

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted 02/12/13 through 02/15/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "F".	F 000	Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals, who draft or may be discussed in this response of this plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.	MAR 2013
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, Interview, record review and review of the facility's policy and procedure it was determined the facility failed to promote the care and services that maintains or enhances the dignity of one resident (#8), in the selected sample of 15 residents, and one resident (#16), not in the selected sample. Resident #8 was observed wearing a thread bare, transparent hospital gown on two occasions and a Licensed Massage Therapist failed to close the door and pull the curtain while providing care to Resident #16. The findings include: A review of the Bill of Resident Rights, dated 07/01/09, revealed residents have the right to personal privacy and confidentiality of their personal and clinical records. Personal privacy	F 241		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Todd W. Smith, NHA Administrator</i>			TITLE Administrator	(X6) DATE 3-8-13

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

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F 241	<p>Continued From page 1</p> <p>includes privacy in accommodations and medical treatment".</p> <p>1. A record review revealed Resident #8 was admitted to the facility on 03/28/06 and readmitted on 04/16/12 with diagnoses to include Rheumatoid Arthritis, Chronic Obstructive Pulmonary Disease, Osteoporosis, Contractures, Irritable Bowel Disease, Anxiety, Depression, Mild Dementia, and Dysphagia.</p> <p>A review of the annual Minimum Data Set assessment (MDS), dated 10/27/12, revealed the facility had assessed Resident #8 to be cognitively intact. Further review revealed the resident required extensive assistance from one person to physically assist with dressing.</p> <p>A review of the Certified Nursing Assistant (CNA) Activities of Daily Living (ADL) Plan of Care, undated, revealed one staff should provide extensive assistance to Resident #8 for dressing. Further review of the ADL Flow Sheet, dated February 2013, revealed Resident #8 was not dressed on any day during the month of February.</p> <p>An observation, on 02/12/13 at 4:15 PM, revealed Resident #8 was in bed and was wearing a hospital gown with large areas of transparent fabric.</p> <p>An observation, on 02/13/13 at 12:50 PM, revealed Resident #8 was in bed and was wearing a hospital gown with sufficient transparency to visualize the resident's breasts. The resident stated he/she was not comfortable wearing the transparent gown and had been</p>	F 241	<p>F 241</p> <p>1.</p> <p>a. In regards to Resident #8 the facility's Housekeeping/Laundry Supervisor audited all facility linen and discarded any linen that was observed to be transparent on 2-15-13. An observation by the Director of Nursing on 2-20-13 noted no resident to be wearing transparent gowns.</p> <p>b. In regards to Resident #16 the facility contacted the resident's guardianship office on 2-15-13 to address the situation. Since 3-5-13 the Licensed Massage Therapist (LMT) has performed care ensuring the resident's dignity and privacy during treatment was maintained as observed by the Director of Nursing on 3-7-13. The LMT was re-educated on Guardianship Resident Rights on 3-5-13 by the Administrator.</p> <p>2. To identify other residents having the potential to be affected by the alleged deficient practice:</p> <p>a. The facility Housekeeping/Laundry Supervisor conducted a 100% audit of all facility linen and discarded any linen that was observed to be transparent or worn. New linen arrived at the</p>		

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F 241	<p>Continued From page 2</p> <p>informed by staff that there were no new gowns available.</p> <p>An interview with CNA #1, on 02/13/13 at 12:50 PM, revealed she would not be comfortable wearing the gown Resident #8 was currently wearing.</p> <p>An interview with the Housekeeping and Laundry Supervisor, on 02/13/13 at 1:10 PM, revealed she was responsible for the evaluation and disposal of gowns and linens, however, the Laundry Manager actually performed the task. The Housekeeping and Laundry Supervisor described the gown worn by Resident #8 as "faded" and stated she would not, personally, be comfortable wearing the gown related to the transparency.</p> <p>An interview with the Laundry Manager, on 02/14/13 at 10:30 AM, revealed she disposed of gowns when identified as worn or ripped and linens and blankets were discarded when "worn out" or stained. She stated the evaluation of the fabric was based on her opinion and "if they are thin and I can see through them, they are tossed".</p> <p>An observation of all linen carts and storage areas with the Laundry Manager, on 02/14/13 at 10:35 AM, revealed 12 gowns and five flat sheets were identified as transparent and discarded immediately.</p> <p>2. A record review revealed Resident #16 was admitted to the facility on 03/02/04 with diagnoses to include Dementia with Behavior Disturbances, Intellect Disability, Urinary Tract Infection, Anxiety State, Depressive Disorder, and Psychosis.</p> <p>Observation, on 02/15/13 at 11:20 AM, revealed</p>	F 241	<p>facility on 2-18-13. On 2-20-13 the Director of Nursing noted that no resident was wearing transparent gowns.</p> <p>b. On 3-7-13 the Director of Nursing noted that privacy and dignity were maintained while providing care by the massage therapist.</p> <p>3. Measures put into place or systemic changes made to prevent recurrence:</p> <p>a. All laundry staff will be re-educated by the Administrator, Director of Nursing or Housekeeping/Laundry Supervisor regarding ensuring linen is in good condition and discarding linen that is not in good condition. This education will be completed by 3-25-13.</p> <p>b. All staff will be re-educated by the Administrator, Director of Nursing, Unit Manager or Education and Training Director regarding the assurance of maintaining residents' dignity and privacy during any resident care. The re-education will be completed by 3-25-13.</p> <p>4. Monitoring of the Plan of Correction is as follows:</p>	

