

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

PRINTED: 03/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/16/2013
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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A Recertification and Abbreviated Survey investigating KY#00019783 was conducted 02/12/13 through 02/16/13. KY#00019783 was substantiated with no deficiencies cited related to the allegation. Deficiencies were cited with the highest scope and severity of an "E".

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review and facility policy review it was determined the facility failed to provide service in accordance with the plan of care for three (3) of fourteen (14) sampled residents (Residents #4, #9, and #11). Resident #4 had a falls risk care plan with interventions which included a floor mat beside the bed, however observations revealed no evidence of a floor mat.

Resident #9 was care planned to have his/her oxygen set on three (3) liters per minute (LPM); however, observation from 02/13/13 through 02/15/13 revealed the resident's oxygen was set on four (4) LPM.

Resident #11 had a falls care plan related to a history of falls with an intervention that included a

F 000 To the best of my knowledge and belief, as an agent of Boyd Nursing & Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.

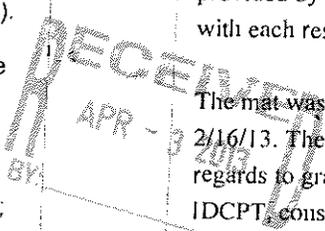
F 282 Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.

It is the policy of Boyd Nursing and Rehabilitation Center to ensure services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

The mat was replaced by the charge nurse on 2/16/13. The care plan for Residents #4 in regards to gray impact mat was reviewed by IDCPT, consisting of the MDSC, Activity Director, Social Service Director and Dietary Manager, on 02/27/13 and is reflective of resident's current needs.

The oxygen was set on the ordered level by

3/29/13



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

[Signature]

TITLE

Administrator

(X6) DATE

4-3-13

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 282	Continued From page 1 restraint free alarm (RFA) attached to him/her at all times; however, observation on 02/13/13 during the dinner meal revealed the RFA to not be attached to the resident's clothing as per the plan of care. The findings include: 1. A review of Resident #4 medical record revealed the facility admitted the resident on 08/02/12, with diagnoses which included Alzheimer s disease, Failure To Thrive, muscle weakness and difficulty walking. Review of the Admission Minimum Data Set (MDS) Assessment, dated 08/09/12, revealed the facility assessed the resident as being constant with disorganized thinking, fluctuating inattention, wandering occurring daily and with a history of a fall last month. Review of the resident's Comprehensive Care Plan, dated 08/09/12, revealed under special equipment, the resident was to have hip protectors and a gray impact mat. Review of the Physician's Order, dated 09/19/12, revealed an order for a floor mat to open side of bed. Observation of Resident #4, on 02/13/13 at 9:15 AM, revealed the resident was sitting dressed at bedside with breakfast on bedside table, feeding self and there was no floor mat beside the bed. Observation of Resident #4, on 02/13/13 at 10:30 AM, revealed the resident up in room, dressed and trying to ambulate and there was no floor mat to open side of the bed. Observation of Resident #4, on 02/13/13 at 1:30 PM, revealed the resident sitting on the side of the bed with lunch tray, the Speech Therapist assisting the resident with his/her lunch and there was no floor mat bedside	F 282	the charge nurse on 2/16/13. The care plan for Resident #9 in regards to oxygen at three liters per minute was reviewed by IDCPT consisting of the MDSC, Activity Director, Social Service Director and Dietary Manager, on 02/27/13 and is reflective of resident's current needs. Restorative Aide #19 received one-on-one education regarding the appropriate utilization of a breakaway alarm on 02/18/13 by the Director of Nursing. The care plan for Resident #11 in regards to the breakaway alarm to be used at all times was reviewed by IDCPT consisting of the MDSC, Activity Director, Social Service Director and Dietary Manager, on 02/27/13 and is reflective of resident's current needs. The plan of care for each resident will be reviewed by the IDCPT to ensure that the current plan of care is reflective of individual needs by 03/15/13. The plan of care will be utilized by the IDCPT consisting of the MDSC, Activity Director, Social Service Director and Dietary Manager, via weekly walking care plan rounds to ensure that all recorded interventions are implemented by 03/15/13.	
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F 282	<p>Continued From page 2</p> <p>the bed. Observation of Resident #4, on 02/13/13 at 4:15 PM, revealed the resident was lying on his/her bed with eyes open and there was no floor mat beside the bed.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1, on 02/13/13 at 5:00 PM, revealed the fall precautions for the Resident #4 included wheelchair and redirecting for safety if he/she tries to ambulate and no floor mat because the resident may fall. Further interview revealed the Care Plans were updated by the Nurses and were located at the Nurses' station.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 02/14/13 at 9:40 AM, revealed Resident #4 had fall precautions with hip protectors, redirection for safety and no mat because the resident may fall. Interview with LPN #1, on 02/14/13 at 9:50 AM, revealed she had made an error, per the Physician's order and the Care Plan, the resident was supposed to have a fall mat at bedside when in bed.</p> <p>Interview with MDS Coordinator #3, on 02/14/13 at 3:30 PM, revealed Resident #4 had appeared to have a decline since admission. Further interview revealed that the Care Plans were reviewed every Thursday by the care plan team members and the Care Plans were available to the SNRAs at the nursing station. She further stated Resident #4 should have had a mat by the bed as per the Care Plan.</p> <p>2. Review of Resident #9's medical record revealed the facility admitted the resident on 06/29/10, with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD). Review</p>	F 282	<p>All staff received education by the Staff Development Coordinator on 02/25/13 regarding the importance of proper implementation of each resident's written plan of care by qualified personnel.</p> <p>All nursing staff received additional education by the Director of Nursing and Staff Development Nurse on 02/25/13 regarding the importance of providing care and services by qualified persons in accordance with each resident's written plan of care.</p> <p>The IDCPT consisting of the MDSC, Activity Director, Social Service Director and Dietary Manager, received additional education by the Director of Nursing on 02/28/13 regarding the importance of ensuring implementation of individual interventions via weekly walking care plan rounds.</p> <p>The Director of Nursing will audit all scheduled care plans for four weeks and accompany the IDCPT consisting of the MDSC, Activity Director, Social Service Director and Dietary Manager, on weekly walking care plan rounds. Thereafter, the Director of Nursing or the RN Supervisor will audit at least two care plans per week for 8 weeks to ensure that care and services is provided in accordance with each resident's</p>		

