

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

PRINTED: 03/26/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/13/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222	
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F 000	INITIAL COMMENTS A Standard Health Survey was initiated on 03/11/14 and concluded on 03/13/14 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code survey was initiated and concluded on 03/11/14 with deficiencies cited at the highest scope and severity of an "E".	F 000	<u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	F 253 Housekeeping & Maintenance Services	4/19/14
	This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain five (5) of ninety-three (93) wheelchairs used by residents in a sanitary and safe manner for Resident #12, and Unsampled Resident A, B, C, and D. Wheelchair arm coverings were observed frayed, torn, and with the foam exposed. In addition the facility failed to maintain a sanitary environment in good repair in all seven (7) shower rooms. The ceiling ventilation fan covers had a thick, dark gray, fuzzy substance. One shower room sink that attached directly to the tiled wall was not sealed exposing a gap between the wall and the sink. Four (4) privacy curtains were taken down for cleaning without putting up replacement curtains. Two (2) privacy curtains in room 227-2, and one (1) curtain each in the AACU shower room and shower room D, between the sink and the toilet were missing.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The wheelchairs were repaired by the maintenance director on 3/28/14. The exhaust vents were cleaned/replaced by the maintenance director and housekeeping supervisor on 3/28/14. The shower room sink was caulked/repared by maintenance director on 3/14/14. The privacy curtains were re-hung by the housekeeping supervisor during the survey on 3/14/14.	

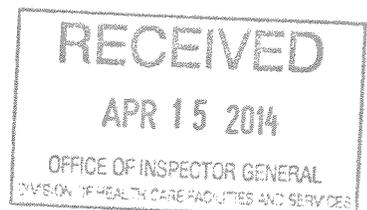
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *NHA* (X6) DATE: *4/15/14*

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

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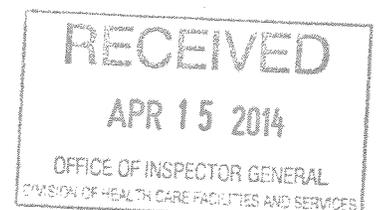
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F 253	<p>Continued From page 1 The findings include:</p> <p>The facility did not provide a policy specific for maintaining wheelchairs. The facility utilized computer work orders for repairs and the Maintenance Department whenever a wheelchair was in need of repairs. The facility provided an undated policy noted as ABM Healthcare Environmental Services for housekeeping, review of page 40 revealed the staff was to perform high dusting of doorframes, door hinges, ceiling vents, lights and tops of mirrors. The facility did not provide policies on maintenance of the facility shower rooms or on taking down, cleaning and replacing privacy curtains in the facility.</p> <p>Observation of wheelchair arms, on 03/12/14 at 9:15 AM, revealed Resident #12's right arm rest to the wheelchair was cracked.</p> <p>Observation of wheelchair arms during lunch service in the dining room, on 03/12/14 at 12:23 PM, revealed four (4) of ninety-three (93) wheelchairs in the facility had torn, frayed and foam exposed to the arm rest. Unsampled Resident A had a right arm rest that was cracked and torn away. Unsampled Resident B had a left arm rest with the vinyl torn away. Unsampled Resident C had a left arm rest with the vinyl cracked and torn away. Unsampled Resident D had a left arm rest with the vinyl completely gone with all the yellow foam exposed.</p> <p>Interview with the Maintenance Director, on 03/13/14 at 4:25 PM, revealed it was his responsibility to repair the wheelchairs in the facility. The Maintenance Director stated his work orders and repair records were generated and reviewed on the computer. Completed job status</p>	F 253	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected. Wheelchairs were audited to ensure they are in a safe and sanitary condition on 3/28/14 by the nursing home administrator (NHA). All vents in the facility have been audited to ensure that they are clean by the NHA on 3/28/14. All sinks have been audited to ensure they are hung correctly by the NHA on 3/28/14. All resident areas where a privacy curtain is needed have been checked to ensure that a curtain is in place by the NHA on 3/28/14.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All staff will be trained by 4/11/14 by the NHA to ensure understanding of putting maintenance requests in the computer system when issues are identified. Staff will also be trained by the NHA by 4/11/14 to understand that broken/cracked armrests covers, gaps around sinks are not acceptable and the need to be reported. Housekeepers will be trained by NHA by 4/11/14 to ensure that vents are kept clean and that when we remove privacy curtains that they must be replaced. Extra</p>	



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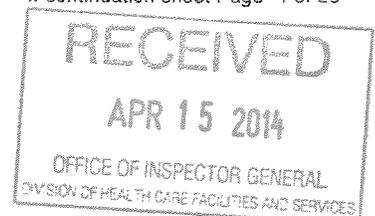
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F 253	<p>Continued From page 2</p> <p>was also maintained on the computer. He further stated monthly resident room checks were done for any monthly repair and maintenance. The Maintenance Director denied any work orders for repair of wheelchair arms were in the computer on 03/11/14.</p> <p>Interview with the Director of Nursing (DON), on 03/13/14 at 4:30 PM, revealed it was the responsibility of all facility staff to identify and report any needs for repair to wheel chair arms. She further stated frayed and torn wheelchair arms could cause skin tears and increase the risk of infection to the residents and should be repaired.</p> <p>Observation, on 03/13/14 at 3:40 PM, revealed all seven (7) shower rooms had ceiling ventilation fan covers with a thick, dark gray, fuzzy substance.</p> <p>Interview, with the Housekeeping Director, on 03/13/14 at 3:40 PM, revealed he was not aware of the buildup on the ceiling ventilation fans in the shower rooms.</p> <p>Interview with the DON, on 03/13/14 at 4:30 PM, revealed the buildup of on the ceiling ventilation fans could cause allergies or respiratory problems to the resident if not kept clean.</p> <p>Observation, on 03/12/14 at 11:45 AM, on the ACU revealed in the shower room the sink had been previously sealed with caulking and this had broken away from the tiled wall which left an open space.</p> <p>Interview, on 03/13/14 at 3:40 PM, with the Maintenance Director revealed he was not aware</p>	F 253	<p>curtains were ordered by the NHA on 04/03/14 to avoid having to put up temporary curtains.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The NHA and housekeeping supervisor will complete audits weekly for four weeks, then bi-weekly for four weeks, then monthly for four months. The NHA will bring audit results to two quarterly QAPI committee meetings. Any issue with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule of additional audits if needed.</p>	



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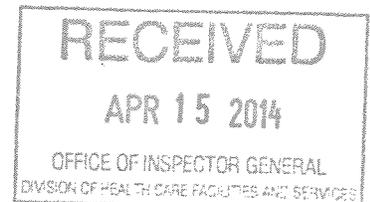
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F 253	Continued From page 3 of the need for repair to the sink and that it needed more caulk. The Maintenance Director could not explain the risk this presented to the residents. Interview, on 03/13/14 at 3:40 PM, with the DON revealed the risk of having an unsealed sink in the shower room could grow mold which was a health concern. Observation, on 03/11/14 at 8:30 AM, during tour on the ACU revealed two (2) privacy curtains in room 227 were missing from the tract. Observation, on 03/12/14 at 11:45 AM, on the ACU revealed a tract for a privacy curtain was missing between the sink and toilet.	F 253		
	Observation, on 03/12/14 at 11:02 AM, in shower room D revealed a tract for a privacy curtain was missing between the sink and toilet. Interview with License Practical Nurse (LPN), on 03/12/14 at 11:45 AM, revealed the privacy curtain in the ACU shower had been taken down to be cleaned, she was not sure how long the curtain had been down. Interview with the Resident Counsel, on 03/11/14 at 3:30 PM, revealed Resident #15 voiced concerns about a missing privacy curtain in shower room D. Interview, on 03/13/14 at 3:40-350 PM, with the Housekeeping Director revealed all four privacy curtains were taken down for cleaning and a replacement was not used. He further stated the vinyl curtains in the shower rooms had no replacements to put up until the originals were			



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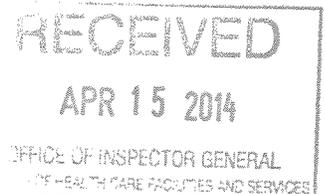
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F 253	Continued From page 4 cleaned. Interview, on 03/13/14 at 3:40-350 PM, with the Administrator, the Housekeeping Director and the DON revealed the Administrator stated it was a concern and privacy must be provided to the facility residents.	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to develop a care plan for an indwelling urinary catheter on one (1) of the twenty-four (24)	F 279	F 279 Develop Comprehensive Care Plans This facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Care plan for resident #19 was developed to include an indwelling urinary catheter on 3/14/14 by the registered nurse assessment coordinator (RNAC) to include measurable objectives and timetables. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. A review of ten residents physician orders and assessments will be completed daily at enhanced start up and care plans will be developed to ensure that a comprehensive care plan is in place by the care plan team. Enhanced start up occurs five days a week. What measures will be put into place or what systemic changes you will	4/9/14	