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F 241	Continued From page 3 Resident #16's bedroom door and privacy curtain were open revealing the resident's gown hiked up baring the resident's midriff and a part of his/her back with a Licensed Massage Therapist (LMT) rubbing palm of hands up and down the resident's back. Interview with the LMT, on 02/15/13 at 11:25 AM, revealed she had been providing services to Resident #16 once a month for six years. She stated she was not thinking when she did not pull the curtain to provide privacy to the resident. Interview with the ADON, on 02/15/13 at 11:35 AM, revealed the LMT should have provided privacy to the resident and she considered it a major problem. She stated outside vendors should follow the federal guidelines and HIPPA issues. Interview with the Administrator, on 2/15/13 at 12:05 PM, revealed the LMT should have made sure the curtain was closed when providing care to the resident. He stated when they are providing care for a resident, a staff member should be with them or have knowledge of them providing care.	F 241	a. The Housekeeping/Laundry Supervisor will conduct a weekly audit of all facility linen to ensure linen is in good condition and that laundry personnel are discarding as needed. The audit will be done one (1) time a week for three (3) months. b. The Director of Nursing, Assistant Director of Nursing, Unit Manager, Director of Education and Training or Wound Care Nurse will conduct rounds five (5) times per week for four (4) weeks followed by three (3) times per week for four (4) weeks then weekly for four (4) weeks to assure privacy and dignity are maintained while providing patient care. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee to consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.	
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to	F 366		3/26/13

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F 366	<p>Continued From page 4</p> <p>honor likes and dislikes and/or offer food substitutes for two residents (#1 and #8), in the selected sample of 15 residents. Resident #1 was served a meal with items he/she expressed he/she did not like and was not offered a substitute and Resident #8 was served oatmeal when the dietary tray card showed oatmeal as a dislike and/or allergy.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. A record review revealed Resident #8 was admitted to the facility on 03/28/06 and readmitted on 04/16/12 with diagnoses to include Rheumatoid Arthritis, Chronic Obstructive Pulmonary Disease, Osteoporosis, Contractures, Irritable Bowel Disease, Anxiety, Depression, Mild Dementia, and Dysphagia. <p>A review of the annual Minimum Data Set (MDS) assessment, dated 10/27/12, revealed the facility assessed Resident #8 to be cognitively intact. Further review revealed the resident required set up of meals by staff and was independent with eating.</p> <p>A review of the Certified Nursing Assistant (CNA) Activities of Daily Living (ADL) Plan of Care, undated, revealed Resident #8 was care planned for the "house" diet with thickened liquids to be eaten in his/her room. The staff should provide meal set up with foam utensils and a red scoop plate.</p> <p>An observation of the breakfast tray, on 02/13/13 at 8:15 AM, revealed a bowl of oatmeal with butter on top of the food and a spoon in the oatmeal. Resident #8 stated he/she did not like</p>	F 366	<p>F 366</p> <ol style="list-style-type: none"> 1. The facility Dietary Manager met with Resident #1 on 3-6-13 and Resident #8 on 3-6-13 to complete an updated food preference form with updates on their tray cards. An observation by the Dietary Manager on 3-6-13 noted resident #1 and resident #8 were served the appropriate foods per their tray card. 2. To identify other residents having the potential to be affected by the alleged deficient practice the Dietary Manager completed a 100% audit of all residents' food preferences and updated the residents' tray cards as needed on 3-25-13. On 3-8-13 the Dietary Manager observed meal service and noted that the tray cards were followed and residents were offered substitutes as needed. 3. Measures put into place or systemic changes made to prevent recurrence are as follows: The Administrator will re-educate the Dietary Manager regarding completing food preference forms for residents and updating tray cards at least upon admission and then annually or as needed due to a 	

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F 366	<p>Continued From page 5</p> <p>oatmeal. The breakfast tray card listed oatmeal as a dislike/ allergy.</p> <p>An interview with CNA #1, on 02/13/13 at 8:15 AM, revealed oatmeal was the food on the resident's breakfast tray and it was listed as a dislike/ allergy on the breakfast tray card. The CNA did not ask Resident #8 if he/she liked or was allergic to the oatmeal and did not offer a food substitution before leaving the room.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 02/13/13 at 8:20 AM, revealed the cereal on the breakfast tray was oatmeal and the breakfast tray card listed oatmeal as a dislike/ allergy. She stated the oatmeal on the tray was not acceptable and "if I had a ticket with that dislike on it I would hope the kitchen wouldn't send it to me." LPN #1 did not offer Resident #8 a food substitution before leaving the room.</p> <p>An interview with the Assistant Director of Nursing (ADON), on 02/13/13 at 10:14 AM, revealed her expectations related to the resident meal tray cards was the staff was to offer food substitutions. She stated the tray cards were updated routinely by the dietary manager and with a critical evaluation or weight loss. The ADON stated the kitchen personnel and staff who served the trays to the residents were to check the card with the tray. She stated "if the resident says I don't like that, staff should call the kitchen and get something else."</p> <p>2. A record review revealed Resident #1 was admitted to the facility on 04/07/10 and readmitted on 10/17/12 with diagnosis to include Trigeminal Neuralgia, Multiple Sclerosis,</p>	F 366	<p>resident request or change in resident condition. This education will be completed by 3-25-13. All dietary staff will be re-educated by the Dietary Manager related to following dietary tray cards. This education will be completed by 3-25-13. In addition, all dietary and all nursing staff will be re-educated by the Dietary Manager, Director of Nursing, Assistant Director of Nursing, Unit Manager, or Director of Education and Training regarding the role of the staff to offer substitute meals to residents that do not like the meal being served. This education will be completed by 3-25-13.</p> <p>4. Monitoring of the Plan of Correction is as follows: The Dietary Manager will perform food preference audits for six (6) residents per week for 4 weeks followed by four (4) residents per week for 4 weeks then two (2) residents for 4 weeks to ensure residents are being served meals they like. The Dietary Manager will audit five (5) tray cards per week to the actual tray served for twelve (12) weeks to ensure ongoing compliance.</p>		