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F 282	Continued From page 3 of the February, 2013 monthly Physician's Orders revealed an order for Resident #9 to have oxygen (O2) at three (3) liters per minute (LPM). Review of Resident #9's Comprehensive Care Plan revealed a care plan for shortness of breath upon exertion dated 06/17/11 which had an approach to provide supplemental oxygen at three (3) LPM per nasal cannula. Observations, on 02/13/13 at 4:50 PM; on 02/14/13 at 8:40 AM, 11:28 AM, and 2:15 PM; and on 02/15/13 at 2:10 PM and 5:40 PM revealed Resident #9's O2 to be set on four (4) LPM. Interview, on 02/15/13 at 5:50 PM, with State Registered Nursing Assistant (SRNA) #4 revealed she thought Resident #9's O2 was to be set on two (2) LPM. Interview, on 02/15/13 at 6:05 PM, with Licensed Practical Nurse (LPN) #5 revealed she thought the resident's O2 was to be set on three (3) LPM. Observation, at 6:08 PM, of Resident #9's O2 by LPN #5 and the surveyor revealed the resident's O2 to be set on four (4) LPM. Interview, at 6:17 PM with LPN #5, after her review of Resident #9's medical record, revealed the resident's O2 should have been set on three (3) LPM as ordered and care planned. Interview, on 02/16/13 at 4:42 PM, with the Director of Nursing (DON) revealed Resident #9's O2 should have been set on three (3) LPM as ordered and care planned. 3. A review of the facility's policy, "Personal Alarm, Guidelines for Utilization", dated August 1,	F 282	written plan of care. The results of these audits will be forwarded to the weekly Focus Committee consisting of the Director of Nursing, Administrator, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, and RN Supervisor. Results will also be reviewed monthly by the Continuous Quality Improvement (CQI) Committee consisting of the Administrator, Director of Nursing, Pharmacy Consultant, Medical Director, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, Housekeeping/Laundry Supervisor, and the Maintenance Supervisor, for further monitoring and continued compliance. The committee will determine, based on the results of audits received, how long monitoring should continue.		

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F 282 Continued From page 4

2012, revealed "The device used needs to be routinely monitored for position and functionality on a regular basis. This monitoring should be included in the resident's medical record".

A review of the medical record for Resident # 11, revealed the facility admitted Resident #11 on 01/21/13 with diagnoses which included Muscle Weakness, difficulty walking, Psychosis, Hypersomnia, personal history of falls, and diabetes mellitus. Review of the facility's Minimum Data Set (MDS) and the Brief Interview for Mental Status, dated 12/11/12, revealed Resident #11 scored a seven (7) out of fifteen (15). Review of Resident #11's care plan initiated 01/27/12, revealed Resident #11 was care planned for a history of falls and has poor safety awareness secondary to dementia. Interventions in place included the Resident wear a RFA (restraint free alarm) at all times. Review of the Physician's order for Resident #11, dated 09/18/12, revealed an order for Resident #11 to for a break away alarm to be used at all times due to decreased safety awareness and increased fall risk.

Record review of the Physician's Order, dated February 2013 revealed a breakaway alarm was to be used at all times due to decreased safety awareness and increased fall risk.

Record review of the e-mar, dated February 12, 2013 revealed Licensed Practical Nurse (LPN) #2 initialed breakaway alarm was on at all times.