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F 279	<p>Continued From page 5 sampled residents (Resident #19).</p> <p>The findings include:</p> <p>Interview with the Minimum Data Set (MDS) Nurse #1, on 03/13/14 at 9:00 AM, revealed the facility utilized the Resident Assessment Manual (RAI) 3.0 manual as policy and guidance for the development and revision of care plans.</p> <p>Review of chapter 4, page 4-8 of the RAI v. 3.0 manual revealed facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI including monitoring each resident's condition and responding with appropriate interventions. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>Observations of Resident #19, on 03/12/14 at 5:00 PM and 03/13/14 at 10:25 AM, revealed the resident had an indwelling urinary catheter connected to a drainage bag and placed in a dignity bag.</p> <p>Review of Resident #19's medical record revealed the facility admitted the resident, on 02/27/13, with the diagnoses of COPD, Diabetes, Myocardial Infarction, Depression, Immobilization Syndrome, and Parkinson's Disease. Review of the resident's Urinalysis Culture and Sensativities, collected 02/24/14 and 02/25/17, revealed two (2) different multi drug resistant organisms were identified. Continued review</p>	F 279	<p>make to ensure that the deficient practice does not recur? Interdisciplinary team will be in-serviced on RAI v3.0 manual requirements for care planning by the RNAC on 3/19/14. Care plans are audited quarterly by the care plan team to ensure that they match the needs identified by the resident assessment and the residents physician orders. New physician order listing will be brought to Enhanced start up meeting daily by the Director of Nursing or the Assistant Director of Nursing in her absence for review of new orders and development of care plans. Five residents will have care plans audited weekly by the Registered Nurse Assessment Coordinator (RNAC) for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure an appropriate care plans has been developed. Audits will be turned into the Director of Nursing (DNS).</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS will bring the results of the audits to the QAPI committee for two quarterly meetings. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to</p>



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F 279

Continued From page 6

revealed a physicians order was obtained to insert an indwelling catheter, on 02/26/14. However, review of the resident's comprehensive plan of care revealed a care plan was not developed for care of the catheter and the potential complications associated with its use.

Interview with Licensed Practical Nurse (LPN) #5, on 03/13/14 at 2:20 PM, revealed care plans were used to give direction for individualized resident care. The LPN revealed he did not regularly use the care plans and was not sure if Resident #19 had a care plan to address the indwelling catheter.

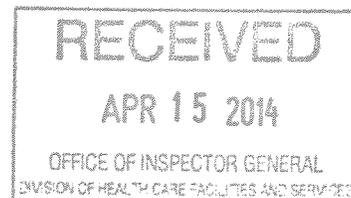
Interview with the ADON, on 03/13/14 at 2:38 PM, revealed the resident did have a care plan to address the urinary tract infection; however, it did not include the care required for an indwelling catheter. The ADON revealed there should be a care plan that included catheter care. The ADON revealed she remembered discussing the catheter in the morning meeting the day after it was ordered, which included the MDS Department, and did not know how it was missed.

Interview with MDS Nurse #1, on 03/13/14 at 3:05 PM, revealed she was in a hurry and forgot to develop a care plan to address Resident #19's indwelling urinary catheter. The MDS Nurse revealed she was focused on the infection and completely forgot about the catheter. The MDS Nurse revealed a potential for not providing the appropriate care placed the resident at risk for another or worsening urinary tract infection.

Interview with the Director of Nursing (DON), on 03/13/14 at 4:20 PM, revealed she was in the morning meeting when Resident #19's infection

F 279

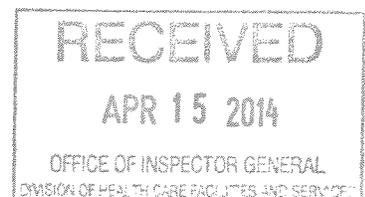
reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. Care plans are audited quarterly by the care plan team to ensure that they match the needs identified by the resident assessment and the residents physician orders.



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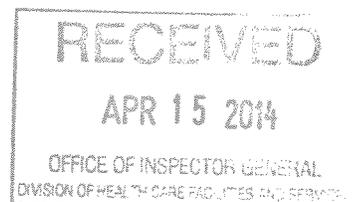
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F 280	<p>Continued From page 8 a Do Not Resuscitate (DNR).</p> <p>The findings include:</p> <p>Interview with the Minimum Data Set (MDS) Nurse #1, on 03/13/14 at 9:00 AM, revealed the facility utilized the Resident Assessment Manual (RAI) 3.0 manual as policy and guidance for the development and revision of care plans.</p> <p>Review of Chapter 4, page 4-8 in the RAI v. 3.0 manual revealed facilities are responsible for assessing and addressing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI, including monitoring each resident's condition and responding with appropriate interventions. Following the decision to address a triggered condition on the care plan, key staff or the IDT should subsequently review and revise the current care plan, as needed. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care.</p> <p>Review of the clinical record for Resident #5 revealed the facility admitted the resident on 03/14/11, with diagnoses of Prostate Cancer, Depression, Leukemia, Diabetes, and Hypertension. On 02/17/14, the facility held a care plan meeting with the resident's family and the decision was made to change the resident's Advanced Directive to a DNR. However, the resident's comprehensive plan of care was not changed and a care plan for a full code remained on the resident's medical record.</p> <p>Interview with Licensed Practical Nurse (LPN) #5,</p>	F 280	<p>make to ensure that the deficient practice does not recur? Interdisciplinary team will be in-serviced on RAI v3.0 manual requirements for care planning by the RNAC on 3/19/14. Care plans are audited quarterly by the care plan team to ensure that they match the needs identified by the resident assessment and the residents physician orders. New physician order listing will be brought to Enhanced start up meeting daily by the Director of Nursing or the Assistant Director of Nursing in her absence for review of new orders and development of care plans. Five residents will have care plans audited weekly by the Registered Nurse Assessment Coordinator (RNAC) for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure an appropriate care plan has been developed. Audits will be turned into the Director of Nursing (DNS).</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DNS will bring the results of the audits to the QAPI committee for two quarterly meetings. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to</p>



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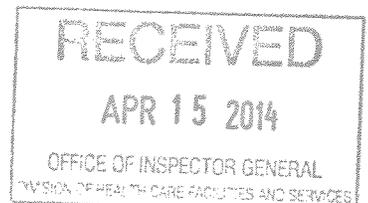
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F 280	Continued From page 9 on 03/13/14 at 2:20 PM, revealed a care plan meeting was held with the resident's children who decided to change the resident's Advanced Directive to a DNR. The LPN revealed the purpose of the care plan was to provide direction in care. The LPN revealed either the MDS Nurse or Social Services could have revised the care plan and should have done so to prevent any potential confusion as to the residents resuscitation status. Interview with MDS Nurse #2, on 03/13/14 at 3:11 PM, revealed Social Services was responsible to revise the care plan regarding advance directives. Interview with Social Services, on 03/13/14 at 3:30 PM, revealed she did update the advance directive information in the computer, but failed to print a new care plan and ensure the information on the medical record was correct. Social Services revealed a potential for resuscitation or confusion regarding the family's wishes for the DNR could occur.	F 280	reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. Care plans are audited quarterly by the care plan team to ensure that they match the needs identified by the resident assessment and the residents physician orders.
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	F 281 Services provided meet professional standard This facility will ensure that all services meet professional standard of quality. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 4/19/14