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F 366	Continued From page 6 Dementia, and History of Altered Mental Status. A dinner meal observation, on 02/12/13 at 5:55 PM, revealed CNA #7 was feeding Resident #1. During the meal, Resident #1 repeatedly stated he/she did not like the food items that were on his/her tray. The CNA assisting the resident did not offer the resident a substitute for the items he/she stated he/she did not like. An interview with CNA #7, on 02/13/13 at 4:30 PM, revealed she would normally ask the resident if they wanted something different to eat if they stated they did not like something. The CNA agreed she should have asked the resident if there was something else he/she wanted to eat. CNA #7 stated, "I guess I thought because he/she was eating some of it, he/she was OK with it and I guess I forgot."	F 366	The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee to consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.	3/26/13	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 1. a. In regards to the observations made during the initial tour of the kitchen items a. through h. the following has been completed: a. Flat top grill was deep cleaned on 3-5-13 by the Dietary Manger b. Industrial can opener was deep cleaned on 2-18-13 by the Dietary Manager. c. The temperature log in the dishwasher room was back in compliance regarding logging of temperatures on 2-16-13 as observed by Dietary Manager. d. The food processing machine		

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F 371	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of temperature logs it was determined the facility failed to ensure food was stored, prepared, and distributed under sanitary conditions. Observations of the kitchen revealed an opening on the flat top grill with thick, black residue stuck to the edge of the grill, the dishwasher temperature log for the evening was completed before the shift arrived, the large can opener attached to the table edge had sticky, black residue under the cutting blade, the walk-in refrigerator contained an opened bag of slaw that was unlabeled, the walk-in freezer contained an opened bag of fish patties that was unlabeled, and the dishwasher log had no temperatures documented for the morning meal.</p> <p>The findings include:</p> <p>1. Observations during the initial tour of the kitchen on 02/12/13 at 1:45 PM, revealed:</p> <p>a. the flat top grill with an opening used to discard foods after cooking on the grill top was found to have a large, black clump of residue stuck to the edge of the opening.</p> <p>An interview with Kitchen Aide #10, on 02/12/13 at 4:35 PM, revealed the flat top grill was not used very much and estimated twice per month usage.</p> <p>b. the industrial can opener attached to the edge of a table had black residue under and</p>	F 371	<p>was cleaned of excess moisture on 2-15-13 by Dietary Manager.</p> <p>e. The slaw mix in the walk-in refrigerator was discarded on 2-12-13 by the Dietary Manager.</p> <p>f. The fish sandwich patties in the walk-in freezer were discarded on 2-12-13 by the Dietary Manager.</p> <p>g. The syrup in the corner of the reach-in refrigerator was noted to be cleaned on 2-13-13 by the Dietary Manager.</p> <p>h. In the milk cooler, the Tupperware drink container of amber colored liquid was discarded on 2-12-13 by the Dietary Manager. The Diet soda was discarded on 2-13-13 by the Dietary Manager. On 2-13-13 the kitchen aide removed the milk crates and cleaned the base of the milk cooler.</p> <p>b. The temperature log in the dishwasher room was back in compliance regarding logging of temperatures on 2-16-13 as observed by Dietary Manager.</p> <p>2. To identify other residents having the potential to be affected by the alleged deficient practice the Dietary Manager performed a complete Kitchen Sanitation Round on 3-8-13 utilizing the Kitchen Sanitation Round form. No concerns were identified.</p>		

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F 371	<p>Continued From page 8 around the cutting blade.</p> <p>c. the temperature log in the dishwasher room revealed all the temperatures logged for the morning, afternoon, and evening shifts on 02/12/13. The evening shift had the initials "MP" as the person who documented the temperatures but the evening shift had not checked the temperatures yet as it was only 1:45 PM.</p> <p>An interview with Kitchen Aide #9, on 02/14/13 at 1:25 PM, revealed he was not working on 02/12/13 and 02/13/13 and the initials on the temperature log were not his handwriting. He stated he did not write the temperatures on the log for February 12 and when he was assigned to the dishwasher machine for the evening meal he logged the temperatures at 8 PM or 9 PM. Kitchen Aide #9 stated the last time he worked was on Sunday, February 10, 2013 and he logged the temperatures for the evening meal.</p> <p>An interview with the Kitchen Manager, on 02/12/13 at 1:45 PM, revealed the kitchen staff with the initials "MP" was not working on 02/12/13 and doesn't know why he would have logged on the wrong date. The Kitchen Manager stated the person who operates the dishwasher is the person who completes the temperature log and for the evening log it would have been documented at about 7 PM or 8 PM.</p> <p>d. the food processing machine had beads of moisture fully covered the interior surfaces of the food holding compartment with the blade and the top was locked into place.</p> <p>An interview with the Kitchen Manager, on</p>	F 371	<p>3. Measures put into place or systemic changes made to prevent recurrence are as follows: The Administrator will re-educate the Dietary Manager regarding kitchen sanitation rounds utilizing the Kitchen Sanitation Round Form. This education will be completed by 3-18-13. The Dietary Manager will re-educate the dietary staff regarding kitchen sanitation rounds using the Kitchen Sanitation Round Form to include storage of personal food items or open food items uncovered. This education will be completed by 3-25-13.</p> <p>4. Monitoring of the Plan of Correction is as follows: The Dietary Manager will conduct three (3) sanitation rounds per week for twelve (12) weeks using the Kitchen Sanitation Round Form.</p> <p>The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make</p>		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186402	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
(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 371	Continued From page 9 02/12/13 at 1:55 PM, revealed the food processing machine was used for every meal to make pureed foods for the residents and there should not be moisture inside the bowl with the top locked. e. An observation of the walk-in refrigerator revealed an opened bag of slaw mix that was not labeled. f. An observation of the walk-in freezer revealed an opened, unlabeled bag which was identified by the Kitchen Manager as fish sandwich patties. g. An observation of the reach in refrigerator revealed two gallon sized containers of pancake syrup were stuck to the floor of the refrigerator with a brown, sticky substance under the containers. h. An observation of the milk cooler in the dry storage area revealed a Diet soda and a Tupperware drink container of amber colored liquid. The aroma coming from the milk cooler when opened was of spoiled milk. 2. An observation of the dishwasher area on 02/13/13 at 10:45 revealed a dish washer log with no temperatures recorded for the morning meal. An interview with Kitchen Aide #11, on 02/13/13 at 10:45 AM, revealed she ran the dishwasher machine for the morning meal and did not check the temperatures.	F 371	further recommendations. The Quality Assurance Committee to consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.	3/26/13
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	F 431 1. RN #1 retrieved the two (2) Fentanyl transdermal patches from the trash can in Resident #4's room on 2-13-13. After retrieval of the patches the patches were discarded in an appropriate location according to Federal Guidelines from the Office of National Drug Control. 2. To identify other residents having the potential to be affected by the alleged deficient practice the Director of Nursing observed on 3-12-13 that Fentanyl patches were properly disposed of.	