Record review of nurse aid care card, (no date) revealed Resident #11 was to have a break away personal alarm.

F 282

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F 282	Continued From page 5 Observation, on 02/12/13 from 5:40 PM to 5:59 PM revealed, Resident #11 was sitting in the main dining room in a wheel chair with his/her restraint free alarm (RFA) not attached to him/her. Observation further revealed Restorative Aide #19 approached Resident #11 three (3) times and did not reattach the alarm to the resident. Interview, on 02/16/13 at 10:40 AM, with Restorative Aide #19 revealed she approached Resident #11 three (3) times in the dining room and was not aware the alarm was not attached. Interview with SRNA #7, on 2/16/13 at 10:19 AM, revealed Resident #11 should have RFA attached to him/her at all times. Interview, on 02/16/13 at 9:05 AM, with LPN #2, who was assigned to Resident #11 revealed the alarm was not to be taken off during meals and should be on at all times. Interview with the DON, on 02/16/13 at 4:45 PM, revealed everyone was responsible for monitoring Resident #11's RFA and it should have been on at all times.	F 282			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	It is the policy of Boyd Nursing and Rehabilitation Center to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The mat was replaced by the charge nurse on 2/16/13. The care plan for Residents #4 in regards to gray impact mat was reviewed by	3/29/13	

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F 323

Continued From page 6

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, review of the facility's Material Safety Data Sheet (MSDS), and review of the facility's policies, it was determined the facility failed to ensure received adequate supervision and assistance devices to prevent accident for two (2) of fourteen (14) sampled residents (Residents #4 and #11). Additionally the facility failed to ensure the environment remained free from accident hazards as evidenced by the facility failing to properly repair and maintain a self closing door to function properly to maintain the locking mechanism leaving a room used for the storage of hazardous chemicals left unlocked and accessible to the facility's residents.

The findings include:

1. A review of Resident #4 medical record revealed the facility admitted the resident on 08/02/12, with diagnoses which included Alzheimer s disease, Failure To Thrive, muscle weakness and difficulty walking. Review of the Admission Minimum Data Set (MDS) Assessment, dated 08/09/12, revealed the facility assessed the resident as being constant with disorganized thinking, fluctuating inattention, wandering occurring daily and with a history of a fall last month. Review of the resident's Comprehensive Care Plan, dated 08/09/12, revealed under special equipment, the resident was to have hip protectors and a gray impact mat. Review of the Physician's Order, dated 09/19/12, revealed an order for a floor mat to open side of bed.

F 323

IDCPT consisting of the MDSC, Activity Director, Social Service Director and Dietary Manager, on 02/27/13 and is reflective of resident's current needs.

Restorative Aide #19 received one-on-one education by the DON on 02/18/13 regarding the correct utilization of a breakaway alarm. The care plan for Resident #11 in regards to the breakaway alarm to be used at all times was reviewed by IDCPT consisting of the MDSC, Activity Director, Social Service Director and Dietary Manager, on 02/27/13 and is reflective of resident's current needs.

The laundry room door was repaired to automatically close and lock by the Maintenance Director on 02/18/13.

An environmental audit was conducted by the Administrator on 03/04/13 to ensure the environment was as free of accident hazards as possible.

Each resident of the facility who had an assistive device in use to prevent accidents was checked by administrative nursing staff on 02/21/13 for placement and function. This included, but not limited to; sensor pads, break away alarms, wheel chair devices and bed devices.

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F 323 Continued From page 7

Observation of Resident #4, on 02/13/13 at 9:15 AM, revealed the resident was sitting dressed at bedside with breakfast on bedside table, feeding self and there was no floor mat beside the bed. Observation of Resident #4, on 02/13/13 at 10:30 AM, revealed the resident up in room, dressed and trying to ambulate and there was no floor mat to open side of the bed. Observation of Resident #4, on 02/13/13 at 1:30 PM, revealed the resident sitting on the side of the bed with lunch tray, the Speech Therapist assisting the resident with his/her lunch and there was no floor mat bedside the bed. Observation of Resident #4, on 02/13/13 at 4:15 PM, revealed the resident was lying on his/her bed with eyes open and there was no floor mat beside the bed.

Interview with State Registered Nursing Assistant (SRNA) #1, on 02/13/13 at 5:00 PM, revealed the fall precautions for the Resident #4 included wheelchair and redirecting for safety if he/she tries to ambulate and no floor mat because the resident may fall. Further interview revealed the Care Plans were updated by the Nurses and were located at the Nurses' station.

Interview with Licensed Practical Nurse (LPN) #1, on 02/14/13 at 9:40 AM, revealed Resident #4 had fall precautions with hip protectors, redirection for safety and no mat because the resident may fall. Interview with LPN #1, on 02/14/13 at 9:50 AM, revealed she had made an error, per the Physician's order and the Care Plan, the resident was supposed to have a fall mat at bedside when in bed.

