

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

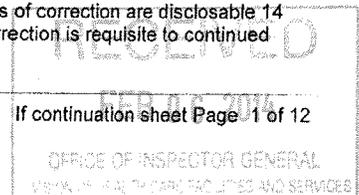
PRINTED: 01/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2014
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245		
(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 standard health survey was conducted on 01/22/14 through 01/24/14 and a Life Safety Code Survey was conducted on 01/23/14 through 01/24/14 with deficiencies cited at the highest scope and severity of an "E".	F 000			
F 281 SS=E	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, and review of the facility standards of practice, it was determined the facility failed to ensure appropriate standards of clinical practice were utilized by staff regarding hand hygiene during treatments for four (4) of twenty-four (24) sampled residents (Residents #3, #7, #11, and #15). The findings include: Interview with the Director of Nursing, on 01/24/14 at 2:50 PM, revealed the Lippincott Nursing Procedures, 5th Edition, (2009), was the Standards of Practice reference used by the facility. Review of special considerations related to hand hygiene revealed the staff was to wash their hands before and after performing patient care or procedures or having contact with contaminated objects, even though they may have worn gloves and always wash their hands after removing gloves.	F 281	F281 Oaklawn provides services that meet professional standards of quality. On 1-25-14, LPN #1, LPN #4, and RN #4 were counseled and trained by the Director of Nursing on the professional standards with hand hygiene. Training included education of the facility policy and procedure regarding hand hygiene, including the need to perform hand hygiene prior to applying gloves, after removing gloves, after cleaning any soiled area including incontinent care, after application of treatments, prior to moving to a clean area, prior to moving to another treatment site, and prior to exiting the room. Residents #3, 7, 11, & 15 will have additional and ongoing observation for signs and symptoms of presenting infections. Identification of other residents potentially affected by same deficient practice:	2/14/14 2-15-14 B. Stephens by PK 2-7-14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *M Burke Stephens administrator* TITLE: _____ (X6) DATE: *1/30/14*

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.