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F 281	<p>Continued From page 10</p> <p>and review of the facility's policy, it was determined the facility failed to meet professional standards of care, as evidenced by the incorrect administration of medications per gastrostomy tube during the medication pass observation, on 03/12/14, for one (1) of twenty four (24) sampled residents (Resident #8). In addition, the gastrostomy tube was not checked for placement for Resident #8 prior to the administration of the medications.</p> <p>The findings include:</p> <p>Review of the facility policy regarding Administration of Enteral Feeding: Enteral Pump, revised 2013, revealed verification of feeding tube placement would be done each time before the administration of a feeding, medications or free water flushes, or at least one time per shift.</p> <p>Review of the Medication Administration Competency Checklist for Enteral Tube, dated 2010, revealed the staff was to administer each medication separately, unless the Medical Doctor had given the approval to mix the medications. The staff was to flush the tube with 5 milliliters (ml.) or more of water after each dose and not add feeding solution.</p> <p>Review of the clinical record revealed the facility readmitted Resident #8, on 04/04/11, with diagnoses of Pneumonitis/Aspiration, Gastrostomy, Acute Respiratory Failure, and Dysphagia. Review of the resident's plan of care revealed the resident was at risk for aspiration and dehydration due to placement of a gastrostomy tube for feedings, status post Aspiration Pneumonia and severe Dysphagia. In addition, the care plan showed a risk for</p>	F 281	<p>RN#1 received training by the Director of Clinical Education (DCE) on 3/20/14 on protocols for checking gastrostomy tube placement and the policy for administering medications. RN#1 demonstrated appropriate technique to the DCE.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents with gastrostomy tubes have the potential to be affected by the alleged deficient practice. All nurses will be inserviced by the DNS by 4/11/14 on checking gastrostomy tube policies for placement and administration of medications.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>All floor nurses will demonstrate checking for gastrostomy tube placement and correct medication administration technique to DCE by 4/18/14. After completion of check-off's by DCE, DCE will check five nurses per week for correct technique for four weeks, then bi-weekly for four weeks, then monthly for four months</p>	



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F 281

Continued From page 11
swallowing difficulty related to the diagnosis of Aspiration Pneumonia.

Observation of the medication administration for Resident #8, on 03/12/14 at 7:30 AM, revealed Unit Manager RN #1 gave four (4) medications, Oscal, Namenda, Seroquel, and Klonopin, crushed together in water, through the gastrostomy tube. Prior to administration, RN #1 checked the gastrostomy tube for residual amounts; however, the nurse failed to check the tube for correct placement.

Interview with RN #1, on 03/12/14 at 11:30 AM, revealed she had checked Resident #8's gastrostomy tube for placement earlier, because the resident was at risk for aspiration. In addition, RN #1 stated she really thought the medications could be mixed together, except for liquids, and stated this must be something new, because she had been doing this for 22 years.

Interview the Assistant Director Of Nursing (ADON) on the West Hall, on 03/13/14 at 3:00 PM, revealed gastrostomy medications should be crushed and administered separately and flushed with 30 ml. water between each medication. She further revealed that gastrostomy placement should always be verified prior to medication administration, and stated that competency check-offs were performed with all nursing staff yearly. The ADON stated that Resident #8 had a positive history of aspiration and swallowing problems.

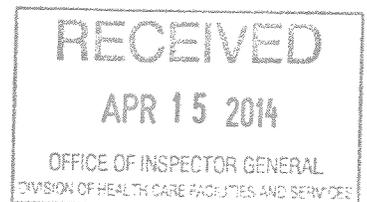
Interview with the Staff Development Coordinator (SDC), on 03/13/14 at 2:00 PM, revealed the standards of practice for Administration of Gastrostomy Medications was enforced by

F 281

to ensure compliance with policy.
Audits will be turned into the DNS.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

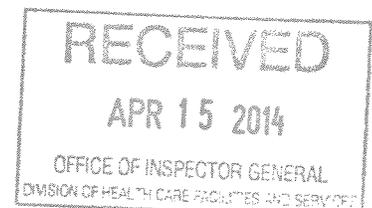
The DNS will bring the results to the QAPI committee for two quarterly meetings. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. Annually nurses will have gastrostomy tube proficiency checks by the DCE.



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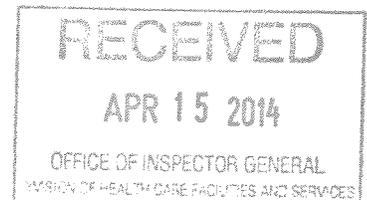
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F 281	Continued From page 12 completing competencies for gastrostomy medication administration yearly. The SDC revealed the Unit Manager RN # 1 had completed the competency last year. Interview with the Director of Nursing, on 03/13/14 at 4:00 PM, revealed she concurred with the interview with the SDC.	F 281	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow the care plan for one (1) of twenty-four (24) sampled residents, Resident #1, by not applying TED Hose (compression stockings) as care planned. The finding include: Observations, on 03/11/14 at 11:40 AM, 1:30 PM, 2:15 pm, and 3:01 PM and on 03/12/14 at 8:00 AM, 8:52 AM, 10:01 AM, and 11:00 AM, revealed Resident #1 did not have TED Hose on. Review of the Physician Order Report, revealed on 11/25/13 there was a physician order for knee high TED Hose to be on in the AM and off in the PM. Review of the comprehensive nursing care plan revealed there was to be an application of	F 282	<p>F 282 Services provided by qualified person per the care plan</p> <p>This facility will ensure that all services be provided by a qualified person in accordance with each residents written plan of care</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>LPN#1 received training by the DCE on 3/21/14 on application of resident #1's TED hose, appropriate sizes and following care plan. LPN#1 also trained by the DCE to notify physician when unable to carry out orders. TED hose applied per the physicians orders.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. All nurses and certified nursing assistants will be inserviced by the DNS or DCE by 4/17/14 on implementation of the care plan and physician notification in the event they are unable to carry out their orders. A review of ten residents care plans will be completed daily in enhanced start</p> <p style="text-align: right;">4/19/14</p>



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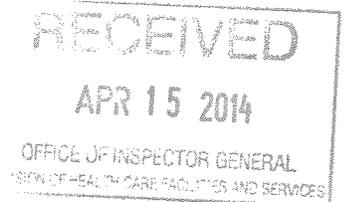
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F 282	Continued From page 13 TED Hose for twelve (12) hours on and twelve (12) hours off for Resident #1. Review of the Treatment Administration Record (TAR) revealed on 03/11/14 and 03/12/14 the TAR had been electronically signed by LPN #1 that the knee high TED Hose had been applied. Interview with Licensed Practical Nurse (LPN) #1, on 03/12/14 at 3:30PM, revealed the Certified Nursing Assistant (CNA) had put the knee high TED Hose on Resident #1 and the hose were too tight, so this nurse removed the hose. When asked if the TED Hose had been applied the day before 03/11/14, the nurse replied no the TED Hose had not been applied. In addition, the LPN further stated the physician should have been notified when she removed the knee high TED Hose because they were too tight. She stated no reason why the knee high TED Hose had not been applied on 03/11/14.	F 282	up and then compared to actual services provided to determine if care plan is being followed. This will be completed by the care plan team. Enhanced start up occurs five days a week. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? All nurses and certified nursing assistants will be inserviced by the DNS or DCE by 4/17/14 on implementation of the care plan and physician notification in the event they are unable to carry out their orders. A review of ten residents care plans will be completed daily in enhanced start up and then compared to actual services provided to determine if care plan is being followed. This will be completed by the care plan team until all residents have been reviewed. Enhanced start up occurs five days a week. DNS will audit five residents care plans per week for proper implementation for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure compliance with policy.		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to	F 309	How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what		



quality assurance program will be put into place?

The DNS will bring the results to the QAPI committee for two quarterly meetings. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. Upon completion of the quarterly assessment and comprehensive care plan the care plan team will review care given to ensure it follows the developed plan of care.



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F 309 Continued From page 14
follow a physician order for knee high TED Hose (compression stockings) for one (1) of twenty-four (24) sampled Residents, Resident #1.

The findings include:

Observations, on 03/11/14 at 11:40 AM, 1:30 PM, 2:15 pm, and 3:01 PM and on 03/12/14 at 8:00 AM, 8:52 AM, 10:01 AM, and 11:00 AM, revealed Resident #1 did not have TED Hose on.

Review of the Physician Order Review Report, revealed on 11/25/13 Resident #1 had a physician order for knee high TED Hose that were to be worn 12 hours on and 12 hours off. The order was active with a start date of 11/25/13. There was no end date for the order.

Review to the Treatment Administration Record (TAR), revealed an order for knee high TED Hose to be on in the AM and off in the PM. The order date was 11/25/13 at 6:45 AM. In the 8:00 AM slot for electronic initials for 03/11/14 and 03/12/14 there were the initials for LPN #1.