Interview with MDS Coordinator #3, on 02/14/13

F 323 A listing of all residents with assistive devices ordered or in use for safety will be maintained and available for all staff at each nurse's station beginning 03/08/13. This list will be updated weekly by the Director of Nursing, Staff Development Coordinator or RN Supervisor.

All staff will receive additional education by the Staff Development Coordinator by 03/15/13 regarding the importance of maintaining an environment as free of accident hazards as is possible, providing adequate supervision, and the appropriate utilization of assistive devices to prevent accidents.

Daily for the next 30 days and weekly thereafter, the RN supervisor will check one third of all residents with assistive devices to assure they have proper placement and function. The Director of Nursing will spot check at least five residents with assistive devices randomly per week (M-F) for the next 30 days. The Director of Nursing or RN Supervisor will monitor daily, via nursing report and visual compliance rounds, that all other residents receive adequate supervision and assistive devices to prevent accidents.

An audit tool will also be utilized by the Maintenance Director weekly for 4 weeks, Monday through Friday, then monthly

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F 323	Continued From page 8 at 3:30 PM, revealed Resident #4 had appeared to have a decline since admission. Further interview revealed that the Care Plans were reviewed every Thursday by the care plan team members and the Care Plans were available to the SNRAs at the nursing station. She further stated Resident #4 should have had a mat by the bed as per the Care Plan. 2. A review of the facility's policy, "Personal Alarm, Guidelines for Utilization", dated August 1, 2012, revealed "The device used needs to be routinely monitored for position and functionality on a regular basis. This monitoring should be included in the resident's medical record". A review of the medical record for Resident # 11, revealed the facility admitted Resident #11 on 01/21/13 with diagnoses which included Muscle Weakness, difficulty walking, Psychosis, Hypersomnia, personal history of falls, and diabetes mellitus. Review of the facility's Minimum Data Set (MDS) and the Brief Interview for Mental Status, dated 12/11/12, revealed Resident #11 scored a seven (7) out of fifteen (15). Review of Resident #11's care plan initiated 01/27/12, revealed Resident #11 was care planned for a history of falls and has poor safety awareness secondary to dementia. Interventions in place included the Resident wear a RFA (restraint free alarm) at all times. Review of the Physician's order for Resident #11, dated 09/18/12, revealed an order for Resident #11 to for a break away alarm to be used at all times due to decreased safety awareness and increased fall risk. Record review of the Physician's Order, dated	F 323	thereafter to visually review the resident environment to ensure the environment remains as free of accident hazards as possible. Results audits will be forwarded to the facility's weekly Focus Meeting (a sub-committee of the Continuous Quality Improvement consisting of the Director of Nursing, Administrator, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, and RN Supervisor) for further review and discussion to assure compliance. Additionally, the results of the audits will be forwarded to the facility's monthly CQI (Continuous Quality Improvement consisting of the Administrator, Director of Nursing, Pharmacy Consultant, Medical Director, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, Housekeeping/Laundry Supervisor, and the Maintenance Supervisor,) meeting for further monitoring and continued compliance.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/16/2013
NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELAND DRIVE ASHLAND, KY 41102		
(X4) IO 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 323	<p>Continued From page 9</p> <p>February 2013 revealed a breakaway alarm was to be used at all times due to decreased safety awareness and increased fall risk.</p> <p>Record review of the e-mar, dated February 12, 2013 revealed Licensed Practical Nurse (LPN) #2 initialed breakaway alarm was on at all times.</p> <p>Record review of nurse aid care card, (no date) revealed Resident #11 was to have a break away personal alarm.</p> <p>Observation, on 02/12/13 from 5:40 PM to 5:59 PM revealed, Resident #11 was sitting in the main dining room in a wheel chair with his/her restraint free alarm (RFA) not attached to him/her. Observation further revealed Restorative Aide #19 approached Resident #11 three (3) times and did not reattach the alarm to the resident.</p> <p>Interview, on 02/16/13 at 10:40 AM, with Restorative Aide #19 revealed she approached Resident #11 three (3) times in the dining room and was not aware the alarm was not attached.</p> <p>Interview with SRNA #7, on 2/16/13 at 10:19 AM, revealed Resident #11 should have RFA attached to him/her at all times.</p> <p>Interview, on 02/16/13 at 9:05 AM, with LPN #2, who was assigned to Resident #11 revealed the alarm was not to be taken off during meals and should be on at all times.</p> <p>Interview with the DON, on 02/16/13 at 4:45 PM, revealed everyone was responsible for monitoring Resident #11's RFA and it should have been on at all times.</p> <p>3. Review of the facility's policy titled "Chemical</p>	F 323		

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F 323 Continued From page 10
Storage" effective date of August 1, 2012, revealed the doors for starge of chemical should have locks for security purposes.