BJB



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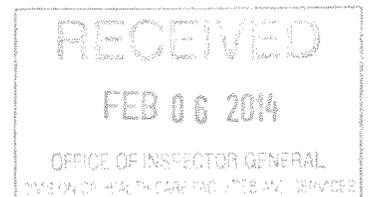
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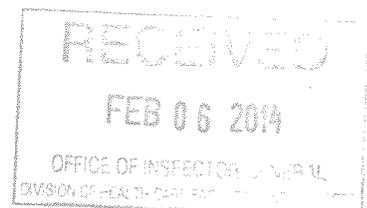
F 281	<p>Continued From page 1</p> <p>1. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 01/13/14, with diagnoses of Intracranial Bleed, Aspiration Pneumonia, Fecal Incontinence, Sacrum Decubitus, and Diabetes Mellitus II. Further review revealed a long rectal tube was inserted extending from the anus to a catheter bag to prevent leakage onto the sacral Decubitus. Review of the admission History and Physical revealed the resident required total care with personal hygiene and extensive assistance with bed mobility.</p> <p>Observation during a skin assessment and wound dressing change for Resident #7, on 01/23/14 at 12:30 PM, revealed the rectal tube was leaking. LPN #4 was observed to provide incontinent care after washing her hands and putting on gloves. After cleaning the feces from the resident, LPN #4 changed her gloves and proceeded to the wound treatment to the coccyx without washing her hands. After completing the coccyx treatment, the nurse changed her gloves again, without washing her hands, and applied Magic Butt Cream to Resident #7's rectal area. LPN #4 did not wash her hands until the skin assessment and treatments were completed.</p> <p>Interview with LPN #4, on 01/23/14 at 2:45 PM, revealed she should have washed her hands before and after doing wound care, and after providing incontinent care to the resident. The LPN revealed she did not wash her hands until the entire process was completed.</p> <p>Interview with the Unit Manager (UM) on the EOT Unit, on 01/24/14 at 2:00 PM, revealed the facility's standards of practice would be to follow the Infection Control Policy, proper hand washing,</p>	F 281	<p>All residents requiring wound care will be observed and/or interviewed regarding wound care services, and specifically if hand hygiene is occurring prior to applying gloves, after removing gloves, after cleaning any soiled area including incontinent care, after application of treatments, prior to moving to a clean area, prior to moving to another treatment site, and prior to exiting the room by February 14, 2014.</p> <p>To ensure the deficient practice does not reoccur:</p> <p>The Director of Nursing and Director of Education will re-educate all Nurses on following professional standards and the facility policy and procedure regarding hand hygiene. This training will include education of the facility policy and procedure regarding hand hygiene. There will also be education on the need to perform hand hygiene prior to applying gloves, after removing gloves, after cleaning any soiled area including incontinent care, after application of treatments, prior to moving to a clean area, prior to moving to another treatment site, and prior to exiting the room. This will be completed by February 14, 2014.</p>	
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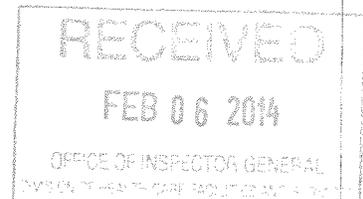
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F 281	<p>Continued From page 2</p> <p>with pre-medicating residents before treatments, and monitoring for signs and symptoms of infection. The UM stated she would look at preventive measures to prevent complications. The UM stated the facility follows the Policy Manual on Infection Control or follows the physician's orders. The UM stated infection control in-services are completed yearly, and if doing CQI (continuous quality improvement) meetings, infections are looked at with areas needed to improve. The UM also stated re-education should be completed with nurses doing treatments.</p> <p>2. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 01/06/14 with diagnoses of a Sprained Left Hip, Bursitis Left Hip, Left Ankle Sprain, Left Knee Sprain, Contusion Right Elbow, and Chronic Renal Insufficiency. The resident also had gross edema in both legs, extending from both feet to the knees.</p> <p>Observation of Resident #15, on 01/23/14 at 9:30 AM, revealed RN #4 completed a wound treatment to the resident's buttocks. RN #4 applied Zenaderm to the resident's buttocks, then changed her gloves, but did not wash her hands. The RN then assessed the resident's skin folds of the abdomen, and changed her gloves; however, she did not wash her hands. In addition, the RN then changed the dressing on both legs, which had large blisters with gross edema. The nurse did not change her gloves or wash her hands when moving from the left leg to the right leg.</p> <p>Interview with RN #4, on 01/23/14 at 10:30 AM, revealed she did not wash her hands when going from the buttocks to the abdominal fold. She also</p>	F 281	<p>To monitor the above to ensure the solution is sustained:</p> <p>A sample of 20% of residents receiving wound care will be observed monthly by the Unit Managers to determine if the Nurses are following hand hygiene procedures according to professional standards and facility policy and procedure. The results of the study will be reported to the Quality Assurance committee on a quarterly basis until substantial compliance is achieved and maintained for two quarters.</p>		



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F 281	Continued From page 3 stated she did not wash her hands when she progressed to the legs. However, the RN stated she did not usually wash her hands between each leg, but would have to check with her Director of Nursing. Another interview later that day at 12:30 PM, revealed she should have washed her hands and changed her gloves between sites from the left leg to the right leg. 3. Observation of Licensed Practical Nurse (LPN) #1 during a dressing change for Resident #3, on 01/24/14 at 10:00 AM, revealed hand hygiene was not practiced once the gloves were removed. LPN #1 was observed to remove wound care supplies from a treatment cart in the corridor. The nurse touched the treatment cart several times while supplies were being obtained. She carried the supplies into the resident's room and proceeded to put on a pair of clean gloves without hand hygiene performed. She proceeded to remove the old dressing from the resident's buttocks. She removed the soiled gloves and put on a clean pair of gloves without performing hand hygiene between glove change. She separated the resident's buttocks for visualization of the coccyx area. She removed her gloves and put on a clean pair of gloves without performing hand hygiene. She then applied a prescription powder under each breast and in the abdominal folds. She removed her gloves and put on another pair of gloves without hand hygiene. She proceeded to apply a prescription ointment to the resident's right lateral leg. The LPN revealed she did not wash her hands until the entire process was completed. Review of the clinical record for Resident #3 revealed the facility admitted the resident on	F 281			