Interview with Licensed Practical Nurse (LPN) #1, on 03/12/14 at 3:30 PM, revealed Resident #1 returned to the facility after hip surgery for a fracture on 11/25/13. The discharge orders contained an order for the resident to wear knee high TED Hose 12 hours on and 12 hours off. The order had been transferred to the Treatment Administration Record (TAR) and the facility's Order Review Report and to the Certified Nursing Assistant's (CNA) work sheet. LPN #1 stated the CNA had not applied the knee high TED Hose on 03/11/14 and when the CNA had applied the hose on 03/12/14 the CNA reported to the nurse the hose were too tight and they were removed. The

F 309

F 309 Provide care/services for highest well being

4/19/14

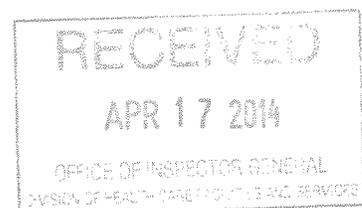
This facility will ensure that all residents receive the necessary care to maintain the highest practical well being.

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?

Licensed Practical Nurse (LPN) received training by the DCE on 3/21/14 on following physicians orders. LPN also trained to notify physician when unable to carry out orders. TED hose applied per the physicians orders.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

All residents the potential to be affected by the alleged deficient practice. All nurses will be inserviced by the DNS or DCE on 4/17/14 on following physician orders and physician notification in the event they are unable to carry out orders. A review of ten residents physician orders will be completed daily in

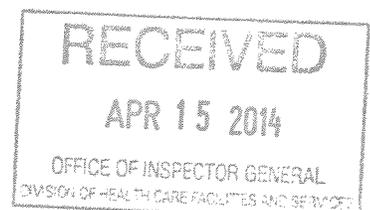


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F 309	Continued From page 14 follow a physician order for knee high TED Hose (compression stockings) for one (1) of twenty-four (24) sampled Residents, Resident #1. The findings include: Observations, on 03/11/14 at 11:40 AM, 1:30 PM, 2:15 pm, and 3:01 PM and on 03/12/14 at 8:00 AM, 8:52 AM, 10:01 AM, and 11:00 AM, revealed Resident #1 did not have TED Hose on. Review of the Physician Order Review Report, revealed on 11/25/13 Resident #1 had a physician order for knee high TED Hose that were to be worn 12 hours on and 12 hours off. The order was active with a start date of 11/25/13. There was no end date for the order.	F 309	F 309 Provide care/services for highest well being This facility will ensure that all residents receive the necessary care to maintain the highest practical well being. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Licensed Practical Nurse (LPN) received training by the DCE on 3/21/14 on following physicians orders. LPN also trained to notify physician when unable to carry out orders. TED hose applied per the physicians orders.
	Review to the Treatment Administration Record (TAR), revealed an order for knee high TED Hose to be on in the AM and off in the PM. The order date was 11/25/13 at 6:45 AM. In the 8:00 AM slot for electronic initials for 03/11/14 and 03/12/14 there were the initials for LPN #1. Interview with Licensed Practical Nurse (LPN) #1, on 03/12/14 at 3:30 PM, revealed Resident #1 returned to the facility after hip surgery for a fracture on 11/25/13. The discharge orders contained an order for the resident to wear knee high TED Hose 12 hours on and 12 hours off. The order had been transferred to the Treatment Administration Record (TAR) and the facility's Order Review Report and to the Certified Nursing Assistant's (CNA) work sheet. LPN #1 stated the CNA had not applied the knee high TED Hose on 03/11/14 and when the CNA had applied the hose on 03/12/14 the CNA reported to the nurse the hose were too tight and they were removed. The		How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents the potential to be affected by the alleged deficient practice. All nurses will be inserviced by 4/17/14 on following physician orders and physician notification in the event they are unable to carry out orders. A review of ten residents physician orders will be completed daily in enhanced start up and then

4/19/14

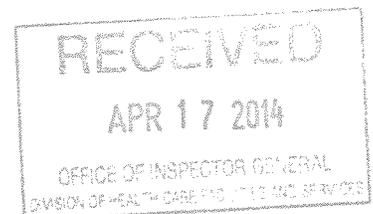


enhanced start up and then compared to actual services provided to determine if the physicians order is being followed. This will be completed by the care plan team. Enhanced start up occurs five days a week.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

All nurses will be inserviced by DNs or DCE 4/17/14 on following physician's and physician notification in the event they are unable to carry out orders. A review of ten residents physician orders will be completed daily in enhanced start up and then compared to actual services provided to determine if the physicians order is being followed. This will be completed by the care plan team. Enhanced start up occurs five days a week. DNS will audit five residents physicians orders per week for correct application for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure compliance with policy.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?



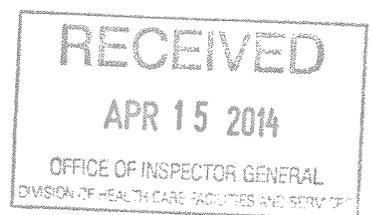
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compared to actual services provided to determine if the physicians order is being followed. This will be completed by the care plan team. Enhanced start up occurs five days a week.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

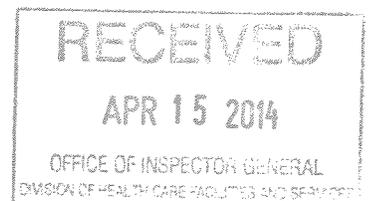
All nurses will be inserviced by 4/17/14 on following physician's and physician notification in the event they are unable to carry out orders. A review of ten residents physician orders will be completed daily in enhanced start up and then compared to actual services provided to determine if the physicians order is being followed. This will be completed by the care plan team. Enhanced start up occurs five days a week. DNS will audit five residents physicians orders per week for correct application for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure compliance with policy.

How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?



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The DNS will bring the results to the QAPI committee for two quarterly meetings. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. Physicians orders are brought to enhanced start up for review and implementation by the DNS or ADNS. DNS or ADNS ensures this by checking if the new order is either on the MAR, TAR, 24 hour report, enhanced follow up sheet or the assignment sheets as indicated. Follow through is monitored by the unit managers who will audit physicians orders three times a week to ensure compliance.

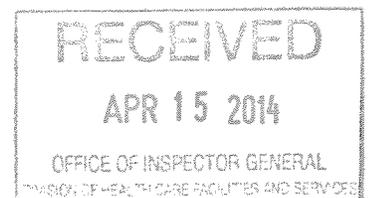


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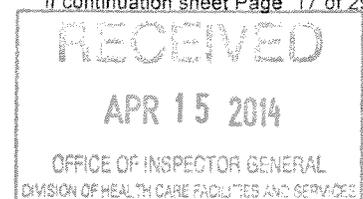
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F 309	Continued From page 15 nurse stated she did not notify the physician and that she had initialed the TAR that the TED Hose were on.	F 309			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, 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.	F 315	F 315 No Catheter, Prevent UTI, Restore Bladder This facility will ensure that all residents who enter the facility without an indwelling catheter is not catheterized unless the residents clinical condition demonstrates that catheterization was necessary. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #19 had a diagnosis of a urinary tract infection. An order was obtained from physician and written for catheter care and catheter care was provided 3/14/14. Foley catheter care for resident #19 was placed on Treatment Record. LPN#5 received training on 3/20/14 by DCE on foley catheter care per physicians orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents with orders for indwelling catheters were assessed by the nurse managers to ensure that they	4/19/14	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Catheter Care, and Indwelling Catheter, it was determined the facility failed to ensure catheter care was completed for one (1) of the twenty-four (24) sampled residents (Resident #19) who was diagnosed with a Urinary Tract Infection (UTI). The findings include: Review of the facility's policy regarding Catheter Care, Indwelling Catheter, dated 2006, revealed a purpose to prevent infection and reduce irritation. Documentation of catheter care was to include: date, time, procedure, condition of the perineum and catheter insertion site; any unusual condition or change in condition; color, amount, consistency, and odor of urine; notification of the				