F 323

Observation during tour of the Laundry Room, on 02/14/13 at 10:00 AM and again on 02/16/13 at 3:50 PM, revealed the door to the laundry room containing a hazardous chemicals storage area to be unlocked and accessible to residents. The chemicals stored in the laundry room and accessible to the residents included, twelve (12) bottles, forty (40) ounces each of Virex TB, thirteen (13) bottles, forty (40) ounces each of Crew Tile and Grout, twelve (12) bottles, forty (40) ounces each of Huskey No Acid Disinfectant Cleaner, nine (9) bottles, forty (40) ounces each of Huskey Uric Acid Eradicator, sixteen (16) bottles ,thirty-three (33) ounces each of Purell Hand Sanitizer containing seventy (70) percent alcohol, twenty-five (25) bottles, two (2) quarts each of Virex 256, three (3) one gallon bottles of Extraction Cleaner, two (2) five gallon containers of Auto Chlor Fabra Kleen Destainer, four (4) five gallon containers of Auto-Chlor Fabra Kleen Sour, four (4) five gallon containers of Auto-Chlor Fabra Kleen Maximizer, and two (2) five gallon containers of Austin A-1 Bleach Commercial Disinfectant Sanitizer.

Review of the manufacturer's Material Safety Data Sheet (MSDS) for Virex 256, revealed the chemical to be a dangerous corrosive that caudns skin and eye burns, and was harmful or fatal if swallowed. Virex 256 causes permanent eye damage, including blindness, permanent skin damage and irritation and corrosive affects to nose, throat and respiratory tract. The MSDS for Auto-Chlor Fabra Kleen Destainer, revealed the

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F 323	<p>Continued From page 11</p> <p>chemical to be a corrosive that causes severe eye and skin burns and is harmful or fatal if swallowed. The MSDS for Austin A-1 Bleach Commercial Disinfectant Sanitizer, Auto-Chlor Fabra Kleen Maximizer, Auto-Chlor Fabra Kleen Sour revealed these chemicals to be a corrosive that may cause severe skin and eye irritation or chemical burns to broken skin and is harmful and potentially fatal if swallowed. The MSDS for the chemical Husky 401 Uric Acid Eradicator, revealed the chemical to be a carcinogen that is harmful if swallowed. The MSDS for Crew Tile and Grout Rejuvenator, revealed the chemical to and irritant to eyes, skin, nose, throat, and respiratory tract. The MSDS for the chemical Purell Instant Hand Sanitizer, revealed the chemical to be seventy (70) percent alcohol and required immediate attention for gross ingestion. The MSDS for Husky Neutral Hospital Disinfectant, revealed the chemical to be a carcinogen that is harmful if swallowed.</p> <p>Interview with Laundry Aide #14, on 02/16/13 at 2:50 PM, revealed the door should have been shut and locked. Continued Interview revealed, the Director of Maintenance was aware of the door not closing properly because he had attempted to repair the door several times. Further interview revealed, he has had to redirect residents from the laundry area.</p> <p>Interview with the Director of Maintenance, on 02/16/13 at 3:15 PM, revealed he was aware that the door did close properly. Continued interview revealed he had attempted to repair the door several times stating the door was heavy and would not stay plum and he continued to re-adjust the door. Further interview with the Director of</p>	F 323			

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F 323	Continued From page 12 Maintenance, revealed he thought the only other option was to "tear the door down and rebuild it". Interview with the DON, on 02/16/13 at 4:50 PM, revealed the door should have been closed and locked. Continued interview revealed that it may be a safety hazard if the residents got into the chemicals. Further interview revealed the facility had two (2) residents that wandered through the facility. Interview with the Administrator, on 02/16/13 at 5:00 PM, revealed the staff was aware that the door did not close properly and the door should have been closed and locked. Continued interview revealed the door not being closed and locked was a safety issue. Further interview revealed the facility had residents that wandered through the facility.	F 323			
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.	F 441	It is the policy of Boyd Nursing and Rehabilitation Center to 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. LPN #1, #5 and #6 were educated on proper glove use and proper hand washing techniques by the Director of Nursing on 02/25/13. Nursing staff was also educated on proper procedure in conducting head to toe skin assessments by Director of Nursing on 02/25/13.	3/29/13	

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F 441 Continued From page 13

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

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure an infection control program was maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection as evidenced by: observations during three (3) separate head to toe skin assessments by three (3) different nurses revealed the nurses to assess the perineal and buttocks areas of residents' bodies and continue assessing other areas without changing gloves and washing or sanitizing their hands.

Additionally, the facility failed to ensure personnel

F 441 Laundry personnel were educated on proper glove use and proper hand washing techniques by the Housekeeping/Laundry Supervisor on 03/07/13. Laundry Aide #14 was educated on contact contamination regarding prevention of development and transmission of disease and infection by the Housekeeping/Laundry Supervisor on 03/07/13.

