

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

PRINTED: 07/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/16/2015
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40862		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 07/14-16/15. Deficient practice was identified with the highest scope and severity at "F" level. An abbreviated standard survey (KY23508) was also conducted at this time. The complaint was unsubstantiated with no deficient practice identified.	F 000	1. Corrective action for those residents found to have been affected by alleged deficient practice. a. Sampled resident 8. and unsampled residents B, C, D, E, & F were not adversely affected and remain safely in the center. b. East Wing and West Wing items that posed as accident hazards to wandering residents were immediately removed from the unlocked storage room by Unit Manager, MDS Coordinators, and ADON. East and West Wing storage rooms were locked. The Tackle Boxes were placed in the locked Medication Rooms on East Wing and West Wing on 07-15-15. c. Maintenance Director secured 2 locking crash carts on 07-15-15. and carts were restocked with appropriate items per policy.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed to ensure that the resident environment was as free from accident hazards as possible for six (6) residents (Sampled Resident #8 and Unsampled Residents B, C, D, E, and F) out of eighty-seven (87) residents of the facility to include both East and West nursing units. Observation on 07/15/15 of the West nursing unit revealed a storage room near the beauty shop to be unlocked and contained items that posed as accident hazards to wandering residents (needles, various skin preparation chemicals, and alcohol-based hand cleaner.) Continued observation of the West nursing unit storage room revealed a "tackle box"	F 323		

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

TITLE

(X6) DATE

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 323	<p>Continued From page 1</p> <p>style box on the crash cart labeled "IV Start Box" that was unlocked and contained several items that could have posed accident hazards to wandering residents. Observation of the East wing clean linen storage closet on 07/15/15 revealed a crash cart with items that could have posed an accident hazard to wandering residents. Continued observation of the East wing clean linen closet revealed a similar "tackle box" style box labeled "IV Start Box" that contained needles and alcohol prep pads were also observed sitting on top of the IV Start Box.</p> <p>The findings include:</p> <p>Review of facility policy titled "Medication Storage & Security in the Facility," undated revealed medications and biologicals were to be stored safely, securely and properly following all manufacturer's recommendations or those of the supplier. Continued review of the facility policy revealed the medication supply was to be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to have access.</p> <p>Observation of the West nursing unit on 07/15/15 at 5:27 PM revealed a storage room near the beauty shop to be unlocked and contained six (6) boxes of safety blood collectors (containing needles to collect blood), two (2) boxes of "no sting skin prep wipes," one (1) box of povidone-iodine swab sticks, one (1) box of alcohol prep pads, one (1) bottle of hand sanitizer with aloe, and, one (1) bottle of advanced refreshing hand sanitizing gel. Continued observation of the West nursing unit storage room revealed a "tackle box" style box on the crash cart labeled "IV Start Box" unlocked and</p>	F 323	<p>2. Identification of other residents having the potential to be affected by the alleged same deficient practice.</p> <p>a. Ambulatory residents that wander without purpose and have lack of safety awareness have the potential to be affected.</p> <p>b. Review of the wandering resident list was completed by the IDON (Interim Director of Nursing) with review of residents' Care Plans and Care Guides.</p> <p>3. Measures put into place or systemic changes made to ensure that the alleged deficient practice will not reoccur.</p> <p>a. Center ordered and received a locked IV Cart from contract pharmacy which was received by the center on 08-4-15.</p> <p>b. Licensed nurses were reeducated on storage and security (locking) of IV supplies and storage crash cart items on 08-4-15.</p>		

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F 323	<p>Continued From page 2</p> <p>containing six (6), three (3) cc syringes with twenty and one-half (20.5) gauge needles, six (6) twenty-four (24) gauge angio catheters with needles, four (4) twenty-two (22) gauge angio-catheters with needles, and two (2) twenty-two (22) gauge butterfly closed IV catheter systems with needles.</p> <p>Observation of the East nursing unit on 07/15/15 at 5:40 PM revealed a clean linen storage closet to be unlocked containing a crash cart with one (1) bottle of hand sanitizer and one (1) box of alcohol prep pads present. Continued observation of the East wing clean linen closet revealed a similar "tackle box" style box labeled "IV Start Box" that contained two (2) twenty-four (24) gauge three quarters of an inch (0.75) IV catheters with needles, one (1) twenty-two (22) gauge one (1) inch IV catheter with needle, three (3) twenty-one (21) gauge one (1) inch needles, one (1) box of gel protective wipes, one (1) germicidal cloth, one (1) two (2) ounce absorbent pack, and, one (1) antiseptic hand wipe. Thirteen (13) alcohol prep pads were also observed sitting on top of the IV Start Box.</p> <p>A list of wandering residents was obtained from the facility Administrator on 07/16/15 that identified six (6) residents to be at risk for wandering who could have had access to the unlocked storage areas, Resident #8 and Residents B, C, D, E, and F were identified to be a wandering risk.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 07/15/15 at 5:48 PM revealed the door to the storage room was not to be locked because it contained the crash cart.</p> <p>Interview with facility Director of Nursing (DON)</p>	F 323	<p>3. All staff will be inserviced on storage and securement of potentially hazardous items by 08-04-15.</p> <p>3. The Unit Managers will complete Observation audits 2 times a week for 4 weeks, then weekly or until compliance is obtained with storage and securement of potentially accident hazards in the resident's environment. Audits will be reviewed by the IDON and corrective actions will be provided as appropriate.</p> <p>4. How facility plans to monitor it's performance to ensure that solutions are sustained.</p>		