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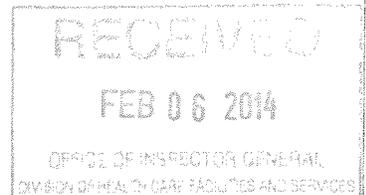
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F 281	<p>Continued From page 4</p> <p>12/26/13, with diagnoses of Anemia, Atrial Fibrillation, Coronary Artery Disease, Hypertension, Diabetes Mellitus, Hip Fracture, Joint Replacement, Aphasia, Cardiovascular Accident (Stroke), Hemiplegia, Non-Alzheimer's Dementia, Anxiety Disorder and Depression.</p> <p>4. Observation of LPN #1 performing a dressing change for Resident #11, on 01/24/14 at 10:45 AM, revealed hand hygiene was not practiced once the gloves were removed. Observation revealed LPN #1 touch the treatment cart when she obtained wound care supplies. The nurse proceeded to remove the resident's support stockings (TED Hose) from the left leg. The blister on the resident's left foot, at the base of the toes, was cleaned with gauze and normal saline. Bactroban ointment was applied to the blister on the top of the resident's left foot with a cotton tip applicator. After completion of the wound care to the resident's left foot, the nurse proceeded to provide care to the scabbed area on the resident's buttocks wearing the same pair of gloves. LPN #1 did not complete hand hygiene until the entire process was completed.</p> <p>Review of the clinical record for Resident #11 revealed the facility admitted the resident on 01/16/14 with diagnoses of Status Post Femoral-Pop Bypass related to Peripheral Vascular Disease, Bilateral Ischemic Lower Extremities, End Stage Renal Disease III, Hypertension, and Deep Vein Thrombosis.</p> <p>Interview with LPN #1, on 01/24/14 at 11:25 AM, revealed she washes her hands when she goes</p>	F 281		
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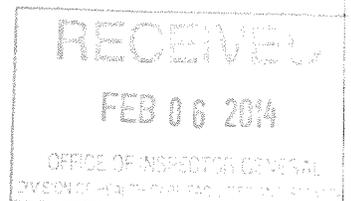
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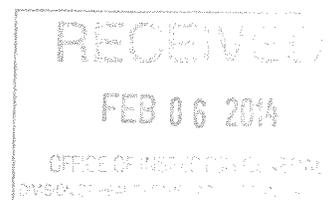
F 281	Continued From page 5 in the room and when she leaves the room. She reported it was not necessary to wash her hands after she took her gloves off while in the same resident's room. She stated it was okay to change her gloves between dressing changes. Interview with LPN #2, Unit Manager of Chestnut Oak Garden (COG), on 01/24/13 at 11:15 AM, revealed hand washing was required when gloves are removed. The staff were instructed to wash their hands with soap and water, or use hand sanitizer, when gloves are removed and prior to putting on a clean pair of gloves. Interview with the Director of Education, on 01/24/14 at 2:10 PM, revealed staff are trained to practice hand hygiene after each glove removal.	F 281		
F 441 SS=E	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 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	F441 Oaklawn maintains an infection control program that provides a safe and sanitary environment and helps prevent the development and transmission of disease and infection. On 1-25-14, LPN #1, LPN #4, and RN #4 were counseled and trained by the Director of Nursing on the facility policy and procedure regarding hand hygiene and preventing the spread of infection.	2-15-14 2/14/14 per B. Stephens by RB 2-7-14