All staff were re-educated by Staff Development on 02/25/13 regarding importance of proper procedures to help prevent the development and transmission of disease and infection. This included, but was not limited to, hand washing techniques and the handling of linens. The Housekeeping/Laundry Supervisor provided additional education to the laundry staff on 03/07/13 regarding proper infection control techniques for the handling of soiled linens.

The DON, Staff Development Coordinator or RN Supervisor and the Laundry Supervisor will monitor staff compliance with facility infection control protocols via visual compliance rounds daily (M-F) for four weeks then weekly for 8 weeks. Any staff member deviating from proper protocol will be educated at that time. The results will be reviewed at the weekly Focus Meeting, consisting of the Director of Nursing,

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F 441: Continued From page 14

handled, stored, and transported linens so as to prevent the spread of infection as evidenced by observation of laundry personnel failing to wash their hands after handling soiled linens and removing soiled gloves.

The findings include:

1. Observation, on 02/13/13 at 10:08 AM, of Resident #5's head to toe skin assessment performed by Licensed Practical Nurse (LPN) #6 revealed the LPN assessed the resident's buttocks, spreading the cheeks. LPN #6 then proceeded to adjust the resident's brief and pants; scratched Resident #5's back per his/her request; adjusted the resident's shirt and bed covers; placed the call light within reach without removing the contaminated gloves or washing or sanitizing her hands.
- Interview, on 02/16/13 at 9:15 AM, with LPN #6 revealed gloves should be changed "anytime" they come in contact with anything "dirty", such as a resident's "groin" area. She stated she should have changed gloves and washed or sanitized her hands after assessing Resident #5's buttocks.
2. Observation, on 02/14/13 at 2:47 PM, of Resident #3's head to toe skin assessment performed by LPN #1, revealed the LPN assessed the resident's perineal area, assisted with turning the resident, and assessed the resident's buttocks. The LPN then assessed the back of Resident #3's scalp, and behind his/her ears without removing the contaminated gloves or washing or sanitizing her hands.

F 441 Administrator, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, and RN Supervisor, in order to identify facility trends and recommend additional education as needed. The results will also be forwarded to the monthly CQI Committee consisting of the Administrator, Director of Nursing, Pharmacy Consultant, Medical Director, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, Housekeeping/Laundry Supervisor, and the Maintenance Supervisor, for further monitoring and continued compliance.

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F 441	<p>Continued From page 15</p> <p>Interview, on 02/14/13 at 5:28 PM, with LPN #1 revealed when performing a skin assessment gloves should be changed if the perineal area is touched. She stated she should have changed her gloves and washed or sanitized her hands after assessing Resident #3's perineal area. The LPN stated "anytime your gloves get contaminated you're supposed to change" gloves.</p> <p>3. Observation, on 02/14/13 at 3:08 PM, of Resident #9's head to toe skin assessment performed by LPN #5, revealed the nurse assessed the resident's perineal area, proceeded to assess the resident's left arm and the rest of his/her body including the buttocks area, reassessed the perineal area without removing the contaminated gloves or washing or sanitizing her hands.</p> <p>Interview, on 02/14/13 at 5:45 PM, with LPN #5 revealed if gloves become soiled during a skin assessment they should be changed. She stated she should have changed gloves and washed or sanitized her hands after assessing Resident #9's perineal area and buttocks.</p> <p>Interview, on 02/16/13 at 4:48 PM, with the Director of Nursing (DON) revealed gloves should be changed if they touch the perineal area or buttocks. She stated that was "kind of standard".</p> <p>4. A review of the facility's guidelines, "Departmental Environmental Services-Laundry and Linen", dated August 2011 revealed staff should wash hands after handling soiled linen and before handling clean linen and always wash hands after completing the task and removing gloves.</p>	F 441			

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F 441 Continued From page 16

Review of the facility's policy titled, "Hand washing/hand hygiene", dated June 2010, revealed all personnel shall follow the hand washing/hand hygiene procedure to prevent the spread of infection to other personnel, resident and visitors. Further review revealed to wash hands after handling soiled or used linens and after removal of gloves or apron.

Observation, on 02/13/13 at 9:50 AM, revealed Laundry Aide # 14 retrieved linens from four (4) containers within the facility halls. Arrival at each container revealed he donned gloves to transfer soiled linen from one (1) container to the transporting container, removed soiled gloves and failed to wash hands prior to continuing to the additional containers for removal of the linens.

Interview with Laundry Aide # 14, on 02/16/13 at 5:00 PM, revealed he should have washed his hands after removing the soiled linens and gloves from each of the containers, but he was unsure of what the hand washing policy stated.

