

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

PRINTED: 10/28/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/16/2014
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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification Survey was conducted on 10/14/14 through 10/16/14 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of a "F".	F 000	Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/7/14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1  <del>This REQUIREMENT is not met as evidenced by:</del>	F 164	<b><u>F 164 (D) 483.10(e), 483.75 (l) (4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</u></b>	
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	<p>Based on observation, interview, and review of the facility's Dignity Policy, it was determined the facility failed to ensure personal privacy for one (1) of fourteen (14) sampled residents (Resident #2). Staff failed to pull the curtain around Resident #2's bed and the resident was exposed during incontinent care.</p> <p>The findings include:</p> <p>Review of the Dignity Policy, last revised 08/01/12, revealed staff should provide privacy when doing resident care by "ensuring curtains are drawn, doors closed, window shades down, etc."</p> <p>Record review revealed the facility admitted Resident #2 on 09/12/14 with diagnoses which included Non-Alzheimer's Dementia and Schizophrenia. Review of the admission Minimum Data Set (MDS) assessment, dated 09/22/14, revealed the facility assessed the resident's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "8" which indicated the resident was possibly interviewable. An attempt to interview the resident, on 10/15/14 at 9:55 AM, was unsuccessful as the resident would answer questions inappropriately and walk away.</p> <p>Observation of Resident #2, on 10/15/14 at 8:32 AM, revealed Licensed Practical Nurse (LPN) #1 and LPN #2 were providing incontinent care to the resident without pulling the privacy curtain between the resident and the door and the resident was exposed. The door was opened by</p>		<p><b><i>Corrective Actions for Residents Found to Have Been Affected</i></b> Personal privacy is being provided to Resident #2. On 10-15-2014 LPN #1, LPN #2, and another staff member cited in F 164 were in-serviced by the Director of Nursing (DON) on following facility privacy policies and how to adequately provide privacy to each resident when providing care.</p> <p><b><i>Identification of Other Residents Having the Potential to be Affected</i></b> The DON reviewed each resident's privacy on 10-15-2014 and 10-16-2014 for compliance with privacy policies and for the provision of privacy to each resident. There were no breaches in the provision of privacy to any resident.</p>	
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F 164	Continued From page 2 another staff member without her waiting for a response after knocking which exposed the resident due to the curtain not being pulled	F 164	On 10-30-2014 thru 11-07-2014 all staff members of the facility were in-serviced by the DON on providing adequate privacy to each and every resident. Employees who are on extended leave will not be permitted to return to work until they have been educated by the DON.		
F 241 SS=D	Interviews on 10/16/14 with Registered Nurse (RN) #1 at 1:48 PM, LPN #2 at 1:52 PM, State Registered Nurse Aide (SRNA) #1 at 1:18 PM, SRNA #2 at 1:23 PM, SRNA #3 at 1:24 PM, and SRNA #4 at 1:26 PM, revealed staff are responsible for closing doors, pulling curtains, and closing blinds to provide resident privacy.  Interview with Director of Nursing (DON), on 10/16/14 at 1:28 PM, revealed staff are expected to pull curtains around residents but stated door should have provided privacy.  483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Dignity Policy, it was determined the facility failed to ensure staff did not enter one (1) of fourteen (14) sampled residents (Resident #2's) room after knocking and prior to receiving a response from staff or the resident. Staff had the resident exposed while providing incontinent care and the curtain was not pulled around the bed.  The findings include:	F 241	<b>Measures or Systemic Changes put into Place to Avoid Recurrence</b>  Effective 11-3-2014 the charge nurses are completing compliance rounds daily that include reviews for the personal privacy of each resident. These monitoring tools will be presented to the DON each day for follow-up.  On 10-30-2014 thru 11-07-2014 all staff members of the facility was in-serviced by the DON on providing adequate privacy to each and every resident. Employees who are on extended leave will not be permitted to return to work until they have been educated by the DON.		