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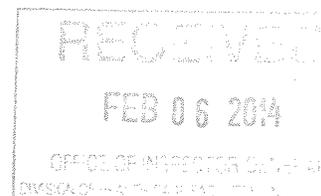
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F 441	<p>Continued From page 6</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to consistently implement their Infection Control policy and procedures in regard to hand hygiene to help prevent transmission of disease or infection for four (4) of twenty-four (24) sampled residents. Three facility nurses on two (2) of four (4) units failed to perform hand hygiene between glove change during wound care for Residents #3, #7, #11 and #15.</p> <p>The findings include:</p> <p>Review of the facility's Hand Hygiene policy, revised 11/01/12, revealed hand hygiene continues to be the primary means of preventing the transmission of infection. The staff should perform hand hygiene before moving from a</p>	F 441	<p>This training included education on the need to perform hand hygiene prior to applying gloves, after removing gloves, after cleaning any soiled area including incontinent care, after application of treatments, before moving from a contaminated body site to a clean body site, prior to moving to another treatment site, and before exiting the room.</p> <p>Residents #3, 7, 11, & 15 will have additional and ongoing observation for signs and symptoms of presenting infections.</p> <p>Identification of other residents potentially affected by same deficient practice:</p> <p>All residents requiring wound care will be observed and/or interviewed regarding wound care services, and specifically if hand hygiene is occurring prior to applying gloves, after removing gloves, after cleaning any soiled area including incontinent care, after application of treatments, prior to moving to a clean area, prior to moving to another treatment site, and prior to exiting the room by February 14, 2014.</p> <p>To ensure the deficient practice does not reoccur:</p>		



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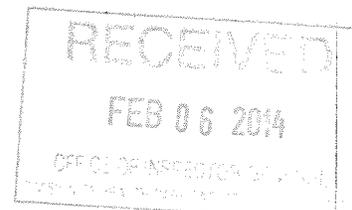
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F 441	<p>Continued From page 7</p> <p>contaminated body site to a clean body site during resident care and after removing gloves or aprons.</p> <p>1. Observation of Licensed Practical Nurse (LPN) #1 during the dressing change for Resident #3, on 01/24/14 at 10:00 AM, revealed hand hygiene was not practiced once the gloves were removed. Observation revealed LPN #1 obtained wound care supplies from a treatment cart in the corridor. The nurse touched the treatment cart several times while supplies were obtained. She carried the supplies into the room and proceeded to put on a pair of clean gloves without washing her hands or using hand sanitizer. The nurse removed the old dressing from the resident's buttocks. She removed her gloves and put on a clean pair of gloves without performing hand hygiene. She separated the buttocks for a visualization of the coccyx area. She removed the gloves and put on another pair without hand hygiene. She proceeded to apply a prescription powder under the resident's breasts and in the abdominal folds. She removed her gloves and put on another pair of gloves without hand hygiene. She proceeded to apply a prescription ointment to the resident's right lateral leg. LPN #1 revealed she had not wash her hands until the entire process was completed.</p> <p>Review of the clinical record for Resident #3 revealed the facility admitted the resident on 12/26/13, with diagnoses of Anemia, Atrial Fibrillation, Coronary Artery Disease, Hypertension, Diabetes Mellitus, Hip Fracture, Joint Replacement, Aphasia, Cardiovascular Accident (Stroke), Hemiplegia, Non-Alzheimer's Dementia, Anxiety Disorder and Depression.</p>	F 441	<p>The Director of Nursing and Director of Education will re-educate all Nurses on infection control procedures that provide a safe and sanitary environment and helps prevent the development and transmission of disease and infection. This education will include the facility policy and procedure regarding hand hygiene. There will also be education on the need to perform hand hygiene prior to applying gloves, after removing gloves, after cleaning any soiled area including incontinent care, after application of treatments, prior to moving to a clean area, prior to moving to another treatment site, and prior to exiting the room. This will be completed by February 14, 2014.</p> <p>To monitor the above to ensure the solution is sustained:</p> <p>A sample of 20% of residents receiving wound care will be observed monthly by the Unit Managers to determine if the Nurses are following hand hygiene procedures according to professional standards and facility policy and procedure. The results of the study will be reported to the Quality Assurance committee on a quarterly basis until substantial compliance is achieved and maintained for two quarters.</p>		