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F 431	<p>Continued From page 10</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to</p>	F 431	<p>3. Measures put into place or systemic changes made to prevent recurrence include the Director of Nursing, Assistant Director of Nursing, or Unit Manager re-educated the licensed nursing staff as to the appropriate discarding of Fentanyl patches according to Federal Guidelines from the Office of National Drug Control. This education will be completed by 3-25-13.</p> <p>4. Monitoring of the Plan of Correction is as follows: The Director of Nursing, Assistant Director of Nursing, Unit Manager, Director of Education and Training or Wound Care Nurse will audit the removal and disposal of fentanyl patches for two (2) residents per week for four (4) weeks then one (1) resident per week for eight (8) weeks to ensure removal and appropriate disposal of Fentanyl patches.</p> <p>The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee to consist of a minimum the</p>	

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F 431	<p>Continued From page 11</p> <p>properly dispose of controlled medication transdermal patches for one resident (#4), in the selected sample of 15 residents. Resident #4 was provided two narcotic (Fentanyl) transdermal patches and when the patches were removed they were discarded in the resident's room trash can.</p> <p>The findings include:</p> <p>A record review revealed Resident #4 was admitted to the facility on 08/08/12 with diagnoses to include Kidney Cancer, Chronic Pain, Diabetes Mellitus and Aftercare Neoplasm Surgery.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 11/05/12, revealed the facility assessed Resident #4 as having pain and in need of routine pain medication.</p> <p>A review of the Physician Orders, dated February 2013, revealed Resident #4 was ordered Fentanyl Transdermal patch 12.5 mcg/hr every three days for pain control.</p> <p>An observation of medication administration, on 02/13/13 at 8:30 AM, revealed Registered Nurse (RN) #1 removed two Fentanyl transdermal patches, dated 02/10/13, from the right shoulder of Resident #4. RN #1 folded the two patches and placed them in the trash can at the foot of the resident's bed. RN #1 placed the two new transdermal patches on the resident's left upper back.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 02/13/13 at 1:30 PM, revealed she places the old transdermal narcotic patches in the</p>	F 431	<p>Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.</p>	3/26/13

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F 431	Continued From page 12 sharps container on the side of the medication cart. An interview with LPN #5, 02/13/13 at 1:32 PM, revealed she disposes the old transdermal narcotic patches in the sharps container outside the resident's room. An interview with the facility's Wound Nurse, on 02/13/13 at 1:34 PM, revealed she disposed of narcotic transdermal patches in the sharps container in the resident's room or the sharps container on the side of the medication cart. An interview with LPN #1, on 02/13/13 at 1:35 PM, revealed the narcotic patch was to be folded in half and put in the trash on the side of the medication cart. An interview with the Assistant Director of Nursing, on 02/13/13 at 1:55 PM, revealed there was no policy for disposal of narcotic patches presently and she was unable to provide any training related to how staff were supposed to dispose of the narcotic transdermal patches.	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 465	F 465 1. a. In regards to the kitchen observation both ceiling air vents were cleaned by the Maintenance Supervisor on 2-14-13. b. In regards to the laundry area the flexible hose, all facility washing dryers, all facility washing machines and the concrete drain area behind the washers were all noted to be cleaned by the Maintenance Supervisor and Housekeeping/Laundry Supervisor by 3-1-13. 2. To identify other residents having the potential to be affected by the alleged deficient practice: a. The Dietary Manager and Maintenance Supervisor conducted a complete inspection of the kitchen's vents to ensure no dust or dirt were present. This audit was completed on 3-1-13. No concerns were identified. b. The Maintenance Supervisor and Housekeeping/Laundry Supervisor conducted a complete inspection of the entire laundry area to ensure no dust or dirt was present. This audit was completed on 2-18-13. No concerns were identified.	