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F 241	Continued From page 3 Review of the Dignity Policy, revised 08/01/12, revealed staff are to knock on resident's door before entering room.	F 241	<b>Plans to Monitor Performance for Sustained Solutions</b> The DON will present the results of the daily monitoring rounds for personal privacy to the Quality Assurance Committee that meets monthly for review, recommendations and follow-up.	
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	Record review revealed the facility admitted Resident #2 on 09/12/14 with diagnoses which included Non-Alzheimer's Dementia and Schizophrenia. Review of the admission Minimum Data Set (MDS) assessment, dated 09/22/14, revealed the facility assessed the resident's cognition as moderately impaired with a Brief Interview of Mental Status (BIMS) score of "8" which indicated the resident was possibly interviewable. An attempt to interview the resident, on 10/15/14 at 9:55 AM, was unsuccessful as the resident would answer questions inappropriately and walk away.			
	Observation of Resident #2, on 10/15/14 at 8:32 AM, revealed Licensed Practical Nurse (LPN) #1 and #2 were providing incontinent care to the resident with the resident exposed when a staff member knocked on the door and opened the door before the nurses could respond that resident care was being provided.			
	Interviews on 10/16/14 with Registered Nurse (RN) #1 at 1:48 PM, LPN #2 at 1:52 PM, and State Registered Nurse Aide (SRNA) #4 at 1:26 PM, revealed staff are expected to knock and ask permission to enter a closed door.			