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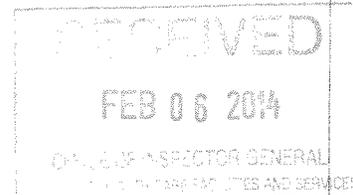
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F 441	Continued From page 8 2. Observation of Licensed Practical Nurse (LPN) #1 during the dressing change for Resident #11, on 01/24/14 at 10:45 AM, revealed hand hygiene was not practiced once the gloves were removed. LPN #1 gathered wound care supplies at the treatment cart in the corridor near the entrance to the resident's room. The treatment cart was touched several times while supplies were prepared. She carried the supplies into the room and put on a pair of clean gloves without performing hand hygiene. She proceeded to remove a support stocking from the resident's left leg. The blister on the resident's left foot, at the base of the toes, was cleaned with gauze and normal saline. Bactroban ointment was applied to the blister on the top of the resident's left foot. Upon completion of wound care to the left foot, the nurse provide care to the scabbed area on the resident's buttocks wearing the same pair of gloves. LPN #1 did not complete hand hygiene until the entire process was completed. Interview with LPN #1, on 01/24/14 at 11:25 AM, revealed she washes her hands when she goes into the room and when she leaves a resident's room. She stated it was okay to change her gloves between dressing changes. She reported it was not necessary to wash her hands after she removed her gloves while in the same resident's room. Interview with LPN #2, Unit Manager of Chestnut Oak Garden (COG), on 01/24/13 at 11:15 AM, revealed hand washing was required when gloves are removed and use hand gel when gloves are removed and prior to putting on a clean pair of	F 441			



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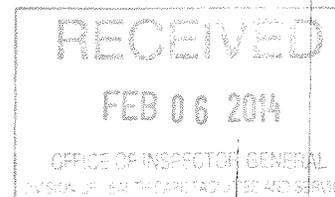
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/24/2014
NAME OF PROVIDER OR SUPPLIER OAKLAWN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245		
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F 441	<p>Continued From page 9 gloves.</p> <p>Interview with the Director of Education, on 01/24/14 at 2:10 PM, revealed staff have been trained to practice hand hygiene after each glove removal.</p> <p>3. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 01/13/14 with diagnoses of Intracranial Bleed, Aspiration Pneumonia, Fecal Incontinence, Sacrum Decubitus, and Diabetes Mellitus II. The resident also had a large rectal tube extending to a catheter bag to prevent leakage to the sacral Decubitus; however, the tubing was continuing to leak bowel movement around the tube. Review of the admission History and Physical revealed the resident required total care and required extensive assistance with bed mobility.</p> <p>Observation during a skin assessment and treatment change for Resident #7, on 01/23/14 at 12:30 PM, revealed LPN #4 to provide incontinent care after washing her hands and putting on gloves. However, after cleaning the bowel movement from the resident, LPN #4 changed her gloves and proceeded to the sacral treatment to the coccyx without washing her hands between glove changes. After completion of the coccyx treatment, the nurse changed her gloves without washing her hands and applied Magic Butt Cream to Resident #7's rectal area. LPN #4 did not wash her hands or perform hand hygiene until all assessments and treatments were completed, and the gloves removed.</p>	F 441			