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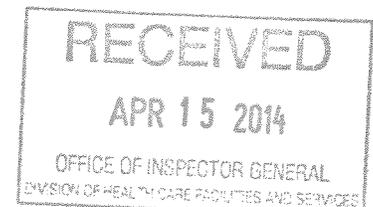
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F 315	<p>Continued From page 16</p> <p>physician of any condition change; intake and output and evaluation of intake and output per facility policy; and signature and title.</p> <p>Review of Resident #19's medical record revealed the facility admitted the resident, on 02/27/13, with diagnoses of COPD, Diabetes, Myocardial Infarction, Depression, Immobilization Syndrome, and Parkinson's Disease. Review of the Minimum Data Set (MDS), dated 02/20/14, revealed a Brief Interview for Mental Status of 15, indicating the resident was cognitively intact and interviewable. Review of the residents Urinalysis Culture and Sensitivities, collected 02/24/14 and 02/25/17, revealed three (3) different organisms were identified with two (2) of the organisms having multi-drug resistance. Continued review revealed a physician's order was obtained on 02/26/14 to insert an indwelling urinary catheter for Urine Retention. Continued review revealed the resident's comprehensive plan of care did not have a care plan for care of the catheter and potential complications for use. Review of the physician's orders and the Treatment Administration Record (TAR) revealed catheter care was not listed.</p> <p>Observations of Resident #19, on 03/12/14 at 5:00 PM and 03/13/14 at 10:25 AM, revealed the resident had an indwelling urinary catheter with cloudy yellow urine to a urinary drainage bag.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #4, on 03/13/14 at 2:00 PM, revealed she used soap and water when performing catheter care. The SRNA paused and was hesitant to verbalize if catheter care was performed on Resident #19. The SRNA revealed she had just completed the resident's catheter care. In</p>	F 315	<p>had physician orders for catheter care on 3/14/14. All nurses will be inserviced by DNS and/or DCE by 4/17/14 on the documentation and care of catheters. Certified Nursing Assistants (CNA) assignment sheets were reviewed by Nurse Managers on 3/31/14 to ensure all residents with catheters are listed per orders.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Inservices will be provided to all nursing staff regarding following residents plan of care concerning foley catheters - their care, protocol and documentation. All nurses will have skill validation on the process of catheter care by the DCE. DCE will then observe five residents with foley catheters per week to ensure that it is on the TAR and that care is provided as ordered for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure compliance with policy. Completed audits will be provided to the DNS.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p>	



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F 315	Continued From page 17 <p>addition the SRNA revealed catheter care was completed every two (2) hours. The SRNA revealed she knew to perform catheter care on the ones listed as having a catheter on the SRNA care sheet.</p> <p>Review of the SRNA care sheet revealed Resident #19 did not have an indwelling urinary catheter listed.</p> <p>Interview with Resident #19, on 03/13/14 at 2:07 PM, revealed catheter care had not been performed that day. In addition, the resident revealed catheter care was not routinely done by any staff member.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 03/13/14 at 2:30 PM, revealed the SRNA's were responsible to complete the urinary catheter care and nurses were to chart it as completed on the TAR. The LPN revealed urinary catheter care should be done every shift. While reviewing Resident #19's TAR, LPN #5 stated catheter care should be on the TAR; however, catheter care was not listed and did not know why. The LPN stated the TAR was generated from the physician's orders that were put into the computer. After reviewing the physician's orders, the LPN indicated there was no order to complete catheter care and care orders should have been obtained at the time the order was written to place the catheter. The LPN revealed he did notify the SRNA's during the stand up meeting at the beginning of the shift who had a catheter to ensure care was provided. The LPN revealed the SRNA care sheet also listed which residents had a catheter. After reviewing the care sheet, the LPN revealed a catheter was not listed for Resident #19 and did not realize it was not on the</p>	F 315	The DNS will bring the results to the QAPI committee for two quarterly meetings. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. Annually nurses will have indwelling catheter care proficiency checks by the DCE.		



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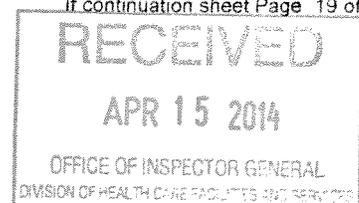
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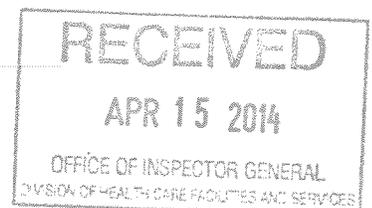
F 315	<p>Continued From page 18 care sheet</p> <p>Interview with SRNA #3, on 03/13/14 at 2:50 PM, revealed catheter care was completed by the day shift staff and charted in the SRNA charting in the computer.</p> <p>Review of the Bowel and Bladder Detail, for 03/11/14, revealed there was no documentation of the resident having a catheter and catheter care completed. The resident was documented as being incontinent. Documentation, for 03/12/14, revealed charting for the resident as being continent of urine and later as having an appliance. Documentation for 03/13/14 on Resident #19 revealed the resident was documented as being both incontinent of urine and had an appliance. Further review for the month of March revealed continued inconsistencies with SRNA charting.</p> <p>Interview with Registered Nurse (RN) #2, on 03/13/14 at 4:35 PM, revealed the SRNA's were responsible for catheter care and the charting. The RN revealed urinary catheter care did not need to be on the TAR and was done daily on the second shift.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 03/13/14 at 2:44 PM, revealed catheter care should be done daily and was a part of the nursing standard used at the facility.</p> <p>Interview with Staff Development, on 03/13/14 at 3:20 PM, revealed catheter care should be documented on the TAR. Further interview, on 03/13/14 at 4:51 PM, revealed the Nursing Standards were available as policy and on the facility's intranet which could be retrieved by every</p>	F 315		
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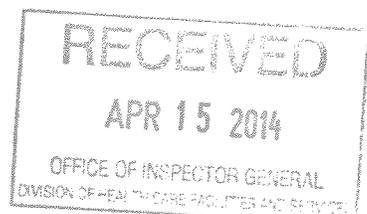
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F 315	Continued From page 19 employee. However, Staff Develop revealed the policy did not provide guidance as to when or how often catheter care should be done. Additionally, Staff Development revealed frequency of catheter care was not discussed during training. Interview with the Director of Nursing (DON), on 03/13/14 at 4:20 PM, revealed urinary catheter care should be done once a day and is scheduled for the 3:00 PM to 11:00 PM shift. The DON revealed there should be orders for catheter care which would include the frequency and the order would generate the TAR to be charted by the nurse when the catheter care was completed. The DON revealed she did not know how it was overlooked to not have an order, or be placed on the TAR. The DON revealed she did not know why there were inconsistencies in SRNA documentation. The DON revealed a potential for development or worsening of a UTI. The DON revealed she was not monitoring catheter care to ensure it was being done.	F 315		
F 431 SS=E	(see F 279) 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	F 431 Drug Records, Label/Store Drugs & Biological's This facility will store all resident medications safely, securely and properly, following the manufacturer's recommendations or those of the supplier. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Identified items were removed from medication rooms and treatment carts on 3/14/14 by the DNS and Pharmacist. Items removed included 10 cc syringes, antibiotic Tazicef, vancomycin, unidentified liquid bottle, bottle of alcohol, tube of Xenaderm, bottle of hydrogen proxide, tube of aquaphor cream, gastric tubes, tube of clobetasol, tube of bio freeze and povidine iodine solution.	4/19/14



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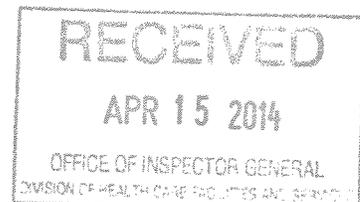
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F 431	<p>Continued From page 20</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure drugs and biologicals were not expired, contained appropriate labels, and were dated when opened for two (2) halls (East and West), on three (3) of four (4) units (A and B units on East, and A unit on West).</p> <p>The findings include: Review of the facility's policy regarding Storage of Medications, revised November 2011, revealed all medications dispensed by the pharmacy are</p>	F 431	<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>All residents have the potential to be affected by the alleged deficient practice. All treatment carts and Med Rooms have been checked on 3/31/14 by DNS & Pharmacist.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Nursing staff will be inserviced by pharmacy consultant and DCE by 4/17/14 on facility policy and procedure for storage of medications, expired medication and biologicals and dating/labeling open gastric tubing. DNS will audit one treatment cart and one medicine room per week to ensure that no expired medications, biologicals and/or supplies are in use for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure compliance with policy. Pharmacist to audit treatment carts and medicine rooms monthly.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what</p>	



