

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

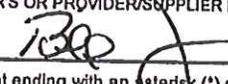
PRINTED: 05/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2013
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NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1614 PARRISH AVE, WEST OWENSBORO, KY 42301
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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 survey was conducted 04/16/13 through 04/19/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "E".	F 000	Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers it response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225	1. Resident #2 was assessed by the Assistant Directors of Nursing on 5/7/2013 to ensure no negative outcome was caused by the alleged deficient practice. 2. Nursing Administration (A/B ADON, C/D/E ADON, Staff Development Coordinator, Medical Records Assistant LPN, Admissions Nurse, Central Supply Nurse, and Medical Records/Scheduler LPN) team completed skin assessments on all other residents in facility by 5/15/2013 to ensure no new areas were identified. All new areas identified were placed on incident/accident investigation, investigation completed on how area(s) occurred, new orders implemented as prescribed by physician, with family notification, and treatment and care	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/29/13
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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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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility policy review it was determined the facility failed to report and investigate the injuries of unknown origin (three bruises) on one (1) resident (#2), in the selected sample of eighteen (18) residents.</p> <p>Findings include:</p> <p>A review of the facility policy, titled Incident Reporting, dated 12/2012 revealed an incident report should be completed for all falls, bruises and skin tears of known or unknown origin. The incident should be reported to the Department Supervisor. The report should be completed by the Charge Nurse on the shift that the Incident/occurrence occurred. The Incident/Occurrence Investigation Form should be initiated by the Charge Nurse and completed by the DON/designee. The Charge Nurse/designee will add interventions to the care plan as needed.</p> <p>A record review revealed Resident # 2 was admitted to the facility on 05/13/13 with diagnoses</p>	F 225	<p>plans updated as appropriate by licensed nursing staff.</p> <p>3. Licensed nursing staff, Certified Medication aides and Certified Nursing Assistants were in-serviced on 5/17/2013 by Staff Development Coordinator and Nursing Administration team. The in-service included the following, the importance of completing incident/accident investigations and notifying Physician and Responsible party of new skin areas. Certified Medication aides and Certified Nursing Assistants were in-serviced on the importance of notifying Charge Nurse immediately on any new skin area identified.</p> <p>4. Nursing Administration (A/B ADON, C/D/E ADON, Staff Development Coordinator, Medical Records Assistant LPN, Admissions Nurse, Central Supply Nurse, and Medical Records/Scheduler LPN) team will be assigned a specific resident hall to review weekly skin assessments for three months to ensure all areas noted have incident/accident investigation completed and investigated in a timely manner. Director of Nursing will audit monthly 10% of resident's weekly skin assessments for three months to ensure investigation is completed on all areas documented. Nursing Administration team will report findings to Director of Nursing weekly in the Clinical Whiteboard Meeting to ensure proper follow up.</p>		

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F 225	Continued From page 2 to include Fracture Right Hip, Dementia, Alzheimer's Disease, History of fractured right thumb, and tib/fib fracture Observation during Resident #2's skin assessment and wound care, on 04/18/13 at 10:30 AM, revealed Registered Nurse (RN) #1 identified three areas of bruising on the resident's bilateral lower legs. A review of the weekly skin round report, dated 04/19/13, revealed the left lower leg areas of bruising were not documented. A review of the nurse's note written by RN #1, on 04/18/13 at 6:00 PM, revealed there was no evidence of the identification of the three areas of unidentified bruising on Resident #2's lower legs. In addition, there was no evidence she reported the areas to the charge nurse, and no evidence she made Resident #2's family and physician aware. A review of the 24 hour shift reports, dated 04/18/13 and 04/19/13 revealed there was no evidence the injuries of unknown origin were identified. An interview was attempted with RN #1, but she was not working at the facility on 04/19/13, and was unable to be reached by telephone. An interview with the Assistant Director of Nursing (ADON), on 04/19/10 at 9:30 AM, revealed she did not know why RN #1 did not report or initiate the investigation of the injuries of unknown origin, but it was her expectation that all nursing staff report and begin the investigation of any identified areas of injuries of unknown origin.	F 225	The Director of Nursing will report any discrepancies weekly, biweekly, and monthly to the Administrator. The Director of Nursing will report findings monthly to Quality Assurance team for three (3) months for monitoring and follow up. 5. Corrective Action Date: 5/20/2013	5/20/13	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241	1. Resident #19 that was affected by alleged deficient practice was assessed by the Assistant Director of Nursing on		

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F 241	<p>Continued From page 3</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review and facility policy review, it was determined the facility failed to provide dignity for one resident (#19), not in the selected sample, during toileting.</p> <p>Findings include:</p> <p>A review of facility's policy titled; "Federal Resident /Patient Rights", Quality of Life, (a) Dignity, last revised 08/2006, revealed the facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>A record review revealed Resident #19 was admitted to the facility on 06/29/10 with diagnoses to include Depressive Disorder, Dementia, and Anxiety State. A review of the annual Minimum Data Set (MDS) assessment, dated 03/30/13, revealed the facility assessed Resident #19's cognition as severely impaired.</p> <p>Observation on 04/17/13 at 11:08 AM revealed Resident #19 was toileted by Licensed Practical Nurse (LPN) #2 and State Registered Nurse Aide (SRNA) #1. LPN #2 and SRNA #1 failed to close the privacy curtain in the common shower room</p>	F 241	<p>5/7/2013 to ensure no negative outcome was caused by the alleged deficient practice.</p> <p>2. Through weekly Team Tackling and management (A/B ADON, C/D/E ADON, Staff Development Coordinator, Medical Records Assistant LPN, Admissions Nurse, Central Supply Nurse, Medical Records/Scheduler LPN, Social Services Director, Environmental Director and Maintenance Director) observations found no "interviewable" or "non-interviewable" residents were affected by the alleged deficient practice. Social Services Director completed 10% resident interviews for each resident hall to ensure that "interviewable" resident's feel that staff provide privacy and dignity when providing care. These interviews will be completed by 5/15/2013 with all new concerns identified placed on facility grievance form, investigations completed with final findings and resolutions added to grievance form.</p> <p>3 Facility staff was in-serviced on 5/17/2013 by Staff Development Coordinator and Social Services Director regarding Resident Rights, Quality of Life, Resident Dignity (knocking before entering, closing door for privacy, closing privacy curtains for</p>	