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F 441	<p>Continued From page 10</p> <p>Interview with LPN #4, on 01/23/14 at 2:45 PM, revealed she should have washed her hands before and after doing wound care, and after providing incontinent care to the resident. The LPN revealed she did not wash her hands until the entire process was completed.</p> <p>Interview with the Unit Manager on the English Oak Terrace (EOT) Unit, on 1/24/14 at 2:00 PM, revealed the facility policy stated hand washing should be completed between glove changes when changing sites, or going from dirty to clean. The UM stated infection control in-services are completed yearly, and if doing CQI (continuous quality improvement) meeting, infections are looked at with areas needed to improve. The UM also stated re-education should be completed with nurses doing treatments.</p> <p>4. Review of the clinical record for Resident #15 revealed the facility admitted the resident on 01/06/14 with diagnoses of a Sprained Left Hip, Bursitis Left Hip, Left Ankle Sprain, Left Knee Sprain, Contusion Right Elbow, and Chronic Renal Insufficiency. The resident also had gross edema in both leg, extending from the feet to the knees.</p> <p>Observation of Resident #15, on 01/23/14 at 9:30 AM, revealed RN #4 completed a treatment to the resident's buttocks. RN #4 applied Zenaderm to the resident's buttocks, then changed her gloves, but failed to wash her hands. The RN then assessed the resident's skin folds of the abdomen, and changed her gloves; however, did not wash her hands. In addition, the RN then changed the dressings on both legs, which had large blisters and gross edema. The nurse did not change her gloves or wash her hands when</p>	F 441			



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F 441	Continued From page 11 moving from the left leg dressing to the right leg dressing. Interview with RN #4, on 01/23/14, at 10:30 AM, revealed she did not wash her hands when going from the buttocks to the abdominal fold. She also stated she failed to wash her hands when she progressed to the legs. However, the RN stated she did not usually wash her hands between each leg, but would have to check with the Director of Nursing. Continued interview with RN #4 at 12:30 PM revealed she should have washed her hands and changed her gloves between sites from the left leg to the right leg. Interview with the Unit Manager on the English Oak Terrace (EOT) Unit, on 1/24/14 at 2:00 PM, revealed facility policy stated hand washing should be completed between glove changes when changing sites, or going from dirty to clean. The UM stated that specific competencies, or monitoring of how nurses complete dressing changes are not usually done.	F 441			



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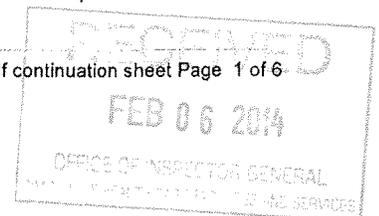
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2005</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (111)</p> <p>SMOKE COMPARTMENTS: Five (5) per floor (story).</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Automatic (wet) sprinkler system, hydraulically designed.</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 01/23/14 and concluded on 01/24/14. Oaklawn Health and Rehabilitation Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for one hundred thirty (130) beds with a census of one hundred</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *M. Burke Stephens* TITLE *administrator* (X6) DATE *1/31/14*

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.

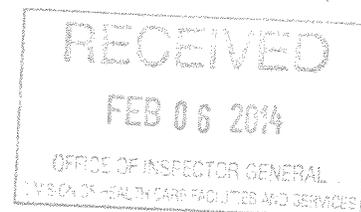
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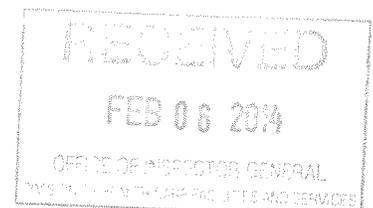
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K 000	Continued From page 1 nineteen (119) on the day of the survey.	K 000		
K 025 SS=E	<p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "E" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect five (5) of ten (10) smoke compartments, sixty four (64) residents, staff and visitors. The facility is certified for one hundred</p>	K 025	<p>K025</p> <p>The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiency. This plan of Correction is prepared and executed solely because it's required by state law.</p> <p>1. Repairs to the deficient smoke barriers that were discovered upon inspection have been completed on 1/31/2014. This was repaired by the facility's maintenance director and staff using rated material equal to the partition to resist the passage of smoke to meet the one hour requirement.</p> <p>2. All Partitions will be reviewed and inspected by the Executive Maintenance Director. All penetrations will be repaired with material rated</p>	<p>2/24/14</p> <p>2-25-14</p> <p>per B. Stepters</p> <p>by PB 2-7-14</p>