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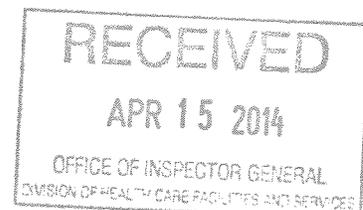
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F 431	Continued From page 21 stored in the container with the pharmacy label. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. Expiration dates of dispensed medications shall be determined by the pharmacist at the time of dispensing. Observation of the East Wing Hall A Medication Room, on 03/13/14 at 1:45 PM, revealed three (3) vials of the antibiotic Tazicef with an expired date of 03/01/14, and two (2) vials of Vancomycin with expired dates of 02/20/14. Review of Treatment Cart #1 on the East Hall A Unit, on 03/13/14 at 1:50 PM, revealed an unidentified liquid bottle with no date or label and one (1) bottle of alcohol with an expiration date of 02/12/12. Review of Treatment Cart #2 on the East Hall B Unit, revealed one (1) tube of Zenaderm, one (1) bottle of hydrogen peroxide, and one (1) tube of Aquaphor cream with no date or label. In addition, observation of the Medication Room on the West Hall Unit A, on 03/13/14 at 1:55 PM, revealed one (1) box of 10 cc syringes with an expired date of 2010, and two (2) packages of gastric tubes (#14 and #18) opened with no date when opened. Review of Treatment Care #1 on the West Hall A Unit, on 03/13/14 at 2:00 PM, revealed one (1) tube of Clobetasol 0.5% with no label or date when opened, one (1) tube of Bio Freeze with no label, and one (1) Povidine Iodine solution 10% for Resident #10 opened with no expiration date, and a dispensed date of May 2013. Interview with LPN Charge Nurse #4 on the East	F 431	quality assurance program will be put into place? The DNS will bring the results to the QAPI committee for two quarterly meetings. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. Pharmacist to audit treatment carts and medicine rooms monthly to identify expired medications and biologicals.		



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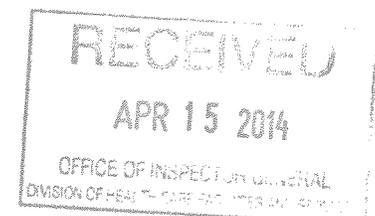
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F 431	Continued From page 22 Hall, on 03/13/14 at 2:00 PM, revealed the treatment nurses were responsible for checking the treatment carts on the West Hall, one time per week to ensure all drugs expired was discarded. Interview with Unit Manager RN #1 on the West Hall, on 03/13/14 at 2:30 PM, revealed it was the responsibility of the night shift to check for expired medications on the treatment carts, but but it was all the nurse's duty to check and remove if there are discharged medications. The UM stated this should be done weekly, and revealed everyone needs to get back on track, and check more frequently. Interview with the ADON, West Hall, on 03/13/14 at 3:00 PM, revealed the nurses doing the treatments are responsible for checking the treatment carts weekly for expired supplies, and stated all nurses should be watching for expired supplies or medications and disposing if needed.	F 431	F441 - Infection Control, Prevent, Spread, Linens This facility will provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection.
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT 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	F 441	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Both residents were assessed and it was determined that there were no signs or symptoms of infection over the following three days. Nurses and CNA with deficient practice was in-serviced by DCE 3/20/14 on aseptic technique when changing from a bedside drainage bag to a leg bag and proper handling of medications during a medication pass to prevent cross contamination. 4/19/14



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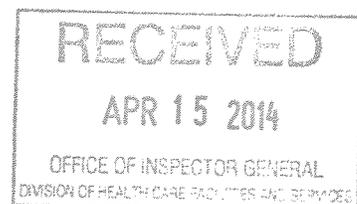
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F 441	Continued From page 23 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread 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.	F 441	How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All resident's have the potential to be affected by the alleged deficient practice. Though no other residents were identified to have been adversely affected. All nursing staff will receive training on infection control and aseptic technique by the DCE by 4/17/14. All nursing staff will have proficiency checks by the DCE by 4/17/14.
	(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy, it was determined the facility failed to ensure procedures were in place to prevent the transmission of infection for two (2) of twenty-four (24) sampled residents, Resident #3 and Resident #8. Aseptic (free from pathogenic organisms) technique was not practiced by staff when Resident #3's urinary drainage system was changed from a leg drainage bag to a bedside drainage bag. In addition, the staff failed to ensure medications were not handled or placed on dirty surfaces when administering medications to Resident #8.		What measures will be put in to place or what systemic changes you will make to ensure that the deficient practice does not recur? DCE will observe five nursing staff members a week to ensure that they can perform patient care without violations of infection control for four weeks, then bi-weekly for four weeks, then monthly for four months to ensure compliance with policy. The results of the observations will be provided to the DNS. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?



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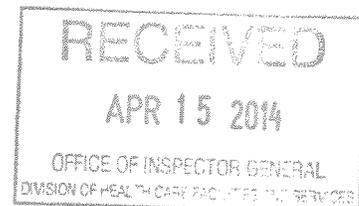
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F 441	<p>Continued From page 24</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Catheter Indwelling, Insertion and Removal, dated 2006, revealed at no time should the tubing be placed above the level of the bladder to allow back flow of urine into the bladder. No policy was provided regarding changing a catheter from a bedside drainage system to a leg bag drainage system when residents with a catheter were gotten out of bed.</p> <p>Observation of Resident #3, on 03/11/14 at 11:30 AM, revealed the resident was laying on their right side in bed with his/her catheter attached to a bedside drainage sytem. Observation at 1:00 PM, revealed the resident was up in a wheelchair in the dining room with his/her catheter attached to a leg bag drainage system. Observation at 3:30 PM, revealed the resident was laying supine in bed with his/her catheter attached to a leg bag drainage system. Observation of Resident #3, on 03/12/14 at 8:30 AM, revealed the resident was up in a wheelchair in the dining room with his/her catheter attached to a leg bag drainage system. Observation at 9:00 AM revealed the resident was laying supine in the bed with his/her catheter attached to a leg bag drainage system. Observation at 9:00 AM revealed the resident was laying supine in the bed with his/her catheter attached to a leg bag drainage system and his/her legs bent with the drainage system tubing above the level of the resident's bladder.</p> <p>Observation of a brief change and catheter drainage system change for Resident #3, on 03/13/14 at 9:00 AM, revealed State Registered Nursing Assistant (SRNA) #2 removed a bedside</p>	F 441	<p>The DNS will bring audit results to the QAPI committee for two quarterly meetings. The audit results will be brought to two quarterly QAPI committee meetings. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for additional audits. Annually nursing staff will have infection control proficiency checks by the DCE.</p>



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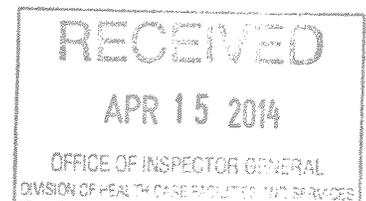
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F 441	<p>Continued From page 25</p> <p>drainage bag with tubing from a plastic bag which had been stored in the bathroom. The male adapter end of the tubing was not covered with the protective tip which came with the tubing and drainage bag in a sterile container used with the insertion of the catheter for Resident #3. CNA #2 removed the catheter from the tubing of the leg drainage system and inserted the male adapter of the bedside drainage tubing without cleansing the male adapter. Observation at that time also revealed CNA #2 touched the male adapter of the bedside drainage system tubing with his gloved finger which had been contaminated by touching the outside of the plastic bag containing the drainage bag and tubing.</p> <p>Review of the clinical record for Resident #3 revealed the facility admitted the resident on 08/10/09 with diagnoses of Alzheimer's Dementia, Prolapsed Uterus and a current Urinary Tract Infection (UTI). The facility assessed the resident as being non-interviewable with a score of ninety-nine (99) on the Brief Interview of Mental status indicating he/she could not complete the assessment interview. Review of the most current physician orders indicated the resident had a catheter inserted into the urinary bladder (initiated on 08/21/13) due to Urinary Retention. Review of infection control tracking data revealed Resident #3 had a UTI in December 2013 and the current UTI was diagnosed on 03/07/14.</p> <p>Interview with CNA #2, on 03/13/14 at 9:15 AM, revealed most residents with catheters were to have their urinary drainage systems changed from a bedside drainage system to a leg bag drainage system when they got out of bed for their dignity. He stated some residents with catheters did not have this done, but he was not</p>	F 441		