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<p>K 000</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartment: Three (3)</p> <p>Fire Alarm: Full fire alarm (upgrade completed in 2009)</p> <p>Sprinkler System: Full sprinkler system</p> <p>Generator: Type II Diesel installed 1995</p> <p>A standards Life Safety Code survey was conducted on 02/13/2013. Boyd County Nursing and Rehabilitation was found not to be in compliance with the Life Safety Code. The census the day of the survey was fifty two (52). The facility is licensed for sixty (60) beds.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>K 027 SS=E</p>	<p>INITIAL COMMENTS</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches</p>	<p>K 000</p> <p>K 027</p>	<p>The care plan for Resident #11 in regards to the breakaway alarm to be used at all times was reviewed by IDCPT on 02/27/13 and is reflective of resident's current needs.</p> <p>The plan of care for each resident will be reviewed by the IDCPT to ensure that the current plan of care is reflective of individual needs. The plan of care will be utilized by the IDCPT via walking care plan rounds to ensure that all recorded interventions are implemented by 03/15/13.</p> <p>It is the policy of Boyd Nursing and Rehabilitation Center to maintain door openings in smoke barriers at a least 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7.</p> <p>The door located in the smoke barrier located in the Service Hall was repaired by maintenance contractor Clark and Company on 03/06/13.</p>	<p>3/29/13</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 4-3-13
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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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K 027 Continued From page 1
from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barrier doors to resist the passage of smoke, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke barriers, thirty three (33) residents, staff and visitors.

The findings include:

Observation, on 02/13/2013 at 2:00 PM, revealed the door located in the smoke barrier located in the Service Hall had a gap of 1/2 inch between the door facing and the door jamb. Further observation revealed the door had a gap between the top of the door and the door frame of 2/8 inch. The observation was confirmed with the Maintenance Director.

Interview, on 02/13/2013 at 2:00 PM, with the Maintenance Director, revealed work had been performed on the door several times in the past but the gaps could not be repaired.

Reference: NFPA 101 (2000 edition)
8.3.4.1* Doors in smoke barriers shall close the

K 027 Administrator educated Maintenance Director on 02/27/13 on the importance of maintaining safety environment and method of reporting any areas identified that are a safety concern including identified smoke barrier penetrations.

An environmental audit, that includes but not limited to identification of areas of smoke barrier penetration, will be completed daily Monday through Friday by the Maintenance Director for a period of 4 weeks then once weekly thereafter. The results of these audits will be forwarded to the weekly Focus Committee consisting of the Director of Nursing, Administrator, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, and RN Supervisor. The results will also be reviewed monthly by the CQI Committee consisting of the Administrator, Director of Nursing, Pharmacy Consultant, Medical Director, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, Housekeeping/Laundry Supervisor, and the Maintenance Supervisor, for further monitoring and continued compliance.

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K 027 Continued From page 2
opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.

K 027

K 029 Centers for Medicare and Medicaid Services survey and certification letter: 7-18
SS=E NFPA 101 LIFE SAFETY CODE STANDARD

K 029

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

It is the policy of Boyd Nursing and Rehabilitation Center to maintain one hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

3/29/13

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain hazardous areas, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke barriers, thirty three (33) residents, staff and visitors.

Areas of penetration located in mechanical rooms were repaired by maintenance director on 02/14/13. All mechanical rooms were inspected by Maintenance Director on 02/14/13. Any other identified areas of penetration were repaired on 02/14/13 by Maintenance Director.

The findings include:

Observation, on 02/13/2013 at 11:20 AM, revealed a Mechanical Room (containing a fuel fired heating unit) located in the front hall had

Administrator educated Maintenance Director on maintaining smoke resisting partitions and doors on 02/15/13.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185418	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/13/2013
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NAME OF PROVIDER OR SUPPLIER BOYD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12800 PRINCELANO DRIVE ASHLAND, KY 41102
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K 029 Continued From page 3
penetrations in the ceiling. Further observation revealed two (2) addition mechanical rooms (containing fuel fired heating units) had penetrations in the ceilings. Rooms containing fuel fired heating units must be maintained as hazardous areas. Penetrations must be sealed to prevent the spread of smoke during a fire. The observations were confirmed with the Maintenance Director.

Interview, on 02/13/2013 at 11:20 AM, with the Maintenance Director revealed the facility tried to check the hazardous areas and smoke barriers monthly, but do not have a written policy for this.

Reference: NFPA 101 (2000 edition)

Ref: 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:

- (1) Boiler and fuel-fired heater rooms
- (2) Central/bulk laundries larger than 100 ft² (9.3 m²)
- (3) Paint shops
- (4) Repair shops
- (5) Soiled linen rooms
- (6) Trash collection rooms
- (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of

K 029 Maintenance Director will check all smoke barriers for areas of smoke penetrations weekly for 8 weeks then monthly thereafter. The results of these audits will be forwarded to the weekly Focus Committee consisting of the Director of Nursing, Administrator, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, and RN Supervisor. The results will also be reviewed monthly by the CQI Committee consisting of the Administrator, Director of Nursing, Pharmacy Consultant, Medical Director, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, Housekeeping/Laundry Supervisor, and the Maintenance Supervisor, for further monitoring and continued compliance.