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F 241	Continued From page 4 surrounding the area where Resident #19 was toileted. LPN #2 opened the door to the hallway when leaving and opened the door again upon re-entering the shower room while SRNA #1 was providing toileting care to the resident. This exposed the resident to anyone on the hallway when the SRNA opened the door. In addition, SRNA #2 failed to knock on the door and wait for a response when she re-entered the shower room. Interview on 04/17/13 at 11:12 AM and 11:38 AM with SRNA #1 revealed the privacy curtain should have been pulled to provide privacy when the resident was in the common shower room on the toilet in case someone opened the door to the hallway. Interview on 04/17/13 at 11:30 AM with LPN #2 revealed staff should pull the privacy curtain in the common shower room when providing care in case someone opens the door to the hallway. Interview on 04/17/13 at 11:36 AM with Registered Nurse (RN) #1 revealed staff should provide privacy by pulling the privacy curtain when providing care. RN #1 stated the SRNA should have knocked on the door and waited for a response before re-entering the shower room. Interview with the Director of Nursing (DON), on 04/19/13 at 11:39 AM, revealed she expected staff to provide privacy by pulling the curtain, and closing the blinds and door. She stated she also expected staff to knock on the door and wait for a response prior to entering the room.	F 241	privacy, closing window blinds/curtains for privacy) and how to report such grievances to Charge Nurse, Social Services Director and Facility Administration. 4. Nursing Administration (A/B ADON, C/D/E ADON, Staff Development Coordinator, Medical Records Assistant LPN, Admissions Nurse, Central Supply Nurse, and Medical Records/Scheduler LPN) team will complete 2 audits per week for three months on staff providing care to ensure resident privacy and dignity is being met. Nursing Administration team will report findings weekly to Director of Nursing to ensure proper follow up. Director of Nursing will report findings monthly to Quality Assurance team for three (3) months for monitoring and follow up. 5. Corrective Action Date: 5/20/2013	5/20/13	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253			

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F 253	<p>Continued From page 5</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure effective housekeeping and maintenance services necessary to maintain a sanitary and orderly environment related to four storage areas with items stored directly on the floors and clean items stored near the dirty mop sink.</p> <p>Findings include:</p> <p>An interview with the Housekeeping Supervisor, on 04/19/13 at 10:30 AM, revealed there was no specific policy for housekeeping storage rooms</p> <p>An observation with the Maintenance Supervisor and the Housekeeping Supervisor of four storage areas, on 04/19/13, from 9:45 AM until 10:30 AM, revealed:</p> <p>A. the D-Hall Housekeeping Closet with several boxes of cleaning supplies stored on the floor;</p> <p>B. the C-Hall Biohazard Closet with Isolation door hangers stored on the floor;</p> <p>C. the B-Hall Storage Area with clean mop heads stored above the sink used to empty dirty mop water, in addition, vent dusters and brooms were stored near this area;</p>	F 253	<ol style="list-style-type: none"> 1. Upon reviewing the four storage areas the Maintenance Director and Environmental Director removed the cleaning supplies off floor of D-hall Housekeeping closet, removed the isolation door hangers stored on floor in C-hall Biohazard closet, removed the clean mop heads, vent dusters and brooms stored above sink in B-hall storage area and removed the wet floor signs located on floor of A-hall shower room. All items mentioned above were cleaned/disinfected and located to new locations in order to avoid cross contamination. This was completed on 5/6/2013. 2. Through weekly Team Tackling and Management (Maintenance Director, Environmental Director, A/B ADON, C/D/E ADON) observations found no resident was affected by the alleged deficient practice. 3. An in-service was conducted with the housekeeping/maintenance staff and facility staff by the Maintenance and Environmental Director on 5/17/2013. The in-service included properly storing of chemicals/cleaning supplies safely, items should not be stored on floor for any reason, proper storage of mop heads/vent cleaners/brooms to reduce cross contamination, proper storage of wet floor signs and isolation door hangers to reduce cross contamination and general floor safety. 4. The Maintenance Director and Environmental Director will each audit 	

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F 253	Continued From page 6 D. the A-Hall Shower Room was noted to have five wet floor signs lying folded on the floor. An interview with the Housekeeping Supervisor, on 04/19/13 at 10:30 AM, revealed she was unaware of the possibility of cross contamination of the dirty mop water that would be spread to other objects hanging near-by and items stored on the floor, where germs would be spread throughout the facility.	F 253	the storage closets and shower rooms weekly for three months to ensure compliance with proper storage of chemicals/supplies and maintaining an orderly sanitary environment. Findings will be reported to the Administrator weekly. Maintenance Director and Environmental Director will report findings monthly to Quality Assurance team for 3 months for monitoring and follow up.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to implement the care plan for one (1) resident (#1), in the selected sample of eighteen (18) residents, related to the bed being in the lowest position to prevent falls. A record review revealed Resident #1 was re-admitted to the facility on 03/06/13 with diagnoses to include Fracture Dislocation (right ankle) and Dementia. A review of a significant change Minimum Data Set (MDS) assessment, dated 04/10/13, revealed the facility assess Resident #1's cognition as moderately impaired.	F 282	5. Corrective Action Date: 5/20/2013 1. Resident #1 that was affected by alleged deficient practice was assessed by Medical Records Assistant, LPN 4/17/2013 to ensure no negative outcome was caused by the alleged deficient practice. 2. Through weekly Nursing Administration Team Tackling and management (A/B ADON, C/D/E ADON, Staff Development Coordinator, Medical Records Assistant LPN, Admissions Nurse, Central Supply Nurse, and Medical Records/Scheduler LPN) observations found no other residents were affected by the alleged deficient practice. 3. Nursing staff were in-serviced on 5/17/2013 by Staff Development Coordinator and Nursing Administration team regarding quality of care, accident/incident prevention and resident beds placed in lowest position.	5/20/13