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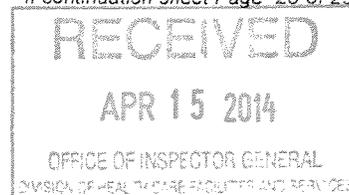
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F 441	<p>Continued From page 26</p> <p>sure why. He stated Resident #3 went to bed after each meal and the drainage system was to be changed back and forth several times a day as he/she was not supposed to have the leg bag drainage system when laying down. CNA #2 stated the concern with touching the male adapter of the tubing with contaminated gloves would be an increased risk of infection. He indicated the caps for the bedside drainage system's tubings tended to fall off in the plastic bags they were stored in and that could lead to contamination of the male adapter and further risk of infection.</p> <p>Interview with LPN #3, on 03/13/14 at 9:30 AM, revealed the concern of touching the male adapter of the drainage system tubing for either the leg bag or the bedside drainage bag would be the increased risk of infection. He further stated it was the responsibility of the CNA's or the nurses to change a resident's catheter drainage system from a leg bag to a bedside drainage bag. He indicated he could not remember an inservice which addressed aseptic technique when changing the drainage systems.</p> <p>Interview with the Infection Control Nurse (ICN), on 03/13/14 at 10:00 AM, revealed she was aware daily of infections in the facility and she would determine the necessity for an inservice based on any tracking/trending concerns. She stated she had not determined any trends or increase in UTI's over the past year. She further stated the facility's practice of changing catheter drainage systems from a bedside drainage system to a leg bag drainage system when the residents got out of bed had been in effect during the past one and one-half (1 1/2) years she had worked there. The ICN stated the bedside</p>	F 441	



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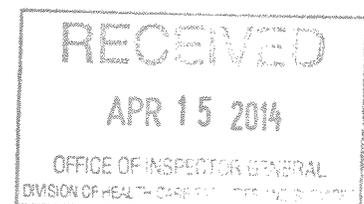
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F 441	<p>Continued From page 27</p> <p>drainage tubing had an antflow valve (to prevent urine from flowing back into the bladder) and the leg bag drainage system did not. The ICN further stated she had not specifically trained the CNA's on how to change a catheter tubing from one drainage system to another.</p> <p>Interview with the Advanced Registered Nurse Practitioner (ARNP), on 03/13/14 at 11:30 AM, revealed the facility staff should be using aseptic technique when they changed urinary catheter drainage systems as they could increase the risk of UTI's if they did not.</p> <p>Interview with the Director of Nursing (DON), on 03/13/14 at 2:10 PM, revealed it was the practice of the facility to change the urinary drainage system for most of the residents with catheters to maintain their dignity and to keep them from pulling their catheters out. However, she stated it could increase the risk of infection if aseptic technique was not maintained when the resident's closed drainage system was broken several times a day. She stated it was the responsibility for the charge nurses and supervisors to monitor the work of the CNA's and report to her if there was a problem. The DON indicated she had not been made aware of any problem with the CNA's not using aseptic technique when changing catheter drainage systems, but she did no monitoring herself.</p> <p>2. Review of the facility's policy regarding regarding Administering Medications, dated August 2012, revealed staff should follow established facility infection control procedures (e.g., hand washing antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable.</p>	F 441		



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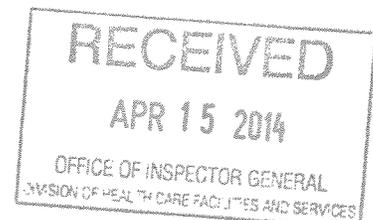
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F 441	<p>Continued From page 28</p> <p>Observation during the medication pass, on 03/12/14 at 7:30 AM, revealed Unit Manager RN #1, removed an oral medication from the old medication cart, with her bare hands and carried it across the hall to the new medication cart, then place the oral medication on top of her contaminated clip board, rather than place in a medicine cup. RN #1 stated, "My hands are clean, I just washed them." The RN stated the new medication cart had just been delivered yesterday, and all of the medications had not been transferred to the new cart yet.</p> <p>Interview with the Unit Manager RN #1, on 03/12/14 at 11:30 AM, revealed she realized she had placed the pill on top of the medication cart, and realized afterwards she should not have done this.</p> <p>Interview with the ADON on the West Hall, on 03/13/14 at 3:00 PM, revealed all nurses should follow the Infection Control Guidelines when giving any kind of medications. The ADON stated nurses should not be touching any medications, and are responsible for completing medication competencies yearly; the ADON revealed the Unit Manager (RN #1) had that training.</p> <p>Interview with the Director of Nursing, on 03/13/14 at 4:00 PM, revealed she concurred with the Assistant Director of Nursing's interview that policies should be followed and competencies completed as required.</p>	F 441		



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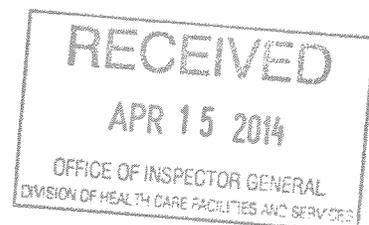
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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at E level.	K 000	<p><u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u></p> <p>K 29 NFPA Life Safety Code</p> <p>This facility will ensure that all smoke barriers will be sealed to ensure a safe environment.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The closet identified in the business office has a self closing device installed 03/31/14 by the maintenance director.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Audit of all closets was completed by the nursing home administrator (NHA)</p>	4/19/14
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, residents, staff and visitors. The facility has one-hundred and forty-five (145) certified beds and the census was one-hundred and thirty-six (136) on the day of the survey.	K 029		



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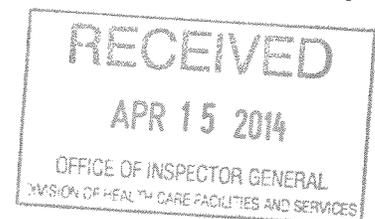
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K 029	<p>Continued From page 2 The findings include:</p> <p>Observation, on 03/11/14 at 10:57 AM, with the Administrator and the Maintenance Director revealed the door to the Storage Room located in Business Office, did not have a self-closing device installed on the door.</p> <p>Interview, on 03/11/14 at 10:57 AM, with the Administrator and the Maintenance Director revealed the room had previously been used as a coat closet. It had recently been converted to store copier paper and other supplies. They acknowledged the room is now used for the storage of combustible items and should be equipped with a self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²)</p>	K 029	<p>on 3/31/14. No other areas were identified as needing a self closing device.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Monthly audits will be completed by the maintenance director to ensure no closets are used for storage with potentially combustible items is added to any room without a self closing device on the door.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Closets will be audited monthly by maintenance director and/or the administrator for any combustible items in any room. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) monthly for three months and then quarterly for three quarters.</p>	



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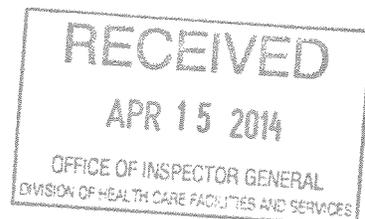
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K 029	Continued From page 3 (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029	K 45 NFPA 101 Life Safety Code This facility will ensure that all exits are arranged so that any failure of any single lighting fixture will not leave the area in darkness.	4/19/14
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, approximately sixty-five (65) residents, staff and visitors. The facility has one-hundred and forty-five (145) certified beds and the census was one-hundred and thirty-six	K 045	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The exits to the Alzheimer's unit have been replaced 3/31/14 by the maintenance director to ensure that any failure of any single lighting fixture will not leave the area in darkness. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Audit of all exits was completed on 3/31/14 by the NHA and no other exit needed additional lighting to ensure compliance.	



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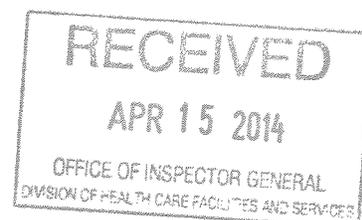
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K 045	<p>Continued From page 4 (136) on the day of the survey. The facility failed to provide the required level of illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observations, on 03/11/14 between 10:19 AM and 10:31 AM, with the Maintenance Director revealed both of the exits from the Alzheimer Unit, did not have exterior egress lighting to provide the required level of illumination at the exit discharges. The exits were equipped with light fixtures containing one bulb.</p> <p>Interviews, on 03/11/14 between 10:19 AM and 10:31 AM, with the Maintenance Director revealed he was not aware of the requirement for exterior light fixtures required for egress to have two (2) bulbs.</p> <p>Interview, on 03/11/14 at 3:16 PM with the Administrator at the Exit Conference revealed he was not aware of the two (2) exits from the Alzheimers Unit not having a light fixture with two (2) bulgs.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>19.2.8 Illumination of Means of Egress.</p> <p>Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided</p>	K 045	<p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>On-going monthly audits will be completed by the maintenance director to ensure that any failure of any single lighting fixture will not leave the exit area in darkness. Lights will be tested monthly to ensure fixture is working appropriately. Maintenance director was trained on 4/11/14 on the significance of ensuring that the lights are working.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>On-going monthly audits will be completed by the maintenance director to ensure that any failure of any single lighting fixture will not leave the exit area in darkness. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) monthly for three months and then quarterly for three quarters.</p>	



