, the census was forty nine (49). The findings include: Fire alarm testing record review, on 06/17/14 at 2:02 PM with the Maintenance Director, revealed during the 02/20/14 quarterly fire alarm test	K 047 K 052	K 052 NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Criteria #1: Two new batteries were replaced by the testing contractor and the system re-tested and passed all testing on 6/18/14. Criteria #2: All residents had the potential to be affected by this alleged deficient practice. Criteria #3: The Maintenance Director received in-service education on Life Safety Code Standards and NFPA standards including but not limited to the requirements of K 052, reporting any issues with tests conducted immediately to the administrator, and timely follow-up on issues found during testing. In-service education conducted by the Administrator on 6/17/14. Criteria #4: The QA monitoring tool for the monitoring of Life Safety Code Standards in regards to Fire Alarm Testing shall be utilized monthly X2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Criteria #5: Target Date	6/19/14

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K 052	Continued From page 10 records the batteries in the fire alarm control panel (FACP) were marked as " Fail ". The FACP is equipped with two (2) batteries. One (1) of the two (2) batteries was replaced; however the other battery is marked " BAD " and was still in use. During the 05/30/14 quarterly fire alarm test the batteries were noted by the testing contractor to " PASS " however; the battery marked " BAD " was still in use. Interview, on 06/17/14 at 2:03 PM with the Maintenance Director, revealed he was aware the batteries in the FACP had failed but was not aware the testing contractor had not changed both batteries. The census of forty nine (49) was verified by the Administrator on 06/17/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/17/14. Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 11 This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for fifty eight (58) beds with a census of forty nine (49) on the day of the survey. The findings include: Observation, on 06/17/14 at 12:40 PM with the Maintenance Director, revealed the facility did not have battery-powered lighting installed in the area where the transfer switch for the emergency generator was located. Interview, on 06/17/14 at 12:41 PM with the Maintenance Director, revealed he was not aware of the requirement for the battery backup lighting. The census of forty nine (49) was verified by the Administrator on 06/17/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/17/14. Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment location shall be	K 144	K 144 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Criteria #1: A battery-powered light has been installed in the area where the transfer switch for the emergency generator is located. Criteria #2: All residents had the potential to be affected by this alleged deficient practice. Criteria #3: The Maintenance Director received in-service education on Life Safety Code Standards and NFPA standards including but not limited to the requirements of K 144, maintaining the generator set by National Fire Protection Association standards. In-service education conducted by the Administrator on 6/17/14. Criteria #4: The QA monitoring tool for the monitoring of Life Safety Code Standards in regards to battery-powered lighting working properly in the area where the transfer switch for the emergency generator is located shall be utilized monthly X2 months and then quarterly as per established QA calendar under the supervision of the Administrator. Criteria #5: Target Date	7/17/2014

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K 144	Continued From page 12 provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.	K 144	K 147 NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Criteria #1: The open electrical junction box located above the ceiling in the North Lobby has been covered to comply with section 370.28(c) Covers of K 147 NFPA 101 Life Safety Code Standard. The (5) gallon buckets of laundry detergent sitting on milk crates in the Laundry Room were relocated away from the electrical panel on 6/18/14 by the facilities detergent vender under observation of the Maintenance Director to comply with K 147 NFPA 101 Life Safety Code Standard. Criteria #2: All residents had the potential to be affected by this alleged deficient practice. Criteria #3: The Maintenance Director received in-service education on Life Safety Code Standards and NFPA standards including but not limited to the requirements of K 147, junction boxes required covers per NFPA standards and not blocking the electrical panels within three feet of the panel. In-service education conducted by the Administrator on 6/17/14. Criteria #4: The QA monitoring tool for the monitoring of Life Safety Code Standards in regards to monitoring the facility for any open junction boxes and monitoring to ensure space surrounding electrical panels in accordance with K 147 NFPA 101 Life Safety Code Standard shall be utilized monthly X2 months and then quarterly as per established QA calendar by the Maintenance Director under the supervision of the Administrator. Criteria #5: Target Date	7/17/2014
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, fourteen (14) residents, staff and visitors. The facility has the capacity for fifty eight (58) beds and at the time of the survey, the census was forty nine (49). The findings include: Observations, on 06/17/14 at 11:40 AM with the Maintenance Director, revealed an open electrical junction box located above the ceiling in the North Lobby. Interview, on 06/17/14 at 11:41 AM with the Maintenance Director, revealed he was unaware of the open electrical junction box.	K 147		

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K 147	<p>Continued From page 13</p> <p>Observations, on 06/17/14 at 1:21 PM with the Maintenance Director, revealed the electrical panel located in the Laundry Room next to the washing machine had storage within three (3) feet of the electrical panels. The panel was blocked by five (5) gallon buckets of laundry detergent sitting on milk crates.</p> <p>Interview, on 06/17/14 at 1:22 PM with the Maintenance Director, revealed the facility had just changed suppliers for laundry products and was not aware they had installed the buckets of detergent under the electrical panels.</p> <p>The census of forty nine (49) was verified by the Administrator on 06/17/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/17/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 70 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. (A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of</p>	K 147		

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K 147	<p>Continued From page 14</p> <p>110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td>1 m (3 1/4 ft)</td> <td>1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3 1/4 ft)	1.2 m (4 ft)	K 147		
Nominal Voltage to Ground	Minimum Clear Distance																			
Condition 1	Condition 2	Condition 3																		
0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)																	
151-600	900 mm (3 ft)	1 m (3 1/4 ft)	1.2 m (4 ft)																	

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K 147	Continued From page 15 than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a	K 147			

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NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1695 US HWY 231 S. BEAVER DAM, KY 42320		
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K 147	Continued From page 16 passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for	K 147			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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: 185334	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/17/2014
NAME OF PROVIDER OR SUPPLIER BEAVER DAM NURSING & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1595 US HWY 231 S. BEAVER DAM, KY 42320		
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K 147	Continued From page 17 switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only. 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147			