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F 282	Continued From page 7 A review of the Comprehensive Care Plan for "at risk for falls related to weakness, Dementia, Cardiac Disease, Diabetes, Degenerative Joint Disease, Incontinent Episodes, and medications" dated 04/16/13, revealed an intervention for staff to provide a low/platform bed and have the bed in lowest position when the resident was in the bed. Observation on 04/16/13 at 6:20 AM and 9:51 AM and on 04/17/13 at 11:26 AM, revealed Resident #1's bed was approximately two (2) feet off the floor and was not in the lowest position. Interview with State Registered Nurse Aide (SRNA) #2, on 04/17/13 at 11:26 AM, revealed she should have the bed in the lowest position according to the care plan. The SRNA checked the bed to see if it would go lower by pushing the bed remote and the bed went down into the lowest position. SRNA #2 further stated the bed had not been in lowest position since being raised for breakfast around 8:15 AM to 8:20 AM. Interview with the Director of Nursing (DON), on 04/19/13 at 11:39 AM, revealed she expects the staff to follow the care plans.	F 282	4. Nursing Administration team (A/B ADON, C/D/E ADON, Staff Development Coordinator, Medical Records Assistant LPN, Admissions Nurse, Central Supply Nurse, and Medical Records/Scheduler LPN) will audit weekly 10% of residents on assigned hall for three months to ensure beds are in lowest position and accident prevention is being observed. Nursing Administration team will report findings weekly to Director of Nursing to ensure proper follow up. Director of Nursing will report findings monthly to Quality Assurance team for three (3) months for monitoring and follow up. 5. Corrective Action Date: 5/20/2013	5/20/13
F 323 SS=D	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 1.	Resident #1 that was affected by alleged deficient practice was assessed by Medical Records Assistant, LPN 4/17/2013 to ensure no negative outcome was caused by the alleged deficient practice.	

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F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, it was determined the facility failed to ensure one resident (#1), in the selected sample of eighteen (18) residents, environment remained free of hazards. The facility failed to ensure Resident #1's bed was in the lowest position to prevent falls. Findings include: A record review revealed Resident #1 was re-admitted to the facility on 03/06/13 with diagnoses to include Fracture Dislocation (right ankle) and Dementia. A review of a significant change Minimum Data Set (MDS) assessment, dated 04/10/13, revealed the facility assess Resident #1's cognition as moderately impaired. A review of the Comprehensive Care Plan for "at risk for falls related to weakness, Dementia, Cardiac Disease, Diabetes, Degenerative Joint Disease, Incontinent Episodes, and medications" dated 04/16/13, revealed an intervention for staff to provide a low/platform bed and have the bed in lowest position when the resident was in the bed. Observation on 04/16/13 at 6:20 AM and 9:51 AM and on 04/17/13 at 11:26 AM, revealed Resident #1's bed was approximately two (2) feet off the floor and was not in the lowest position. Interview with State Registered Nurse Aide (SRNA) #2, on 04/17/13 at 11:26 AM, revealed she checked the bed to see if it would go lower by	F 323	2. Through weekly Nursing Administration Team Tackling and management (A/B ADON, C/D/E ADON, Staff Development Coordinator, Medical Records Assistant LPN, Admission Nurse, Central Supply Nurse, and Medical Records/Scheduler LPN) observations found no other residents were affected by the alleged deficient practice. 3. Nursing staff were in-serviced on 5/17/2013 by Staff Development Coordinator and Nursing Administration team regarding quality of care, accident/incident prevention and resident beds placed in lowest position. 4. Nursing Administration team (A/B ADON, C/D/E ADON, Staff Development Coordinator, Medical Records Assistant LPN, Admission Nurse, Central Supply Nurse, and Medical Records/Scheduler LPN) will audit weekly 10% of residents on assigned hall for three months to ensure beds are in lowest position and accident prevention is being observed. Nursing Administration team will report findings weekly to Director of Nursing to ensure proper follow up. Director of Nursing will report findings monthly to Quality Assurance team for three (3) months for monitoring and follow up. 5. Corrective Action Date: 5/20/2013	5/20/13	

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NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1614 PARRISH AVE, WEST OWENSBORO, KY 42301		
(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 323	Continued From page 9 pushing the bed remote and the bed went down into the lowest position. SRNA #2 further stated the bed had not been in lowest position since being raised for breakfast around 8:15 AM to 8:20 AM. Interview with the Director of Nursing (DON), on 04/19/13 at 11:39 AM, revealed she expected the staff to ensure the resident's bed was in the lowest position to prevent a possible fall with injury.	F 323			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1964, 1973 & 1979.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 63 smoke detectors and 42 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1979.</p> <p>GENERATOR: Type II generator installed in 2005. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 04/17/2013. Hermitage Care & Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X8) DATE 5/29/13