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F 465	<p>Continued From page 13</p> <p>by:</p> <p>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to provide a safe, functional, sanitary environment related to dust, dirt, and unknown substances built up in the laundry room and in the facility kitchen. The laundry room was found to be dirty on the flex hose above dryer #3, around the door of the older washing machine, in the back opening of the three dryers, on the top motor fan guard of the newer washing machine, and the concrete drain area behind the washing machines. In addition, two ceiling air vents in the kitchen were identified completely coated with a thick build up of black dust and dirt.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. An observation of the kitchen, on 02/12/13 at 4:35 PM and 02/13/13 at 3:40 PM, revealed two ceiling air vents just inside the entrance door with a thick build up of black dust and dirt. <p>An interview with the Maintenance Supervisor, on 02/13/13 at 3:40 PM and 02/14/13 at 8:30 PM, revealed the vents were cleaned at the same time the air filters were changed and this was completed monthly. He also stated the cleaning of the vents was tied to the maintenance of the roof ventilation units but did not always clean them on the same day at the roof ventilation units. The Maintenance Supervisor revealed he had not cleaned the vents or changed the filters this month. He stated he had no set schedule for cleaning the vents and changing the filters but thought he could show when it was last cleaned from the program in the computer.</p> <ol style="list-style-type: none"> 2. An observation on 02/13/13 at 4:00 PM, of the 	F 465	<ol style="list-style-type: none"> 3. Measures put into place or systemic changes made to prevent recurrence: <ol style="list-style-type: none"> a. The Administrator will re-educate the Dietary Manager and Maintenance Supervisor regarding ensuring all kitchen vents are cleaned timely as to not have any dust or dirt in the vents. This education will be completed by 2-22-13. b. The Administrator will re-educate the Maintenance Supervisor and Housekeeping/Laundry Supervisor regarding ensuring the laundry area and equipment remain free of dust and dirt. This education will be completed by 2-22-13. 4. Monitoring of the Plan of Correction is as follows: <ol style="list-style-type: none"> a. The Dietary Manager or Maintenance Supervisor will audit the kitchen vents for dust and dirt two (2) times per week for four (4) weeks and then one (1) time per week for eight (8) weeks. b. The Housekeeping/Laundry Supervisor or Maintenance Supervisor will audit the laundry area for dust and dirt five (5) times per week for four (4) weeks and then three (3) times per week for eight (8) weeks. 	

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F 465	<p>Continued From page 14</p> <p>laundry area revealed there was thick dust and dirt on the flexible hose extending from the concrete wall to the top of dryer number three, a build-up of visible lint and dirt on top of and hanging from the back opening of the three dryers, a build-up of dust on the top motor fan guard on the top of the newer washing machine and the concrete drain area behind the washers was excessively coated with black lint and dirt.</p> <p>A review of the facility's most recent in-service training record, titled "Laundry Fire Prevention Planning", dated 01/28/13, revealed preventive maintenance should be provided to all dryers to include "lint should not be allowed to build up in the dryer case, exhaust pipes or traps."</p> <p>An interview with the Maintenance Supervisor, on 02/13/13 at 4:00 PM and 02/14/13 at 8:30 AM respectively, revealed he had no set schedule for cleaning the laundry area and stated he removed the front from each dryer and blew out the top, took the cover off the bottom and blew it out and also blew out the back of each dryer on a monthly basis. The Maintenance Supervisor stated he had a log on his computer program to verify the most recent cleaning but stated he had not gotten to it this month. The Maintenance Supervisor revealed he was not responsible to clean the concrete area behind the washing machines. Further interview revealed the laundry cleaning log was no found in the computer system and the program provided the minimum guidelines for maintenance work to be done. He stated the laundry was due to be cleaned and his work was done according to the computer program.</p> <p>An interview with the Housekeeping and Laundry</p>	F 465	<p>The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee to consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.</p>	3/26/13	

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F 465	Continued From page 15 Supervisor, on 02/13/13 at 4:00 PM, revealed the a company came to the laundry to clean and service the washing machines at least one time each month and any time she called them with a problem. She stated she had "never known the [concrete] area [behind the washing machines] to be cleaned since she got this building and that was just over 1 year ago". An interview with the Administrator, on 02/14/13 at 8:30 AM, revealed the Maintenance Supervisor was responsible for the environmental areas, the Housekeeping and Laundry Supervisor was responsible for the laundry, and the Dietary Manager was responsible for the kitchen area to determine the effectiveness of the minimum cleaning guidelines scheduled by the computer program.	F 465			

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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: 1967.</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: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 28 smoke detectors and 197 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator with unknown installation date. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/12/13. Henderson Nursing and Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety (90) beds with a census of seventy-four (74) 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	<p>Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals, who draft or may be discussed in this response of this plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	3/26/13



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Todd W. DeNHA TITLE: Administrator (X6) DATE: 3-8-13

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	Continued From page 1 Fire).	K 000	K 025 1. The identified penetrations in the smoke barrier walls will be corrected by an independent contractor by 3-25-13 to include being able to access the fire wall by the medicine room. 2. On 2-15-13, the Maintenance Supervisor audited the entire facility to identify any smoke barriers with penetrations. This audit was compared to an independent contractor audit. All identified areas will be repaired by 3-25-13 by independent contractor to include being able to access the fire wall by the medicine room. 3. The Administrator will re-educate the Maintenance Supervisor regarding Life Safety Code regulation of no penetrations in smoke barrier walls. This education will be completed by 3-25-13. 4. The Maintenance Supervisor, Housekeeping/Laundry Supervisor and/or facility Housekeeping Floor Technician will audit all smoke barriers to ensure that there are no penetrations four (4) times a month for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly	
K 025 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. 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: 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 four (4) of five (5) smoke compartments, seventy (70) residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure four (4) smoke barriers were sealed around and inside pipes going through the walls. This is a repeat deficiency that was cited on the previous survey conducted on 11-3-11. The findings include:	K 025		