F 371 SS=F	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	<b>Identification of Other Residents Having the Potential to be Affected</b> The DON reviewed each resident's dignity and privacy on 10-15-2014 and 10-16-2014 for	11-14-2014
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F 371	Continued From page 4  The facility must - <del>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</del>	F 371	compliance with dignity and privacy policies and for the provision of dignity and privacy to each resident. There were no breaches in the provision of dignity and privacy to any resident.	
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	(2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure food was stored, prepared and distributed under sanitary conditions. Observations on 10/14/14 revealed: There were sauces in the refrigerator that were out of date and undated; fourteen (14) packages of bread items undated; the food thermometers had not been calibrated prior to taking food temperatures, with the food thermometers inaccurately testing zero (0) degrees Fahrenheit (F) in ice water; the milk cooler was noted to have a blackened area around the gasket; and, the stove burners and range top were noted to have areas of rust-colored debris. In addition, the facility failed to use bleach sanitizer test strips and regularly check sanitizer strips for the proper amount of sanitizer in the low temperature dishwasher.		On 10-30-2014 thru 11-07-2014 all staff members of the facility were in-serviced by the DON on providing dignity and privacy to each and every resident. Employees who are on extended leave will not be permitted to return to work until they have been educated by the DON.  <b>Measures or Systemic Changes put Into Place to Avoid Recurrence</b> Effective 11-3-2014 the charge nurses are completing compliance rounds daily that include reviews for the dignity and personal privacy of each resident. These monitoring tools will be presented to the DON each day for follow-up.	
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	Review of the facility's Census and Condition, dated 10/14/14, revealed there were fifty-six (58) residents in the building with four (4) residents receiving tube feedings.  The findings include:		On 10-30-2014 thru 11-07-2014 all staff members of the facility was in-serviced by the DON on providing dignity and	
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F 371	Continued From page 5  1- Observation during the initial tour of the kitchen, on 10/14/14 at 11:55 AM, revealed the following:	F 371	personal privacy to each and every resident. Employees who are on extended leave will not be permitted to return to work until they have been educated by the DON.	
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	<p>A. Review of an undated facility policy titled, "Food Storage", revealed "All food items are to be dated upon receipt with the month, day and year, if the vendor product and date label is missing."</p> <p>Observation of the bread storage racks in the kitchen revealed undated food items, to include three bags of hamburger buns, one bag of hot dog buns and ten bags of dinner rolls. In the reach-in refrigerator, there was a 32 ounce carton of Sweet and Sour Sauce, dated 04/11/13 and a 32 ounce container of Tarter Sauce, dated 06/19/14, with a "best use date" of 10/05/14.</p> <p>Interview with the Dietary Manager, at the time of the observation, revealed the bread had been "recently" taken out of the freezer and thawed but she was unsure how long ago and stated the sauces should have been discarded when the weekly freezer and refrigerator cleanings were done. However, she had not maintained a cleaning assignment sheet and was unable to determine when the last cleaning had been done.</p>		<p><b>Plans to Monitor Performance for Sustained Solutions</b></p> <p>The DON will present the results of the daily monitoring rounds for dignity and personal privacy to the Quality Assurance Committee that meets monthly for review, recommendations and follow-up.</p> <p><b><u>F 371 (F) 483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY</u></b></p>	11-14-2014
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	<p>B. Review of an undated facility policy titled, "Calibrating Food Thermometers," revealed "All food thermometers will be calibrated weekly and more frequently as needed. If the food thermometer had been dropped, mishandled or if there was a question whether the temperature was correct." The morning cook was to have calibrated the food thermometer using the ice-point method of filling a plastic or metal container with 50 percent (%) ice and 50% water</p>		<p><b>Corrective Actions for Residents Found to Have Been Affected</b></p> <p>Undated and outdated items were discarded on 10-14-2014 by the Dietary Manager (DM).</p> <p>All facility food thermometers were discarded and replaced with new ones on 10-14-2014 by the DM.</p>	
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F 371	Continued From page 8 to ensure a temperature of 32 degrees F, in the ice-water solution.	F 371	The blackened area around the gasket to the milk cooler was removed and sanitized on 10-14-2014 by the DM.	
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	<p>Observation of the tray line, on 10/14/14 at 12:00 PM, revealed the Dietary Manager verified the food thermometer at zero degrees, in ice water and stated the cook was responsible to check and calibrate the thermometer once a week.</p> <p>Interview with the Cook, at the time of the observation, revealed it was the Dietary Manager's job to check and calibrate the thermometers. However, there was no assignment sheet to indicate this had been completed.</p> <p>Further interview with the Dietary Manager revealed she thought this was being done at least monthly, however, she was unable to determine where this may have been recorded or assigned to any specific person.</p> <p>C. Interview with the Dietary Manager, at 10/14/14 at 12:15 PM, revealed there was no facility policy for the cleaning of the stove top and the gaskets around the refrigerators and no cleaning assignment sheet to designate who was responsible to carry out the task.</p>		<p>The rust colored debris on the stove burners and range top was removed and sanitized on 10-14-2014 by the DM.</p> <p>On 10-14-2014 the Dietary Manager secured bleach sanitizer test strips for use in the low temperature dishwasher. These test strips indicated that sanitation is maintained appropriately in the low temperature dishwasher.</p> <p><b>Identification of Other Residents Having the Potential to be Affected</b></p> <p>All residents have the potential to be affected by F 371. See Corrective Actions for Residents Found to Have Been Affected above.</p>	
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	<p>Observation of the milk cooler and stove top, on 10/14/14 at 12:15 PM, revealed a thick rust-colored debris surrounding the stove top and burners and a blackened area on the milk cooler gasket.</p> <p>Interview with the Dietary Manager at the time of the observation, revealed the milk cooler had been recently cleaned and she was unaware the blackened substance was there and stated the</p>		<p><b>Measures or Systemic Changes put into Place to Avoid Recurrence</b></p> <p>All dietary staff were in-serviced on 10-14-2014 on undated and outdated food by the Registered Dietitian. The Dietary Manager will complete</p>	
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F 371	Continued From page 7 stove was cleaned frequently but was unaware how to prevent the the rust-colored substance.	F 371	daily audits to assure that undated and outdated food is discarded immediately.  All dietary staff were in-		
	D. Review of the undated facility policy for "Machine Warewashing" revealed the Chemical Sanitizing Machines used chemicals, rather than hot water, to sanitize and the staff were to have used chlorine litmus test strips to test for 50 parts per million (PPM) and documented the dishwasher temperature and the PPM, on the Dishwasher Temperature Chart. This procedure was to have been followed "before each time the machine was drained and refilled."		serviced on 10-14-2014 on the calibration of food thermometers, and the dating and recording of food thermometer temperatures. The Dietary Manager will review the dating and recording of food thermometer calibration daily.  On 10-14-2014 all dietary staff were in-serviced on the proper cleaning and sanitization of kitchen equipment to include the milk cooler gasket and stove burner and range top. The Dietary Manager will check and record daily the cleaning and sanitization of kitchen equipment.		
	Observation of the dishwasher procedures, on 10/14/14 at 2:00 PM, revealed the water temperature range was between 124 degrees F and 132 degrees F and the test strip used to evaluate the effectiveness of the sanitizer in the low temperature dishwasher, after the rinse cycle, was a bright yellow color after being dipped into the rinse water and did not coordinate with the colors on the test strip container.  Interview with the Dietary Manager at the time of the observation, revealed she did not use the test strips and recorded only the temperatures of the rinse water. The test strips were used by the dishwasher manufacturer, who visited the facility monthly to evaluate the effectiveness of the machine and he stated it was working properly.		The Registered Dietitian in-serviced all dietary staff on 10-14-2014 on the use and effectiveness of bleach sanitizer test strips for proper amounts of sanitizer for the low temperature dishwasher. The dietary aide will check the level of sanitation using the test strips before using the dishwasher. The Dietary Manager will check the records of bleach sanitizer strips daily.		
	Interview with the Consultant Dietician, on 10/15/14 at 9:25 AM, revealed she came to the facility one day a week and was hired for the "clinical aspect" of the Dietary Department, which included the nutritional assessments, monitoring weekly weights, and the Minimum Data Set				