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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K 000 K 012 SS=E	<p>Continued From page 1 Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, thirty-five (35) residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure two (2) porches and one (1) canopy had proper sprinkler protection.</p> <p>The findings include:</p> <p>Observation, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed the exit at the front of E-hall and the back of C-hall had a porch roof that extended over four (4) foot with no sprinkler protection under them. Further observation revealed a canopy at the front entrance of the failing that was over eight (8) feet long with only one sprinkler head located under the canopy.</p>	K 000 K 012	<p>Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <ol style="list-style-type: none"> Automatic sprinkler system was ordered from Century Fire Protection on 5/6/2013 for exit at the front of E-hall and the back of C-hall. Invoice and completion date 5/15/2013 for install of one sprinkler head for each of the above locations. Quote was requested 5/9/2013 from Snyder Awning for noncombustible canopy at front entrance to replace the existing canopy. Snyder Awning quote and approved Purchase Order #100889 for canopy received 5/14/2013 and 5/24/2013 respectively. We will use approved Purchase Order dated 5/24/2013 as our compliance date and Snyder Awning will schedule install upon receiving noncombustible canopy. Maintenance Director conducted environmental audit on 5/6/2013 to ensure facility had automatic sprinklers in all necessary areas; no other issues identified. Administrator will conduct in-service with Maintenance Director and Assistant on 5/17/2013 regarding standards for the installation of sprinkler systems. 	

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K 012	Continued From page 2 . Interview, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed he was under the impression if the attic was sprinkler protected then he was in compliance. Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012	4. Maintenance Director will conduct monthly environmental audit for three months to ensure proper placement of sprinkler heads under roofs/canopies, ensure no new canopies are added in month that would require additional sprinkler head(s) and that sprinkler heads have no potential obstructions and are clear from debris and etc. Maintenance Director will report to QA team monthly for 3 months for recommendations and follow up. 5. Corrective Action Date: 5/24/2013	5/24/13	
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 017	1. Therapy department is part of the exit corridor at the end of A-hall and B-hall, therefore we will install walls at the end of each hall (A&B) to separate therapy gym from exit corridors, thus making exit access readily accessible at all times. Our corporate construction team will order materials for project by 5/17/2013 and start date to begin on 5/22/2013. This project will be completed by 6/1/2013. 2. Maintenance Director conducted environmental audit of facility on 5/6/2013 to ensure all other exits met requirements of egress. No other issues were identified. 3. Maintenance Director will conduct in-service with facility staff on 5/17/2013 regarding upcoming therapy project and that all designated exits shall be arranged so that they are readily accessible at all times.		

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K 017	<p>Continued From page 3</p> <p>failed to ensure that rooms open to the corridor would not interfere with egress requirements in accordance with NFPA standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, fifty (50) residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure the rehab department was not open to the exit corridors.</p> <p>The findings include:</p> <p>Observation, on 04/17/13 at 2:30 PM with the Maintenance Director, revealed the therapy department was part of the exit corridor at the end of A and B Hall. The contents of this room is not permitted to be in an area open to the corridor.</p> <p>Interview, on 04/17/13 at 2:30 PM with the Maintenance Director, revealed this area was originally designed as a television lounge and had been converted to the therapy department.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.1 Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. (See also 19.2.5.9.) Exception No. 1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 shall be permitted to have spaces that are unlimited in size open to the corridor, provided that the following criteria are met: (a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas.</p>	K 017	<p>4. Maintenance Director will conduct weekly environmental audit for three months to ensure all designated exits shall be arranged so that they are readily accessible and meet egress requirements. Maintenance Director will report findings to QA team monthly for 3 months for recommendations and follow up.</p> <p>5. Corrective Action Date: 6/1/2013</p>	6/1/13

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K 017	Continued From page 4 (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.	K 017		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by:	K 025	1. Repaired penetration by large sprinkler pipe above break room with fire chalk on 5/9/2013. Ordered fire door to close off passage from break room to Hall of Fame dining from Granger on 5/31/2013. On 5/17/2013 door with no closing device above dietary office was corrected by installing spring on door to ensure it was closed at all times and the barrier at kitchen where closing spring was removed was corrected with new spring added on 5/10/2013 to keep door closed. Concrete wall at therapy department will be corrected on 5/27/2013 by installing concrete board. Ordered access doors on 5/31/2013 from Granger for inaccessible barriers	

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K 025	<p>Continued From page 5</p> <p>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 seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure four (4) smoke barriers were sealed to resist the passage of smoke and three (3) smoke barriers were accessible.</p> <p>The findings include:</p> <p>Observations, on 04/17/13 between 8:45 AM and 9:45 AM with the Maintenance Director, revealed the smoke partition, extending above the ceiling located above the break room was penetrated by a large sprinkler pipe. Further observation revealed a door with no closing device was open in the barrier above the Dietary Office, the barrier at the kitchen had the closing spring removed and the door was open, drywall mud was used as a sealant on a concrete wall at the rehab department. Further observation revealed the smoke barriers were inaccessible to check the condition of the barriers at the Human Resource Office, above the back hall, and next to the gallery dining. The final observation revealed the smoke barrier wall for doors labeled A on the map did not exist.</p> <p>Interview, on 04/17/13 between 8:45 AM and 9:45 AM with the Maintenance Director, revealed he was unaware the closing springs had been removed from the doors in the smoke barriers.</p>	K 025	<p>at Human Resource Office, above back hall and next to Gallery dining room. Signature Healthcare Construction began work on 5/22/2013 on Smoke barrier wall for doors labeled A on the map that did not exist and will be corrected by 6/14/2013 by building barrier walls in attic above fire doors to match map. We will use compliance date of 5/31/2013 last invoice date for all projects and will be completed by Signature Healthcare Corporate Construction by 6/28/2013.</p> <ol style="list-style-type: none"> Through review of our facility safety compliance monthly audit conducted by Plant Maintenance Director it was determined that no residents were affected by the alleged deficient practice. Maintenance Director will conduct in-service with maintenance staff on 5/17/2013 regarding attic penetrations, proper sealants, doors in the barriers must have closing springs and remain closed. Maintenance Director will conduct monthly environmental audit for three months to ensure no barrier penetrations exist and all doors in attic are closed with closing springs present. Maintenance Director will report monthly findings to Administrator and QA team monthly for 3 months for recommendations and follow up. Corrective Action Date: 5/31/2013 	5/31/13