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K 025	Continued From page 2 Observations, on 02/12/13 between 1:36 PM and 2:00 PM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located at room # 42, #27, and #1 were penetrated by pipes and wires. Further observation revealed the fire wall located at the Medicine Room was inaccessible. The maintenance supervisor tried to access the smoke barrier but was unable to access the wall. Interview, on 02/12/13 between 1:36 PM and 2:00 PM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barriers as they have been inspected several times since the last survey. He stated the smoke barriers had been inspected at least once a quarter since the last inspection as the Plan of Correction stated. He had to sign off with the Administrator every time he went up to the attic to inspect the smoke barriers. He stated he could not properly access the smoke barrier at the medicine room to properly check the wall. Interview, on 02/12/13 at 4:55 PM with the Administrator, revealed he was unaware of the penetrations in the smoke barriers. He gave the Maintenance Supervisor an in-service on inspecting the smoke barriers and stated there was to be no breaks/penetrations in the smoke barriers. The Maintenance Supervisor performed three (3) audits of the smoke barriers as stated in the plan of correction. The Maintenance Supervisor was the only person to inspect the smoke barriers. The Administrator was unaware the Maintenance Supervisor was unable to access the smoke barrier at the medicine room.	K 025	for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.	3/26/13	

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K 025	Continued From page 3 This is a repeat deficiency. Reference: NFPA 101 (2000 Edition). 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: (a) The space between the penetrating item and the smoke barrier shall 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. (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 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. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are	K 027	K 027 1. The facility Maintenance Supervisor identified the issues with the cross-corridor doors coordinating devices identified as not working properly and fixed the coordinators on 2-13-13. The cross-corridor door coordinating devices were observed by the Maintenance Supervisor as closing correctly on 2-13-13. 2. On 2-13-13, the Maintenance Supervisor audited all cross-corridor door coordinators and found all to be in working order. 3. The Administrator will re-educate the Maintenance Director regarding ensuring that the cross-corridor doors operate according to regulation with the coordinating devices. This	

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K 027	<p>Continued From page 4</p> <p>not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure the cross corridors doors would close properly with the installed door coordinators.</p> <p>The findings include:</p> <p>Observation, on 02/12/13 between 2:41 PM and 4:00 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at the front of the hall 1, front of hall 2, hall 1 nurses station, and the back hall next to laundry would not close completely when tested. This was due to the doors not having a coordinating device properly installed on the doors. The doors would not close properly when the doors were opened after the initial close from the magnetic locks.</p> <p>Interview, on 02/12/13 between 2:41 PM and 4:00 PM with the Maintenance Supervisor, revealed the coordinators were recently installed and he was unaware of how they worked properly.</p>	K 027	<p>education will be completed by 3-25-13.</p> <p>4. The Maintenance Supervisor will audit all corridor doors to ensure the doors close appropriately monthly for three (3) months.</p> <p>The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum of the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.</p>	3/26/13

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K 027	Continued From page 5 Reference: NFPA 101 (2000 Edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. 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. 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. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 027	K 038 1. The identified signage without contrast to the lettering on the exit doors was corrected with contrast to the lettering by the Maintenance Supervisor on 2-20-13. 2. On 2-20-13, the Maintenance Supervisor audited every egress door and exit to ensure all exit doors had egress signage that had contrast to the lettering. This audit found all doors had appropriate signage. 3. The Administrator will re-educate the Maintenance Supervisor regarding ensuring all egress doors/exits have the appropriate signage. This education will be completed by 3-25-13. 4. The Maintenance Supervisor will audit all egress doors and exits to ensure appropriate signage is in place monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly	
K 038 SS=F		K 038		

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K 038	<p>Continued From page 6</p> <p>determined the facility failed to ensure egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure four (4) egress doors had the proper signage for delayed egress doors.</p> <p>The findings include:</p> <p>Observation, on 02/12/13 between 1:36 PM and 3:34 PM with the Maintenance Supervisor, revealed the egress doors at the back two (2) exits, the kitchen area exit, and the front exit were equipped with delayed egress signs that had a clear background which was not contrasting to the lettering.</p> <p>Interview, on 02/12/13 between 1:36 PM and 3:34 PM with the Maintenance Supervisor, revealed he was unaware the doors were required to have signage with a contrasting background.</p> <p>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</p>	K 038	<p>for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.</p>	3/26/13

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K 038	<p>Continued From page 7</p> <p>such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)</p> <p>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.</p> <p>Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>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 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</p>	K 038		

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K 038	Continued From page 8 the lock or locking mechanism. (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 releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (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 NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 045 SS=F	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	K 045	K 045 1. The identified emergency lights lacking two (2) bulbs will be corrected by independent contractor by 3-25-13. 2. On 2-15-13, the Maintenance Supervisor audited the entire exterior of the facility regarding exit lights to ensure all have at least two (2) bulbs. Any identified concerns will be corrected by independent contractor by 3-25-13. 3. The Administrator will re-educate the Maintenance Supervisor regarding the requirement for all exits to be lighted with at least two (2) bulbs. This education will be completed by 3-25-13. 4. The Maintenance Supervisor will audit all facility exit lights to ensure proper lighting monthly for three (3) months.	