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F 371	Continued From page 8 (MDS) part of the resident assessment. She had occasionally obtained test trays but had not completed any sanitation audits, as this was the	F 371	<i>Plans to Monitor Performance for Sustained Solutions</i> The Dietary Manager will	
	Corporate Dietician's role. She did look into the problem with the test strips and stated the Dietary Manager was using the wrong ones and should have used test strips for a bleach solution in the rinse cycle of the dishwasher and was not aware they were not checking the proper levels. She also stated the dietary staff should have been documenting the opened date on food products and dates on the breads, when taken out of the freezer.  Interview with the Corporate Dietician, on 10/16 14 at 9:45 AM, revealed the rust colored debris on the stove was an ongoing problem, the stove was constantly cleaned, was approximately four (4) years old and they had been having this problem all this time. She was unaware of the blackened area around the gaskets and stated this should probably have been replaced. She stated she did not assign the Consultant Dietician the Sanitation Audits and stated she had done the last one (1), two (2) months ago and was not aware of any problems. The Dietary Manager was using the dish machine maintenance person's monthly checks instead of completing the test strips on the rinse water and the		present the results of the daily sanitation checks to the Quality Assurance Committee that meets monthly for review, recommendations and follow-up	11-14-2014
	Corporate Dietician was unaware this was the case. She also stated the last time she checked the food thermometers, the Dietary Manager and Cook were using a digital and this was verified as accurate, checking with the laser thermometer she was using. She also stated she was unaware the assignment of dietary duties was not documented and would be following this more closely. As far as dating food products, the pull date should have been written on the product and			

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F 371	Continued From page 9 out of date products should have been thrown away.	F 371		
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Interview with the Administrator, on 10/16/14 at 3:40 PM, revealed he was unaware of any concerns in the kitchen, prior to the survey staff entering the building and stated this would be corrected.