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K 025	<p>Continued From page 6</p> <p>He was unaware the drywall mud was not approved as a sealant on a concrete wall. As for the wall at the doors labeled A he was unaware the map showed the wall existing above the doors.</p> <p>Reference: NFPA 101 (2000 Edition).</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>8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire</p>	K 025		

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K 027	Continued From page 8 The findings include: Observation, on 04/17/13 at 10:40 AM with the Maintenance Director, revealed the cross-corridor doors located on the d-hall and the front hall of fame cross-corridor doors would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Further observation revealed the cross-corridor doors on A-hall were not equipped with a coordinating device to ensure the doors closed properly and the cross corridor doors at the rehab area were equipped with magnets not connected to the fire alarm. Interview, on 04/17/13 at 10:40 AM with the Maintenance Director, revealed he was unaware the doors would not close all the way leaving a gap between the doors in the closed position and the magnets at the rehab area were not allowed. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027	4. Maintenance Director will conduct weekly environmental audit for three months to ensure corridor doors properly close, no magnet holders are in use that are not connected to fire alarm and that door coordinators are installed and operational. Maintenance Director will report weekly findings to Administrator and QA team monthly for 3 months for recommendations and follow up. 5. Corrective Action Date: 6/1/2013	6/1/13

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K 027	Continued From page 9 Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¼ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, thirty-five (35) residents, staff and visitors. The facility is	K 029	1. A self closing device was installed on doors of the following offices/areas, Assistant Director of Nursing, Business Office, Social Service office and the dishwasher room on 5/17/2013. On 5/10/2013 door for dry storage area in the kitchen was ordered from Dunn's Glass LLC. Door and self closing device will be installed by Signature Healthcare corporate construction by 6/1/2013. 2. Maintenance Director conducted environmental audit of facility on 5/6/2013 to ensure no other violations existed. No other issues were identified.	

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K 029	<p>Continued From page 10</p> <p>certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure five (5) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed the Assistant Director of Nursing office, the dry storage room in the kitchen, the Business office, and the Social Services Director office did not have a closer added to the door. This requirement is due to the storage of combustible items inside the areas. Further observation revealed the closer on the dishwasher room had been unhooked leaving the kitchen open to the dining room.</p> <p>Interview, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not. Further interview revealed he was unaware the door closer was taken off the dishwasher room.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>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</p>	K 029	<p>3. Maintenance Director will conduct in-service with facility staff on 5/17/2013 regarding this requirement and the importance of not removing or unhooking the closer from designated doors.</p> <p>4. Maintenance Director will conduct monthly environmental audit for three months to ensure all designated doors have self closing device and operational. Maintenance Director will report findings to QA team monthly for 3 months for recommendations and follow up.</p> <p>5. Corrective Action Date: 6/1/2013</p>	6/1/13	

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K 029	Continued From page 11 extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	1. Egress Doors will be corrected by 6/1/2013 by placing signage with contrasting background reading "Push until alarm sounds door can be opened in 15 seconds". On 5/8/2013 began requesting bids to install 4' wide sidewalk outside of exit from dining room to extend to public way. On 5/21/2013 Signature Healthcare Construction purchased from Home	



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K 038	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure eight (8) egress doors had the proper signage for delayed egress doors and one (1) exit did not have a durable surface to a public way.</p> <p>The findings include:</p> <p>Observation, on 04/17/13 at 10:46 AM with the Maintenance Director, revealed the egress doors located throughout the facility were not equipped with delayed egress signage.</p> <p>Interview, on 04/17/13 at 10:46 AM with the Maintenance Director, revealed he was unaware the doors were required to have signage with a contrasting background on a door with a delayed egress.</p> <p>Observation, on 04/17/13 at 2:14 PM with the Maintenance Director, revealed the Dining Room exit does not have a 4' wide durable surface to a public way.</p> <p>Interview, on 04/17/13 at 2:14 PM with the Maintenance Director, revealed he was unaware exits require a durable path to the public way and</p>	K 038	<p>Depot material to install above sidewalk and deck. On 5/28/2013 and 7/11/213 received Purchase Orders from Signature Healthcare Construction for approval for Rudd Concrete to complete concrete work for egress. We will use approved Purchase Order date 7/11/2013 as our compliance date and Signature Construction and Rudd Concrete will complete project by 9/1/2013.</p> <p>2. Maintenance Director conducted environmental audit of facility on 5/6/2013 to ensure no other violations were identified; no other issues identified.</p> <p>3. Maintenance Director will conduct in-service with facility staff on 5/17/2013 regarding the requirement of egress signage and the installation of sidewalk at exit of dining rooms that will extend to public way.</p> <p>4. Maintenance Director will conduct monthly audit for three months to ensure all designated doors have proper</p>	

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K 038	Continued From page 13 that you could not reenter the building to exit. Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected	K 038	egress signage and that staff are aware of signage, understand delayed egress and new sidewalk project that will improve emergency exit to public way. Maintenance Director will report findings to QA team monthly for 3 months for recommendations and follow up. 5. Corrective Action Date: 7/11/2013	7/11/13

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K 038	<p>Continued From page 14</p> <p>throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the</p>	K 038		

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K 038	<p>Continued From page 15</p> <p>releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge</p>	K 038		

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K 038	Continued From page 16 as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038		
K 045 SS=E	<p>CMS S&C letter 5-38 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of seven (7) smoke compartments, seventy-three (73) residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at three (3) exits.</p> <p>The findings include:</p> <p>Observation, on 04/17/13 at 10:40 AM with the Maintenance Director, revealed the exterior exits at the d-hall exit and the two exits at the rehab area were equipped with a single light for illumination of the outside of the exit.</p>	K 045	<ol style="list-style-type: none"> 1. Illuminated exterior exit lighting at D-hall and the two exits in therapy department will be corrected 6/1/2013 by placing new light fixtures with two light bulb in each of the fixtures to ensure each exit has light fixtures with more than one bulb for illumination. 2. Maintenance Director conducted environmental audit of facility on 5/6/2013 to ensure no other violations existed. Other areas identified were corrected on 6/1/2013. 3. Maintenance Director will conduct in-service with maintenance staff and facility department heads on 5/17/2013 regarding the requirement of each exit fixture requiring more than one bulb for illumination. 	