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K 045	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at two (2) exits. The findings include: Observation, on 02/12/13 between 3:49 PM and 4:30 PM with the Maintenance Supervisor, revealed the exterior exits at the employee smoking area and the middle exit on the Elm Street side only had a single light for illumination of the outside of the exit. Interview, on 02/12/13 between 3:49 PM and 4:30 PM with the Maintenance Supervisor, revealed he was aware the exits needed to have more than one light and that he had submitted a work order but nothing had been done to fix the light fixtures. 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	The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.	3/26/13

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K 054 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure that the battery powered smoke detectors in each resident room were being properly tested and cleaned.</p> <p>The findings include:</p> <p>Record review, on 02/12/13 between 1:36 PM and 4:30 PM with the Maintenance Supervisor, revealed there was no documentation of Smoke Detector weekly testing or monthly cleaning of the battery powered smoke detectors located in the resident rooms. The manufacturer's specifications of the battery powered smoke detectors in the resident rooms recommended a weekly check of the smoke detectors and a monthly cleaning of the detector.</p> <p>Interview, on 02/12/13 between 1:36 PM and 4:30 PM with the Maintenance Supervisor, revealed he checked the battery powered smoke detectors</p>	K 054	<p>K 054</p> <ol style="list-style-type: none"> 1. The Maintenance Supervisor removed all battery powered smoke detectors on 3-4-13. This was done due to the facility having a facility wide automatic sprinkler system and therefore battery powered smoke detectors are not required by Life Safety Code regulation. 2. On 3-4-13, the Maintenance Supervisor audited the entire facility to ensure that there were no battery powered smoke detectors present in the facility with none found. 3. The Administrator will re-educate the Maintenance Supervisor regarding the facility not needing to have battery powered smoke detectors. This education will be completed by 3-25-13. 4. The Maintenance Supervisor will audit the entire facility to ensure there are no battery powered smoke detectors present monthly for three (3) months. 	

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K 054	Continued From page 11 every six (6) months and was unaware of any cleaning done to the detectors. Reference: NFPA 72 (1999 ed.) 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer ' s instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions.	K 054	The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly. K 056 1. The identified sprinkler heads not engaging at the same heat level in the television lounge area will be replaced by an independent contractor by 3-25-13.	3/26/13	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, no residents, staff and visitors. The facility is certified for ninety (90)	K 056			

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K 056	<p>Continued From page 12</p> <p>beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure all sprinkler heads in the same compartment would engage at the same heat level in the television lounge area.</p> <p>The findings include:</p> <p>Observations, on 02/12/13 at 4:23 PM with the Maintenance Supervisor, revealed standard response sprinkler heads and quick response sprinkler head in the same compartment located in the television lounge area.</p> <p>Interview, on 02/12/13 at 4:23 PM with the Maintenance Supervisor, revealed he was not aware that the sprinklers had to have the same engagement heat if the sprinkler heads are located in the same compartment.</p> <p>Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers</p>	K 056	<p>2. On 2-15-13, the Maintenance Supervisor audited the entire facility to identify any other sprinkler head concerns related to sprinkler heads not engaging at the same heat level. This audit was compared to an independent contractor audit. All identified concerns will be corrected by 3-25-13 by an independent contractor.</p> <p>3. The Administrator will re-educate the Maintenance Supervisor regarding the requirement of sprinkler heads in the same compartment to have engagement at the same heat level. This education will be completed by 3-25-13.</p> <p>4. The Maintenance Supervisor will audit the entire facility to ensure sprinkler heads meet the regulatory requirement with Life Safety Code monthly for three (3) months.</p>	

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K 056	Continued From page 13 are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 056	The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.	3/26/13
K 062 SS=E	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 observation and interview, It was determined the facility failed to ensure sprinkler heads were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, sixty (60) residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure fifteen (15) sprinkler heads were maintained in reliable operating condition. The findings include: Observations, on 02/12/13 between 1:36 PM and	K 062	K 062 1. The identified sprinkler heads with concerns related to sprinkler heads with paint or corroded heads will be replaced by independent contractor by 3-25-13. 2. On 2-15-13, the Maintenance Supervisor audited the entire facility to identify any other sprinkler head with paint or corrosion. This audit was	

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NAME OF PROVIDER OR SUPPLIER HENDERSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 NORTH ELM ST. HENDERSON, KY 42420	
(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 062	Continued From page 14 4:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in the closets of resident rooms #16, #17, #19, #21, #25, #43, laundry storage, rehab room, rehab stair room, social services closet, medicine room, hall 2 front wing shower room, and room #27 had paint applied to the sprinkler heads. Further observation revealed the dishwasher room and the kitchen refrigerator had corroded sprinkler heads. Interview, on 02/12/13 between 1:36 PM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware the sprinkler heads in the facility had been painted. Reference: NFPA 25 (1998 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	compared to an independent contractor audit. All identified concerns will be corrected by 3-25-13 by independent contractor. 3. The Administrator will re-educate the Maintenance Supervisor regarding the requirement to maintain sprinkler heads in operating condition (no paint on sprinkler head etc). This education will be completed by 3-25-13. 4. The Maintenance Supervisor will audit the entire facility to ensure sprinkler heads remain free of paint and or corrosion monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.	
K 068 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from end discharged to the outside air. 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview It was determined the facility failed to ensure combustion air and ventilation for fuel fired hot	K 068		3/26/13

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K 068	<p>Continued From page 15</p> <p>water heaters were installed in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, thirty-eight (38) residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure the laundry utility room did not vent directly to the attic.</p> <p>The findings include:</p> <p>Observation, on 02/12/13 at 3:30 PM with the Maintenance Supervisor, revealed the fresh air vent for the laundry utility room was venting directly into the attic to the drywall not being sealed around the vents going through the attic. Further observation revealed there was not a fresh air vent lower on the wall only the ones installed in the ceiling.</p> <p>Interview, on 02/12/13 at 3:30 PM with the Maintenance Supervisor, revealed he was unaware the room was not properly vented for the fuel fired hot water heater.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>Section 19.5 Building Services</p> <p>19.5.2.2 Any heating device other than a central heating plant shall be designed and installed so that combustible material will not be ignited by the device or its appurtanances. If fuel-fired, such heating devices shall be chimney connected or vent connected, shall take air for combustion</p>	K 068	<p>K 068</p> <ol style="list-style-type: none"> 1. The identified concern of not having the laundry utility room related to the fuel fired hot water heater vent directly to the attic will be corrected by independent contractor by 3-25-13. 2. On 2-15-13, the Maintenance Supervisor audited the entire facility to identify any other ventilation issues. No further issues were found. 3. The Administrator will re-educate the Maintenance Supervisor regarding requirement that fuel fired equipment such as the hot water heater should have ventilation to the outside of the facility. This education will be completed by 3-25-13. 4. The Maintenance Supervisor will audit the entire facility to ensure ventilation of fuel fired equipment such as the hot water heater are properly vented and meets the regulatory requirement with Life Safety Code monthly for three (3) months. 	