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.	F 441	<b><u>F 441 (D) 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</u></b> <b><i>Corrective Actions for Residents Found to Have Been Affected</i></b> The Director of Nursing (DON)	
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	(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.		re-educated LPN #1 on 10-15-2014 regarding proper infection control technique as it relates to medication administration and feeding pumps.	
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	(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		<b><i>Identification of Other Residents Having the Potential to be Affected</i></b> The DON reviewed infection control practices and the provision of medications in feeding pumps for each resident receiving the services of a feeding pump on 11-7-2014. No breaches of infection control were noted.	
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			On 10-30-2014 thru 11-07-2014 all licensed nurses of the	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  165263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  10/16/2014
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
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F 441	Continued From page 10 hand washing is indicated by accepted professional practice.	F 441	facility were in-serviced by the DON on infection control policies and feeding pumps. Employees who are on extended leave will not be permitted to return to work until they have been educated by the DON.		
	(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, and review of the facility's policy and procedure, it was determined the facility failed to ensure appropriate infection control practices during a medication pass, for one (1) unsampled resident (Resident A). Licensed Practical Nurse (LPN) #1 failed to cap the distal end of the feeding pump tubing and the tip of the tubing came in contact with the nurse's arm, uniform sleeve and the privacy curtain. The tubing was then re-connected to the resident's gastrostomy tube, after the medications had been administered.  The findings include:  Review of the "Enteral Feeding Policy," dated 07/24/13, revealed when tube feeding are not being administered, cap the end of the feeding tube."  Observation of a medication pass, on 10/15/14 at 12:20 PM, revealed LPN #1 was preparing to administer Reglan (antiemetic) 10 milliliters (ml) and a flush of 15 ml of water per Resident A's gastrostomy tube site. The LPN disconnected the feeding pump tubing and touched the orange tip to her right arm, right uniform sleeve and then		<b>Measures or Systemic Changes put into Place to Avoid Recurrence</b> The DON and Compliance Nurse will complete weekly audits of medication administration and feeding pumps by the licensed nurses to check for compliance in infection control policies. On 10-30-2014 thru 11-07-2014 all licensed nurses of the facility were in-serviced by the DON on infection control policies and feeding pumps. Employees who are on extended leave will not be permitted to return to work until they have been educated by the DON.		

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F 441	Continued From page 11 placed the tubing over the feeding pump pole, touching the tip to the privacy curtain. After <del>administration of the medication and flush, the</del>	F 441	<i>Plans to Monitor Performance for Sustained Solutions</i> <i>The weekly audits completed</i>	
	LPN re-connected the tubing to the gastric tube site, without cleaning the orange tip of the feeding tube.		by the Director of Nursing and the Compliance Nurse will be submitted to the Quality Assurance Committee that meets	
	Interview with LPN #1, on 10/15/14 at 12:25 PM, revealed she was aware of the need to cap the feeding pump tubing and pointed to the cap available, that was hanging on the feeding pump pole, and stated she "just forgot and was nervous."  Interview with the Director of Nursing (DON), on 10/16/14 at 10:05 AM, revealed staff and been trained in these procedures and should have capped the tubing.		monthly for recommendations and follow-up.	11-14-2014

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K 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)	K 000	Preparation and execution of this plan of correction does not constitute an admission of or	
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	BUILDING: 01		agreement by the provider of	
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	<p>PLAN APPROVAL: 1962 Remodeled: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1962 and upgraded in 2008, with 35 smoke detectors and 32 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 2007.</p> <p>EMERGENCY POWER: Type II Diesel Generator installed in 2007.</p>		<p>the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p>	
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	<p>A Life Safety Code Survey was initiated and concluded on 10/14/14. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifty-nine (59) beds with a census of fifty-six (56) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/2/14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
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K 000	Continued From page 1  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	<u>K018 (D) NFPA 101 LIFE SAFETY CODE</u>  <b>CORRECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> On 10/15/14 the doors to rooms 206 and 208 was repaired to assure proper closing and latching.  <b>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:</b> On 10/14/14 all doors in the facility were inspected to ensure they all closed properly and latching.  <b>MEASURE OR SYSTEMATIC CHANGES MADE TO AVOID REOCCURENCE</b> On 10/15/14 the Maintenance Director was in-serviced by the Administrator related to proper door closing and latching throughout the facility.	
	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, twenty-four (24) residents, staff and visitors. The facility has the capacity for			