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K 045	Continued From page 17 Interview, on 04/17/13 at 10:40 AM with the Maintenance Director, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	4. Maintenance Director will conduct monthly audit for three months to ensure all exit fixtures have proper number of bulbs and that they are operational. Maintenance Director will report findings to QA team monthly for 3 months for recommendations and follow up.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on interview and facility record review, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure they conducted an annual emergency lighting testing for the minimum requirement of at least 1-1/2 hour duration. The findings include:	K 046	5. Corrective Action Date: 6/1/2013 1. Emergency lighting with battery backup located on emergency generator was tested for 1 ½ hours on 5/7/2013 with no issues. This will continue to be tested each year for a minimum of 1 ½ hours to ensure compliance. 2. Maintenance Director conducted environmental audit of facility on 5/6/2013 to ensure no other violations existed with emergency lighting with battery backup. No other issues were identified.	6/1/13

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K 046	<p>Continued From page 18</p> <p>Record review, on 04/17/13 at 10:10 AM with the Maintenance Director, revealed that the emergency light, with battery backup, located at the generator had not been tested for 1-1/2 hours within the last year.</p> <p>Interview, on 04/17/13 at 10:10 AM with the Maintenance Director, revealed he was unaware the lighting had to be tested annually for 1-1/2 hours.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of</p>	K 046	<p>3. Maintenance Director will conduct in-service with maintenance staff on 5/17/2013 regarding the requirement of emergency lighting with battery backup must be tested annually for a minimum of 1 1/2 hours.</p> <p>4. Maintenance Director will conduct monthly test 1 1/2 hours for 3 months to ensure compliance and operation of emergency lighting on generator. Maintenance Director will report findings to QA team monthly for 3 months for recommendations and follow up.</p> <p>5. Corrective Action Date: 5/17/2013</p>	5/17/13

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K 046	Continued From page 19 visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 046		
K 047 SS=E	This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, seventy-three (73) residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure the exit paths were clearly marked. The findings include: Observation, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed egress paths were not clearly marked with exit	K 047	1. Ordered additional illuminated exit signs for A-hall, B-hall, C-hall, D-hall, E-hall and both sets of the Hall of Fame Doors on 5/13/2013 from Sexauer and will be corrected by Signature Healthcare Corporate Construction by running additional electrical outlets for exit signs that will hook up to our emergency backup system. We will use Sexauer invoice date 5/13/2013 as compliance date and project will be completed by 6/28/2013. 2. Maintenance Director conducted environmental audit of facility on 5/6/2013 to ensure no other violations existed; those identified will be corrected on 6/28/2013. 3. Maintenance Director will conduct in-service with maintenance staff on 5/17/2013 regarding the requirement of additional exit signs and their locations to be installed.	

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K 047	<p>Continued From page 20</p> <p>signs in the A-hall, C-hall, D-Hall, E-Hall, and both sets of the Hall of Fame Doors.</p> <p>Interview, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed he was unaware the signage was missing for the exits.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.</p>	K 047	<p>4. Maintenance Director will conduct monthly audit for three months to ensure all exit signs are properly located and operational. Maintenance Director will report findings to QA team monthly for 3 months for recommendations and follow up.</p> <p>5. Corrective Action Date: 5/13/2013</p>	5/13/13
K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random</p>	K 050	<p>1. Conducted fire drills for each shift at varied times and varied conditions. These fire drills took place on 5/8/2013 2nd shift at 8:15 p.m. and 5/10/2013 1st shift at 1:10 p.m. Going forward drills will be conducted at varied times and varied conditions.</p> <p>2. Maintenance Director conducted audit of facility previous drills on 5/7/2013 to identify target days and times for future drills in order to make the drills more random.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185346	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/17/2013
NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1614 PARRISH AVE, WEST OWENSBORO, KY 42301		
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K 050	Continued From page 21 times, in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times on second shift. The findings include: Fire Drill review, on 04/17/13, at 10:15 AM with the Maintenance Director, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on second shift were conducted between 6:00 AM and 6:40 AM for the last year. Interview, on 04/17/13 at 10:15 AM with the Maintenance Director, revealed he was unaware the fire drills were not being conducted as required. The Maintenance Supervisor was unaware of the time separation on each shift to consider the times unexpected. Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	3. Maintenance Director will conduct in-service with maintenance staff on 5/17/2013 regarding the requirement of conducting fire drills at varied times and varied conditions, making sure to conduct on different days and different times within the shifts. 4. Maintenance Director will conduct monthly audit for 3 months to ensure all drills are random with varied times and varied conditions. Maintenance Director will report monthly times and days of fire drills to QA team for 3 months to ensure varied times and varied conditions are followed and for recommendations and follow up. 5. Corrective Action Date: 5/17/2013	5/17/13	
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	K 056	1. Placed order for new light fixtures on 5/7/2013 with our corporate office that would allow for compliance with sprinkler heads so that fixtures would not extend below the sprinkler head and would not be within one foot of		