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K 068	Continued From page 16 directly from the outside, and shall be designed and installed to provide for complete separation of the combustible system from the atmosphere of the occupied area. Any heating device shall have safety features to immediately stop the flow of fuel and shut down the equipment in case of either excessive temperature or ignition failure.	K 068	The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.	3/26/13
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, seventy (70) residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure food carts, wheelchairs and chairs for the lobby were properly stored out of the corridor when not in use. The findings include: Observation, on 02/12/13 between 1:47 PM and 3:48 PM with the Maintenance Supervisor, revealed several wheelchairs, two (2) food carts by the kitchen area, and linen carts were stored in	K 072		
			K 072 1. The facility wheelchairs, food carts and linen carts have been relocated as to not be stored in the facility corridor when not in use. In addition, all of the facility lobby furniture and fish tank have been relocated and are not permanently in the front lobby. This was completed by the Maintenance Supervisor on 2-15-13. The Administrator observed on 3-1-13 that there were no obstacles for means of egress.	

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K 072	Continued From page 17 the corridors throughout the facility from 1:47 PM to 3:48 PM. Further observation revealed a lobby area set up in the egress corridor at the front of the building with four (4) chairs, table, and a fish tank stored permanently in the corridor. Interview, on 02/12/13 between 1:47 PM and 3:48 PM with the Maintenance Supervisor, revealed he was unaware of the thirty (30) minute time limit on storage in the corridors. Further Interview revealed the furniture for the lobby area had been there for at least eight (8) years. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 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.	K 072	2. On 2-18-13, the Maintenance Supervisor audited the entire facility to identify any further concerns with facility equipment stored in corridors. All facility equipment was appropriately stored out of the corridors. The Administrator observed on 3-1-13 that there were no obstacles for means of egress. 3. The Administrator will re-educate the Maintenance Supervisor regarding the requirement that facility must remain continuously free of obstructions or impediments to a means of egress. This re-education will be completed by 3-25-2013. In addition, all facility staff will be re-educated regarding the requirement that facility must remain continuously free of obstructions or impediments to a means of egress. This re-education will be completed by 3-25-13. 4. The Maintenance Supervisor will audit facility remains continuously free of obstructions or impediments to a means of egress five (5) times a week for four (4) weeks and then three (3) times a week for eight (8) weeks.		
K 147 SS=F	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 four (4) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety (90) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure power strips were being	K 147			

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K 147	<p>Continued From page 18</p> <p>used properly. One resident room and two offices utilized power strips improperly violating the requirements. Furthermore, the facility was cited this deficiency previously on 11/03/11 regarding power strips, the facility had recently conducted an audit which failed to identify these issues.</p> <p>The findings include:</p> <p>Observations, on 02/12/13 between 1:17 PM and 3:30 PM with the Maintenance Supervisor, revealed:</p> <ol style="list-style-type: none"> 1) A power strip was plugged into another power strip located in the conference room. 2) An oxygen concentrator was plugged into a power strip located in room #1. 3) A coffee pot was plugged into a power strip located in the rehab area. 4) A coffee pot was plugged into a power strip located in the social services office. 5) Battery chargers for medical equipment and a refrigerator were plugged into a multi-plug adapter located in the biohazard room. <p>Interview, on 02/12/13 between 1:17 PM and 3:30 PM with the Maintenance Supervisor, revealed he had just done an audit of the facility looking for any electrical issues. He stated the facility has added many outlets to try and be in compliance with life safety code.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of</p>	K 147	<p>The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.</p> <p>K 147</p> <ol style="list-style-type: none"> 1. The coffee pots plugged into a power strip in the rehab area and Social Services office have been removed by the Maintenance Supervisor on 2-13-13. The power strip in room #1, the conference room, and biohazard room will be corrected by independent contractor adding additional electrical outlets by 3-25-13. 2. On 2-15-13, the Maintenance Supervisor conducted an audit of the entire facility to ensure no other multiple outlet adapters 	3/26/13

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K 147	Continued From page 19 receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147	<p>were present. Additional adapters found will be removed and electrical outlets added by independent contractor by 3-25-13.</p> <p>3. The Administrator will re-educate the Maintenance Supervisor regarding the requirement that multiple outlet adapters are not allowed to be used in the facility. This education will be completed by 3-25-13.</p> <p>4. The Maintenance Supervisor, Housekeeping/Laundry Supervisor and/or facility Housekeeping Floor Technician will audit the entire facility to ensure no multiple outlet adapters are in the facility five (5) times a week for four (4) weeks then one (1) time a week for eight (8) weeks.</p> <p>The results of the audits will be reviewed with the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to review and make further recommendations. The Quality Assurance Committee will consist of a minimum the Administrator, Director of Nursing, Assistant Director of Nursing, and Social Service Director with the Medical Director attending at least quarterly.</p>	3/26/13
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