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K 018	Continued From page 2 fifty-nine (59) beds and at the time of the survey, the census was fifty-six (56)	K 018	<b>PLANS TO MONITOR PERFORMANCE FOR SUBSTAINED SOLUTIONS:</b>	
	The findings include:		The Maintenance Director will monitor proper door closing and latching throughout the facility weekly for 12 weeks. The Maintenance Director will continue to monitor door closing and latching monthly and present findings during monthly QAPI meetings.	11-14-2014
	Observation, on 10/14/14 at 2:40 PM with the Maintenance Director, revealed the corridor door to room #208 would not latch properly.  Interview, on 10/14/14 at 2:42 PM with the Maintenance Director, revealed he was unaware the door was not latching. He stated he checked the resident doors weekly to ensure the doors latch and stated the weather affects the doors.  Observation, on 10/14/14 at 2:41 PM with the Maintenance Director, revealed the corridor door to room #206 would not latch properly.  Interview, on 10/14/14 at 2:42 PM with the Maintenance Director, revealed he was unaware the door was not latching. He stated he checked the resident doors weekly to ensure the doors latch and stated the weather affects the doors.  The census of fifty-six (56) was verified by the Administrator on 10/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/14/14.			
	Actual NFPA Standard:  Reference: NFPA 101 (2000 edition) 19.3.6.3 1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood			

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K 018	Continued From page 3 or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.  19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in	K 018		
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	K 029		

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K 029	Continued From page 4 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 the National Fire Protection Agency (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, and Kitchen staff. The facility has the capacity for fifty-nine (59) beds and the census was fifty-six (56) on the day of the survey.  The findings include:  Observation, on 10/14/14 at 2:20 PM, with the Maintenance Director revealed the door to a hazardous storage room located by the loading dock entrance had a self-closing device installed; however, the closer's control arm had been removed. The removal of the control arm prevented the door from being self-closing as required.  Interview, on 10/14/14 at 2:21 PM, with the Maintenance Director revealed he was not aware the control arm had been removed from the self-closing device.  The census of fifty-six (56) was verified by the	K 029	<u>K029 (D) NFPA 101 LIFE SAFETY CODE</u>  <b>CORRECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> On 10/14/14 the Maintenance Director repaired the self-closure on the door located by the loading dock, to ensure it was functioning properly.  <b>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:</b> On 10/14/14 the Maintenance Director observed all self-closures in the facility to ensure they were functioning properly and connected.  <b>MEASURE OR SYSTEMATIC CHANGES MADE TO AVOID REOCCURENCE:</b> On 10/15/14 the Maintenance Director was in-serviced by the Administrator on assuring all self-closures on door was installed and functioning as they were designed.	

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K 029	Continued From page 5 Administrator on 10/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/14/14.	K 029	<b>PLANS TO MONITOR PERFORMANCE FOR SUBSTAINED SOLUTIONS:</b>  The Maintenance Director will inspect all self-closures on doors in the facility to ensure they are installed and functioning properly weekly for 12 weeks then monthly thereafter. All findings will be presented during QAPI Meeting monthly.	11-14-2014
	Actual NFPA Standard:  Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.  Reference: NFPA 101 (2000 Edition) 9.3.2.1 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 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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.			

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K 029	Continued From page 6 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.  Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.  Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.  Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met: (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the	K 029			

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K 029	Continued From page 7 door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 047 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, staff and visitors. The facility has the capacity for fifty-nine (59) beds and at the time of the survey, the census was fifty-six (56).  The findings include:  Observation, on 10/14/14 at 2:25 PM with the Maintenance Director, revealed the Kitchen had a manual hood suppression pull located at an exit door. However, the exit door did not have proper exit signage making the path of egress clearly recognizable.  Interview, on 10/14/14 at 2:28 PM with the Maintenance Director, revealed he was unaware of the requirements for egress.	K 047	<b><u>K047 (D) NFPA 101 LIFE SAFETY CODE</u></b>  <b>CORRECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> On 11/4/14 illuminating exit signs were placed above the exit door in the kitchen and above the exit door in the basement. The lights are attached to the generator to ensure they function at all times.  <b>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:</b> All exit areas were observed on 10/14/14, to ensure that all areas had exit signage making the path of egress clearly recognizable.  <b>MEASURE OR SYSTEMATIC CHANGES MADE TO AVOID REOCCURENCE:</b> The Maintenance Director was in-serviced by the Administrator on 10/15/14, stating that all exits had to be clearly visible and marked	