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K 029	Continued From page 4 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system, according to the National Fire Protection Association (NFPA). The deficiency had the potential to affect three (3) of three (3) smoke compartments, sixty (60) of sixty (60) residents, staff and visitors.	K 056	It is the policy of Boyd Nursing and Rehabilitation Center if there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. Contractor Sentry Fire Protection Service was contacted to replace corroded sprinkler heads located under front canopy. A bid was received on 03/15/13. Work is to be completed by 03/29/13.	3/29/13

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K 056 Continued From page 5

The findings include:

Observation, on 02/13/2013 at 12:50 PM, revealed a total of eleven (11) sprinkler heads, located under the front porch canopy were corroded. Sprinkler heads corroded must be replaced due to corrosion affecting the sprinkler heads ability to respond to a fire. The observation was confirmed with the Maintenance Director.

Interview, on 02/13/2013 at 12:50 PM, with the Maintenance Director revealed he was unaware the sprinkler heads were corroded.

Reference: NFPA 25 (1998 edition)

2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.

Exception No. 1:* Sprinklers Installed in concealed spaces such as above suspended ceilings shall not require inspection.

Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.

Record review on 02/13/2013 at 1:30 PM, of the sprinkler inspection reports, revealed no indication of the sprinkler gauges being

K 056 Contractor Sentry Fire Protection Service changed gauges, inspected links and measured heads of sprinkler system on 02/26/13.

Administrator educated Maintenance Director on 02/15/13 on importance of inspecting sprinkler heads to ensure no corrosion is present. Maintenance Director inspected all sprinklers within facility for signs of corrosion on 03/07/13. No other identified areas found.

An audit will be completed daily Monday through Friday by Maintenance Director for a period of 4 weeks then once weekly thereafter which will include inspection of sprinkler heads throughout facility and sprinkler system water gauge compliance. The results of these audits will be forwarded to the weekly Focus Committee consisting of the Director of Nursing, Administrator, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, and RN Supervisor. The results will also be reviewed monthly by the CQI Committee consisting of the Administrator, Director of Nursing, Pharmacy Consultant, Medical Director, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, Housekeeping/Laundry

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K 056	Continued From page 6 recalibrated or replaced. Sprinkler gauges must be replaced or recalibrated due to the gauges being used to indicate proper operation of the sprinkler system. Observation revealed a total of five (5) sprinkler gauges on the sprinkler system. The observations were confirmed with the Maintenance Director. Interview on 02/13/2013 at 1:30 PM, with the Maintenance Director, revealed he was unaware of when the sprinkler gauges were replaced or recalibrated. Reference: NFPA 25 (1998 edition) 2-3.2* Gauges. Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced.	K 056	Supervisor, and the Maintenance Supervisor, for further monitoring and continued compliance.	
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain fire dampers, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, thirty three (33) residents, staff and visitors. The findings include: Observation, on 02/13/2013 at 1:20 PM, revealed a fire damper located in the Mechanical Room,	K 130	It is the policy of Boyd Nursing and Rehabilitation Center to maintain life and safety compliance according to the National Fire Protection Association standards. Contractor Sentry Fire Protection Services conducted an estimate for maintenance of fire dampers on 02/26/13 for the facility. Maintenance will be performed and finalized 03/29/2013. Maintenance Director checked all fusible links in facility for compliance on 02/16/13. Any other identified fusible links that needed replaced were included in estimate from Sentry Fire Protection Services completed on 02/26/13 for replacement.	3/29/13

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K 130 Continued From page 7
next to the Kitchen area. The fire damper did not contain labeling indicating the fire damper had maintenance performed as required. Fire dampers must be maintained to ensure the fire dampers operate prevent the spread of fire. Further observation revealed a total of eleven (11) fire dampers through the facility. The observations were confirmed by the Maintenance Director.
Interview, on 02/13/2013 at 1:20 PM, with the Maintenance Director revealed he believed the fire dampers were checked by the outside contractor who performed the fire alarm Inspections.
Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.

K 130 Administrator educated facility Maintenance Director on 03/07/13 on importance for monitoring the fire dampers to ensure the fusible links are replaced every 4 years and maintenance is performed to ensure proper operation.
Maintenance Director will conduct monthly audits for compliance of fire damper maintenance as a routine monthly preventive maintenance task. The results of these audits will be reviewed monthly by CQI Committee consisting of the Administrator, Director of Nursing, Pharmacy Consultant, Medical Director, Staff Development Coordinator, MDSC, Activity Director, Dietary Manager, Social Services Director, Medical Records Supervisor, Housekeeping/Laundry Supervisor, and the Maintenance Supervisor, for further monitoring and continued compliance.