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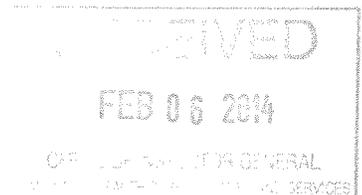
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K 025	<p>Continued From page 2</p> <p>thirty (130) beds with a census of one hundred nineteen (119) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 01/23/13 between 10:00 AM and 12:00 PM, with the Maintenance Director revealed the smoke barrier extending above the ceiling located in the EOG Hall (Garden Level) above room #117 did not have two layers of 5/8" drywall installed to meet the one (1) hour requirement. Further observation revealed the two (2) hour fire wall located in the COG Hall (Garden Level) had a sleeve for wires that was not sealed to the block wall. Further observation revealed the one (1) hour wall located in the COG Hall (Garden Level) was penetrated by pipes and would not resist the passage of smoke.</p> <p>Interview, on 01/23/14 between 10:00 AM and 12:00 PM, with the Maintenance Director revealed he was not aware of the penetrations or the missing drywall.</p> <p>Interview, on 01/24/14 at 11:00 AM, with the Administrator revealed she was not aware of the penetrations or the missing drywall. Further interview revealed the facility did not have a policy for penetrations in smoke partitions, but instead referenced the Life Safety Code for guidance concerning smoke partitions.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3 SMOKE BARRIERS 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the</p>	K 025	<p>equal to the partition to resist the passage of smoke. This will be completed no later than 2/24/2014 by two maintenance assistants under the direction of the Executive Maintenance Director.</p> <p>3. Weekly inspections have been added to our preventative maintenance program (TELS) effective 1/31/2014 to ensure all of our residents, staff and visitors are protected under this requirement.</p> <p>4. The Executive Maintenance Director will make rounds weekly for 4 weeks and monthly thereafter to ensure all existing smoke barriers have been repaired and free of any penetrations. These rounds will be reviewed by the Regional Director of Facilities Management no less than quarterly to ensure rounds are being completed. Results of the inspections will be reported to the Quality Assurance committee on a quarterly basis until substantial compliance is achieved and maintained for two quarters.</p>	



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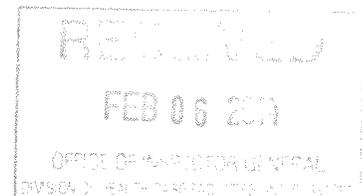
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K 025	Continued From page 3 movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier. 18.3.7* Subdivision of Building Spaces. 18.3.7.1 Buildings containing health care facilities shall be subdivided by smoke barriers as follows: (1) To divide every story used by inpatients for sleeping or treatment into not less than two smoke compartments (2) To divide every story having an occupant load of 50 or more persons, regardless of use, into not less than two smoke compartments (3) To limit the size of each smoke compartment required by (1) and (2) to an area not exceeding 22,500 ft ² (2100 m ²) Exception: The area of an atrium separated in accordance with 8.2.5.6 shall not be limited in size. (4) To limit the travel distance from any point to reach a door in the required smoke barrier to a distance not exceeding 200 ft (60 m). Exception No. 1: Stories that do not contain a health care occupancy, located totally above the	K 025			



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K 025	<p>Continued From page 4</p> <p>health care occupancy.</p> <p>Exception No. 2: Areas that do not contain a health care occupancy and that are separated from the health care occupancy by a fire barrier complying with 7.2.4.3.</p> <p>Exception No. 3: Stories that do not contain health care occupancies and that are more than one story below the health care occupancy.</p> <p>Exception No. 4: Open-air parking structures protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. <p>18.3.7.3</p>	K 025		



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K 025	Continued From page 5 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.	K 025		