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER 8 STREET DAWSON SPRINGS, KY 42408		
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K 047	Continued From page 8 Observation, on 10/14/14 at 2:50 PM with the Maintenance Director, revealed the exit door for the basement located in the basement stairwell did not have proper exit signage making the path of egress clearly recognizable.	K 047	with signage clearly recognizing the means of egress.		
	Interview, on 10/14/14 at 2:51 PM with the Maintenance Director, revealed he was unaware of the requirements for egress.  The census of fifty-six (56) was verified by the Administrator on 10/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/14/14.  Actual NFPA Standard:  Reference: NFPA 101 (2000 edition)  19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.		<b>PLANS TO MONITOR PERFORMANCE FOR SUBSTAINED SOLUTIONS:</b> The Maintenance Director will monitor all exits and signage monthly, to ensure they are functioning properly and clearly marking the egress.	11-14-2014	
	7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits,				

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K 047	Continued From page 9 shall be marked by an approved sign readily visible from any direction of exit access.	K 047			
	7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 80 in. (152 cm) above the finished floor to the centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change.				
	7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.				
	7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or				

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K 047	Continued From page 10 adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame.	K 047		
	7.10.1.8* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2.			
	7.10.1.7* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted.			
	7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent.			
	7.10.3* Sign Legend. Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters.			
	7.10.4* Power Source. Where emergency lighting facilities are required			

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K 047	Continued From page 11 by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.8 Externally Illuminated Signs. 7.10.6.1* Size of Signs. Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their	K 047		

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K 047	Continued From page 12 height. Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high. Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5. 7.10.6.2* Size and Location of Directional Indicator. The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated. Exception: This requirement shall not apply to approved existing signs. Figure 7.10.6.2 Chevron-type indicator.  7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5. 7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and	K 047			

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K 047	Continued From page 13 7.10.1.5. Reference: NFPA 98 (1998 edition)	K 047			
K 076 SS=D	<p>7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other.</p> <p>Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link.</p> <p>Exception No. 2: An automatic sprinkler system.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p>	K 076	<p><b><u>K076 (D) NFPA 101 LIFE SAFETY CODE</u></b></p> <p><b>CORRECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> On 10/14/14 the Maintenance Director removed the blanket from the Oxygen tanks.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:</b> On 10/14/14 the Maintenance Director observed all areas of oxygen storage and removed any combustible items.</p>		

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K 076	Continued From page 14 This STANDARD is not met as evidenced by: <u>Based on observation and interview it was</u> determined the facility failed to ensure oxygen storage was in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for fifty-nine (59) beds and at the time of the survey, the census was fifty-six (56).  The findings include:  Observation, on 10/14/14 at 2:49 PM, with the Maintenance Director revealed a blanket lying on top of the full oxygen tanks stored in the Chart Room.  Interview, on 10/14/14 at 2:50 PM, with the Maintenance Director revealed he was unaware someone had put a blanket on the top of the oxygen tanks.  The census of fifty-six (56) was verified by the Administrator, on 10/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/14/14.	K 076	<b>MEASURE OR SYSTEMATIC CHANGES MADE TO AVOID REOCCURENCE:</b>  On 10/15/14 the Maintenance Director was in-serviced by the Administrator on proper storage of Oxygen tanks and any items in the area.  <b>PLANS TO MONITOR PERFORMANCE FOR SUBSTAINED SOLUTIONS:</b> The Maintenance Director will monitor the proper storage of Oxygen and items located in the same area weekly for 12 weeks and then monthly thereafter. The findings will be reported at the QAPI meeting monthly.	11-14-2014	
	Actual NFPA Standard:  Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 8-3.1.11.2 Storage for nonflammable gases less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that				