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K 056	<p>Continued From page 22</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures and porches over 4 feet wide had proper sprinkler coverage.</p> <p>The findings include:</p> <p>Observations, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed the sprinkler heads located in the bathrooms of resident rooms #66, #64, #65, #62, #60, #61, #58, #50, #56 and #45 were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in the back hallway, employee</p>	K 056	<p>sprinkler heads. The areas that will be corrected are located in the bathrooms of resident rooms #66, #64, #65, #62, #60, #61, #58, #56 and #45. Also light fixtures that were blocking sprinkler heads in the following areas were purchased from Home Depot on 5/21/2013 and will be corrected by Signature Healthcare Construction by 6/28/2013: back hallway, employee break room, Hall of Fame hallway, C-hall, environmental services and clean linen area in laundry. Century Fire was in on 5/15/2013 to measure to drop and order new sprinkler heads for C-hall and identified areas. Ceiling fans that were extending below the sprinkler heads will be corrected by removing ceiling fans in A-hall, Human Resources area, Administrator's office, Social Services office, Assistant Director of Nursing office, dining rooms, chapel, chaplain office, B-hall and the therapy office. These projects above have been scheduled with Signature Healthcare Construction on 5/7/2013 and work began on 5/22/2013. Projects will be completed by Signature Healthcare Corporate Construction by 6/28/2013. We will use 5/22/2013 as compliance date of when material and work was initiated.</p> <p>2. Maintenance Director conducted audit of facility on 5/7/2013 to identify any other areas of concern with none noted.</p>		

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K 056	<p>Continued From page 23</p> <p>break room, hall of fame hallway, c-hall, biohazard on c-hall, environmental services, and the clean linen in the laundry area. The final observation was sprinkler heads were blocked by ceiling fans extending below the sprinkler head in the A-Hall, Human Resource Assistant office, Administrator's office, Social Services Director's office, Assistant Director of Nursing office, Dining Room, Reflection Dining, Chapel, Chaplain office, B-hall, and the Therapy Director office.</p> <p>Interview, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed he was unaware that the light fixtures and ceiling fans could block the spray pattern of a sprinkler head.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.</p> <p>Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;">Maximum Allowable Distance</td> <td></td> </tr> <tr> <td>Distance from Sprinklers to</td> <td style="text-align: center;">of Deflector</td> <td></td> </tr> <tr> <td>above Bottom of</td> <td></td> <td></td> </tr> <tr> <td>Side of Obstruction (A)</td> <td style="text-align: center;">Obstruction (in.)</td> <td></td> </tr> <tr> <td>(B)</td> <td></td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td style="text-align: center;">0</td> <td></td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td style="text-align: center;">2 1/2</td> <td></td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td style="text-align: center;">3 1/2</td> <td></td> </tr> </table>		Maximum Allowable Distance		Distance from Sprinklers to	of Deflector		above Bottom of			Side of Obstruction (A)	Obstruction (in.)		(B)			Less than 1 ft	0		1 ft to less than 1 ft 6 in.	2 1/2		1 ft 6 in. to less than 2 ft	3 1/2		K 056	<p>3. Maintenance Director will conduct in-service with maintenance staff on 5/17/2013 regarding the requirement of sprinkler head clearance, proper light fixture placement and proper ceiling fan placement.</p> <p>4. Maintenance Director will conduct monthly audit for 3 months to ensure all sprinkler heads are located within regulation and have proper clearance from light fixtures, ceiling fans and any other potential obstructions; proper installation and location of light fixtures, ceiling fans and/or any other install during the month that may not meet the proper sprinkler head clearance. Maintenance Director will report audits and any monthly new installs of lighting/ceiling fans to ensure proper sprinkler head clearance to QA team monthly for 3 months for recommendations and follow up.</p> <p>5. Corrective Action Date: 5/22/2013</p>	5/22/13
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K 056	Continued From page 24 2 ft to less than 2 ft 6 in. 51/2 2 ft 6 in. to less than 3 ft 71/2 3 ft to less than 3 ft 6 in. 91/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 161/2 5 ft and greater 18. For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review, and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure the dry sprinkler system had a full flow trip test in the last three years. The findings include:	K 062	1. Contacted Century Fire Protection on 5/6/2013 to schedule "full trip test" to be completed. The test has been scheduled and will be corrected by 6/1/2013. 2. Through review of our facility safety compliance monthly audit conducted my Maintenance Director it was determined no residents were affected by the alleged deficient practice. 3. Maintenance Director will conduct in-service with maintenance staff on 5/17/2013 regarding the requirement of sprinkler system full flow trip test needs to be performed every 3 years and when altered and a partial trip test needs to be completed annually. It is maintenance responsibility to ensure we have these tests completed by Century Fire Protection and documented accordingly.	

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K 062	Continued From page 25 Record review, on 04/17/13 at 10:00 AM with the Maintenance Director, revealed the facility failed to provide documentation that the dry sprinkler system had a full flow trip test performed in the last three (3) years. Further observation revealed there was no documentation of an annual partial trip test. Interview, on 04/17/13 at 10:00 AM with the Maintenance Director, revealed he was unaware the trip test was not performed and had not noticed the area on the annual report was marked n/a. Reference: NFPA 25 (1998 Edition). 9-4.4.2.2.1* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service. 9-4.4.2.2.2* During those years when full flow testing in accordance with 9-4.4.2.2.1 is not required, each dry pipe valve shall be trip tested with the control valve partially open. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour	K 062	4. On 5/8/2013 Maintenance Director scheduled Century Fire Protection for full trip and partial test to be completed annually each June, this schedule was placed in our quality assurance electronic maintenance system (TELS) and life safety binder. Maintenance Director will report this requirement and schedule monthly for 3 months to QA team ensuring that proper documentation is in place for "full trip test" every 3 years and that system has not been altered in reporting month which would require additional "trip test". Reporting this standard monthly for 3 months will increase understanding, communication, and allow for recommendations and follow up to Maintenance Quality Assurance Calendar. 5. Corrective Action Date: 6/1/2013	6/1/13
K 076 SS=D	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour	K 076	1. Removed traditional light switch and combustible materials from oxygen storage room. Installed motion detector lighting in ceiling of oxygen storage room. The install and removal of combustible materials was corrected on 5/17/2013.	