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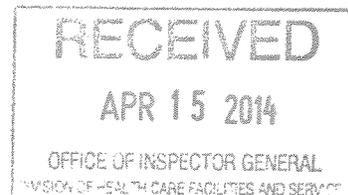
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K 045	Continued From page 5 in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low	K 045			



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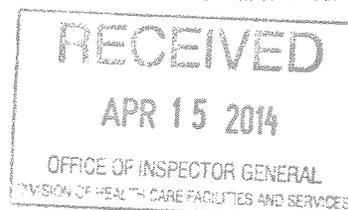
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185165	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/11/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CAMELOT		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 LYNDON LANE LOUISVILLE, KY 40222		
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K 045	Continued From page 6 lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 056 SS=D	NFFA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of eleven (11) smoke compartments, residents, staff and visitors. The facility has one-hundred and forty-five (145) certified beds and the census was one -hundred and thirty-six (136) on the day of the survey.	K 056	<p>K 56 NFPA 101 Life Safety Code</p> <p>This facility will ensure that all areas of the facility has sprinkler coverage in accordance of NFPA 25 standards.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The addition of the sprinkler head for the exterior entrance of the building has been completed by AA Fire and Sprinkler on 4/09/14.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Audit of all the building was completed by the NHA. No other area was in need of sprinkler coverage.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p>	4/19/14



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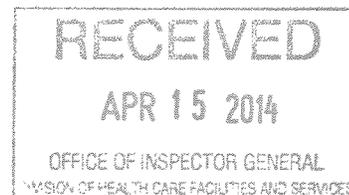
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K 056	Continued From page 7 The findings include: Observation, on 03/11/14 at 9:26 AM, with the Maintenance Director revealed the projected roof overhang from the main entrance vestibule, was not protected by automatic sprinkler coverage. The roof extended greater than four (4) feet from the building and was constructed of combustible materials. Interview, on 03/11/14 at 9:26 AM, with the Maintenance Director revealed the facility had consulted their sprinkler contractor and was informed the extended roof overhang from the main entrance vestibule was not required to be sprinkled and had questioned their interpretation of the Code. Interview, on 03/11/14 at 3:16 PM, with the Administrator during the exit conference, confirmed their sprinkler contractor conducted an audit on their sprinkler system to assure the facility was being protected by complete, automatic sprinkler coverage and thought the facility was in compliance with automatic sprinkler requirements. Reference: NFPA 101 (2000 Edition) 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 056	Monthly audits will be completed by the maintenance director for the next ninety days and audits will completed quarterly thereafter to ensure that sprinkler coverage is in place. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Monthly audits will be completed by the maintenance director for the next ninety days and audits will completed quarterly thereafter to ensure that sprinkler coverage is in place. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) monthly for three months and then quarterly for three quarters.	



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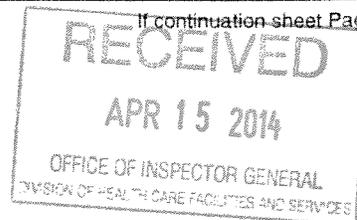
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K 056	Continued From page 8 Reference: NFPA 13 (1999 Edition) 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056			
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K 066 NFPA 101 Life Safety Standard This facility will ensure that outdoor smoking area is properly equipped for safe smoking in accordance with NFPA standards. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A fire extinguisher was obtained and installed from FESCO (vendor) on 3/31/14 and an approved metal container with a self closing lid to empty ashtrays is available for use. This was completed 3/31/14 by the maintenance director. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Facility only has one area for resident smoking. A fire extinguisher and an approved metal container with a self	4/19/14	



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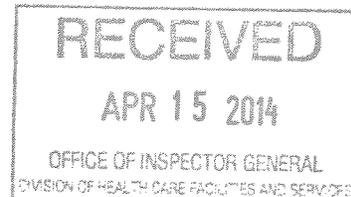
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K 066	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for Residents was properly equipped for safe smoking, in accordance with NFPA standards. The deficiency had the potential to affect the Staff and Residents using the smoking area. The facility has one-hundred and forty-five (145) certified beds and the census was one-hundred and thirty-six (136) on the day of the survey.	K 066	closing lid to empty ashtrays is available for use. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Monthly audits to ensure that the fire extinguisher and metal container are in place will be completed by the maintenance director for the next ninety days and audits will completed quarterly thereafter. Fire extinguishers will be checked annually by FESCO along with the rest of the extinguishers in the building to ensure they are in working order. Maintenance director checks all extinguishers on a monthly basis to ensure they are fully charged.	
	The findings include: Observation, on 03/11/14 at 11:45 AM, with the Maintenance Director revealed the designated outdoor smoking area for Residents did not have an approved metal container with a self-closing lid to empty ashtrays into and a fire extinguisher available for use. Interview, on 03/11/14 at 11:45 AM, with the Maintenance Director revealed he was not aware of the requirements for the designated, outdoor smoking area for Residents to be equipped with an approved metal container with a self-closing lid to empty ash trays into and a fire extinguisher available for use. Interview, on 03/11/14 at 3:16 PM, with the Administrator during the Exit Conference revealed he was aware of the requirements and had been planning on purchasing a metal container with a self-closing lid for the disposal of tobacco waste.		How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Monthly audits will be completed by the maintenance director to ensure that the fire extinguisher and metal container are in place for the next ninety days and audits will completed quarterly thereafter. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) for review and modification if needed..	



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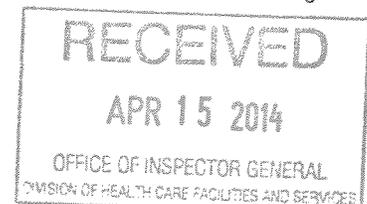
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K 066	Continued From page 10 Reference: NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		



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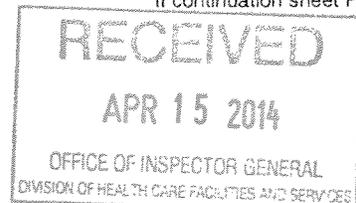
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K 066	Continued From page 11 Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, 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 NFPA standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, approximately fifty (50) residents, staff and visitors. The facility has one-hundred and forty-five (145) certified beds and the census was one-hundred and thirty- six (136) on the day of the survey. The findings include: Observations, on 03/11/14 between 9:56 AM and 12:05 PM, with the Maintenance Director revealed access to electrical panels located within the Mechanical Room in the 200 Hall and within the Storage Room located in the D Hall, East Wing had been blocked with items stored within 3 feet of access to the panels. Interview, on 03/11/14 between 9:56 AM and 12:05 PM, with the Maintenance Director revealed he was aware of the clear access	K 147	K 147 NFPA 101 Life Safety Code Standard This facility will ensure that access is maintained to electrical panels in accordance with NFPA standards. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Items were removed by the maintenance director 3/14/14 from the rooms with the electrical panels - mechanical room in the 200 hall and the storage room located on D-hall in the east wing making sure that the panels have three feet of space in front of them. Staff have been in-serviced and tape has been placed on the floor identifying area that needs to stay clear. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All panels have been audited and marked by tape to ensure that three feet of space is available at all times.	4/19/14



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K 147	Continued From page 12 requirements around electrical panels but unaware of items temporarily stored within three (3) feet of the electrical panels. He emphasized the facility is lacking necessary storage space. Interview, on 03/11/14 at 3:16 PM, with the Administrator revealed he was not aware of items being temporarily stored in front of the electrical panels. 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 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code. (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. Table 110.26(A)(1) Working Spaces	K 147	What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Monthly audits will be completed by the maintenance director for the next ninety days and audits will completed quarterly thereafter to ensure that space is maintained. Staff have received training on why this area must be clear. Training was provided by NHA by 4/10/14. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Monthly audits will be completed by the maintenance director for the next ninety days and audits will completed quarterly thereafter to ensure that space is maintained. Findings of audits will be brought to Quality Assessment & Performance Improvement (QAPI) for review and modification if needed.	



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K 147	Continued From page 13 Nominal Voltage to Ground Minimum Clear Distance Condition 1 Condition 2 Condition 3 0-150 900 mm (3 ft) 900 mm (3 ft) 900 mm (3 ft) 151-600 900 mm (3 ft) 1 m (3½ ft) 1.2 m (4 ft)	K 147		
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