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K 078	Continued From page 15 can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.	K 078			
	(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of 1/2 hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.				
	8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be				

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K 078	Continued From page 16 conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b>	K 078		
K 144 SS=F	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for fifty-nine (59) beds with a census of fifty-six (56) on the day of the survey.  The findings include:  Generator documentation review, on 10/14/14 at 1:55 PM with the Maintenance Director, revealed the facility did not have an annual load bank test performed on the generator. Further record review revealed the facility did not have documentation of the percentage of load the	K 144	<b><u>K144 (F) NFPA 101 LIFE SAFETY CODE</u></b>  <b>CORRECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> On 11/4/14 a generator load test was completed by Evapar. It was determined that the facility was operating above the required 30% at 30.29%.  <b>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:</b> All residents had potential to be affected.  <b>MEASURE OR SYSTEMATIC CHANGES MADE TO AVOID REOCCURENCE:</b> On 10/15/14 the Maintenance Director was in-serviced by the Administrator of the 30% load requirement of the EPS nameplate of the generator.	

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K 144	Continued From page 17 generator was under or the exhaust temperature during monthly tests to determine if an annual load bank test was required.	K 144	<b>PLANS TO MONITOR PERFORMANCE FOR SUBSTAINED SOLUTIONS:</b>  The Maintenance Director will monitor the load test Quarterly and will not remove any items unless a load test is performed prior. These changes will be presented at the QAPI meeting monthly.	11-14-2014	
	Interview, on 10/14/14 at 1:56 PM with the Maintenance Director, revealed he was not aware of the requirement.  The census of fifty-nine (59) was verified by the Administrator on 10/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/14/14.  Actual NFPA Standard:  Reference: NFPA 110 (1999 Edition).  6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction  6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations.				

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	Continued From page 18  6-4.2.2	K 144			
K 147 SS=E	<p>Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 80 minutes, for a total of 2 continuous hours.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for fifty-nine (59) beds and at the time of the survey, the census was fifty-six (56).</p> <p>The findings include:</p> <p>Observation, on 10/10/14 at 2:00 PM with the Maintenance Director, revealed a hair dryer was plugged into a power strip located in the Beauty Shop. The hair dryer was rated at eighteen hundred seventy five (1875) watts and the power</p>	K 147	<p><u>K147 (E) NFPA 101 LIFE SAFETY CODE</u></p> <p><b>CORRECTIVE ACTION FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED:</b> On 10/14/14 the Maintenance Director removed the power strip in the Beauty Shop and the DON's office.</p> <p><b>IDENTIFICATION OF OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED:</b> On 10/14/14 the Maintenance Director observed each room in the building and removed all power strips in unauthorized areas.</p>		

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
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K 147	Continued From page 19 strip was rated at fifteen (15) Amps.	K 147	<b>MEASURE OR SYSTEMATIC CHANGES MADE TO AVOID REOCCURENCE:</b>  On 10/15/14 the Maintenance Director was in-serviced by the Administrator regarding NFPA 70 and 99 regarding the correct use of power strips.  <b>PLANS TO MONITOR PERFORMANCE FOR SUBSTAINED SOLUTIONS:</b> The Maintenance Director will monitor for power strips located throughout the facility weekly. The Maintenance Director will present all findings during the QAPI meeting monthly.	11-14-2014	
	Interview, on 10/10/14 at 2:01 PM with the Maintenance Director, revealed he was not aware the power strip had been misused.  Observation, on 10/14/14 at 2:30 PM with the Maintenance Director, revealed a microwave and a refrigerator were plugged into a power strip located in the Director of Nursing Office.  Interview, on 10/14/14 at 2:31 PM with the Maintenance Director, revealed he was not aware the power strip had been misused.  The census of fifty-six (56) was verified by the Administrator on 10/14/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 10/14/14.  Actual NFPA Standard:  Reference: NFPA 101 (2000 Edition)  9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.				
	Reference: NFPA 70 (1999 Edition) 400-8 ( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:				

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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	Continued From page 20 (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces  Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			