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K 076	<p>Continued From page 26 separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty (20) residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles and ignition sources were located five (5) feet from the floor.</p> <p>The findings include:</p> <p>Observation, on 04/17/13 at 2:00 PM with the Maintenance Director, revealed thirty-five (35) oxygen tanks in the oxygen storage room. The oxygen tanks were being stored within five (5) feet of boxes and supplies and ignition sources were not located over five (5) feet from the floor.</p> <p>Interview, on 04/17/13 at 2:00 PM with the Maintenance Director, revealed he was unaware oxygen tanks could not be stored within five (5)</p>	K 076	<p>2. Through review of our facility safety compliance monthly audit conducted by Maintenance Director it was determined no residents were affected by the alleged deficient practice.</p> <p>3. Maintenance Director will conduct in-service with facility staff on 5/17/2013 regarding the requirement that oxygen tanks must be stored minimum of 5 feet away from combustible items and that these items were relocated per regulation. No combustible items will be stored in the oxygen closet and a motion light was installed in ceiling to meet requirement of ignition sources being 5 feet off of floor.</p> <p>4. Maintenance Director will conduct weekly environmental audit for three months to ensure no combustible items are stored in oxygen closet and that motion light is operational. Maintenance Director will report findings to QA team monthly for 3 months for recommendations and follow up.</p> <p>5. Corrective Action Date: 5/17/2013</p>	5/17/13
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K 076	<p>Continued From page 27</p> <p>feet of combustible materials and the light switch had to be five (5) feet from the floor once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2</p> <p>Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³)</p> <p>(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.</p> <p>(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.</p> <p>(f) Electrical fixtures in storage locations shall</p>	K 076		
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K 076	Continued From page 28 meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of seven (7) smoke compartments, fifty-six (56) residents, staff and visitors. The facility is certified for Ninety-Two (92) beds with a census of Eighty-Eight (88) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them and power strips were being used properly. The findings include: Observations, on 04/17/13 at 10:56 AM with the	K 147	<ol style="list-style-type: none"> On 5/10/2013 maintenance and dietary manager reorganized dry storage room for kitchen to create a minimum of 3 feet of clearance for electrical panels. On 4/18/2013 maintenance removed extension cords from Room #48 and Room #8. On 6/1/2013 will correct by removing bed plugs from power strips and relocate to newly installed electrical outlets in Rooms #25, #26, #15, #3 and oxygen concentrator that was plugged into power strip in Room #19 will relocated to newly installed electrical outlet. On 6/1/2013 will correct "mounted" power strips from E-hall by removing the mounts from wall. Through review of our facility safety compliance monthly audit conducted by Maintenance Director it was determined that no residents were affected by the alleged deficient practice. 	

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K 147	<p>Continued From page 29</p> <p>Maintenance Director, revealed the electrical panels in the dry storage room for the kitchen had storage within six (6) inches of the electrical panels.</p> <p>Interview, on 04/17/13 at 10:56 AM with the Maintenance Director, revealed he was unaware the storage shelves had been placed so close to the electrical panel.</p> <p>Observations, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed:</p> <ol style="list-style-type: none"> 1) Power strips were mounted to the wall throughout the E-Hall. 2) An extension cord was plugged into a tree located in room #48. 3) An oxygen concentrator was plugged into a power strip located in room #19. 4) A bed was plugged into a power strip located in room #25. 5) A bed was plugged into a power strip located in room #26. 6) A bed was plugged into a power strip located in room #15. 7) A bed was plugged into a power strip located in room #3. 8) An extension cord was plugged into a lamp located in room #8. <p>Interview, on 04/17/13 between 10:45 AM and 3:30 PM with the Maintenance Director, revealed he was unaware of the items being improperly plugged into power strips and the two extension cords in use. Further interview revealed he was instructed by the Fire Marshall to mount the power strips to the wall on E-Hall.</p>	K 147	<ol style="list-style-type: none"> 3. Maintenance Director will conduct in-service with facility staff on 5/17/2013 regarding the proper use of power strips, medical equipment is not to be plugged into power strips, power strips should not be mounted on the wall, extension cords are not to be utilized in facility, and electrical panels must have at minimum 3 feet of clearance from storage items. 4. Maintenance Director will conduct weekly environmental audit for three months to ensure proper use of power strips, no use of extensions cords, and electrical panels in kitchen storage area have 3 feet of clearance from storage items. Maintenance Director will report findings to Administrator and QA team monthly for 3 months for recommendations and follow up. 5. Corrective Action Date: 6/1/2013 	6/1/13
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185346	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED. 04/17/2013
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NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1614 PARRISH AVE, WEST OWENSBORO, KY 42301
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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																				
K 147	<p>Continued From page 30</p> <p>Reference: NFPA 99 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft)</td> </tr> <tr> <td></td> <td>1.2 m (4 ft)</td> <td colspan="2"></td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)			1.2 m (4 ft)			K 147		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER HERMITAGE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1614 PARRISH AVE, WEST OWENSBORO, KY 42301	
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K 147	<p>Continued From page 31</p> <p>sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts.</p> <p>Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded.</p> <p>Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p> <p>(a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided.</p> <p>(b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc.</p> <p>(c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit</p>	K 147		