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F 323	Continued From page 3 on 07/16/15 at 5:25 PM revealed she was not aware of either storage room ever being locked in the past due to them containing the crash carts. Continued interview with the facility DON revealed the IV start boxes that were on the crash carts should have been locked and that all blood collecting instruments and other potentially hazardous items should be locked up in the medication rooms on each nursing unit. Further interview with the facility DON revealed no monitoring of storage of hazardous items had been done in the past to ensure items were stored in the appropriate places. Interview with the facility Administrator on 07/16/15 at 5:46 PM revealed the facility crash carts have "always" been stored in the storage closet on the West unit and linen closet on the East unit. Continued interview with the facility Administrator revealed she was not aware of any potentially hazardous items being stored in the closet on the West unit and that the IV Start Kit boxes on the crash carts should have been locked. Further interview with the facility Administrator revealed no monitoring of storage of hazardous items had been conducted in the past.	F 323	a. The results of the audits will be communicated with the QA Performance Improvement (QAPI) on a monthly basis. QAPI Team (consisting of ED, DON, ADON, MDS Coordinator, Unit Managers, Dietary Manager, Activity Director and the Medical Director) to review all audits and make recommendations related to findings weekly x 2 weeks beginning 08-7-15, then at least monthly until this issue is considered resolved. Continued QAPI monitoring of environment for freedom of accident hazards as is possible will be ongoing at least quarterly.	08-7-15
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363	1. Corrective action for those residents found to have been affected by alleged deficient practice. a. Residents that were served pureed white beans from the tray line during the noon meal have not exhibited any changes in condition related to beans since 07-14-15.	

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F 363	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of the facility's planned recipe it was determined the facility failed to follow the recipe for servings of pureed white beans for thirty-two (32) of thirty-two (32) residents who received a pureed diet from the tray line during the noon meal on 07/14/15.</p> <p>The findings include:</p> <p>An interview conducted with the Dietary Manager on 07/15/15 at 4:15 PM, revealed the facility did not have a specific policy for following recipes. According to the Dietary Manager, it was facility practice to prepare items in accordance with the recipes received from the corporation.</p> <p>Observation of the tray line during the noon meal on 07/14/15 at 12:05 PM, revealed residents that were on a pureed diet received pureed white beans. When the beans were placed on the plate, they had a liquid consistency that ran into other foods in the plate.</p> <p>Review of the facility's recipe for pureed seasoned beans revealed the following: 1. Prepare according to regular recipe, 2. Drain beans and place in food processor, 3. Process until smooth and product reaches an applesauce consistency.</p> <p>An interview with Dietary Cook # 1 on 07/14/15 at 12:10 PM revealed that the facility's corporate office "took their food thickener away" and would not let them order it. The cook stated they had been experimenting with different things to use as a thickener, but could not find anything that</p>	F 363	<p>2. Identification of other residents having the potential to be affected by the alleged same deficient practice.</p> <p>a. Residents that have physician orders for pureed diets have the potential to be affected by this alleged deficient practice</p> <p>3. Measures put in to place or systemic changes made to ensure that the alleged deficient practice will not reoccur.</p> <p>a. Dietary staff were reeducated on the process of pureed food preparation on 07-20-15 by the Life Care Centers of America RD.</p> <p>B. Dietary Manager will monitor preparation, consistency, and serving of pureed items by Observation audits 5 x per week for 2 weeks, then weekly thereafter as of 08-07-15.</p> <p>c. The results of the audit will be reviewed by the ED.</p>		

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F 363	Continued From page 5 worked. An interview with the Dietary Manager on 07/15/15 at 4:09 PM revealed that the facility's corporate office would no longer allow her to order food thickener. The Dietary Manager further stated that Cook #1 should not have served the puree beans "running all over the plate" and that the beans should have been placed in bowls. Another interview with the Dietary Manager on 07/16/15 at 5:05 PM revealed the dietary staff was required to follow recipes and the pureed food should have been the consistency of applesauce. An interview with the facility Administrator on 07/16/15 at 4:40 PM revealed that dietary staff should have followed the recipe to assure the beans were the appropriate consistency.	F 363	4. How facility plans to monitor it's performance to ensure that solutions are sustained. a. Results of the audits will be communicated with the Quality Assurance Performance Improvement (QAPI) team on a monthly basis. QAPI Team to review all audits and make recommendations related to findings weekly x 2 weeks beginning 08-07-15, then at least monthly until issue is considered resolved. Continued QAPI monitoring of preparation of pureed diets will be ongoing at least quarterly.	08-07-15	
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 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility policies, it was determined the facility	F371	1. Corrective action for those residents found to have been affected by alleged deficient practice. a. Specific residents were not cited. b. Items were discarded.		

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F 371	<p>Continued From page 6</p> <p>failed to store food under sanitary conditions for fifty-one (51) of eighty-three (83) residents of the facility who received nutrition from the kitchen. Observations in the kitchen on 07/14/15 revealed food in the walk-in cooler was outdated.</p> <p>The findings include:</p> <p>Review of the facility's policy for "Food Safety," dated 01/01/07, revealed food was to be stored and maintained in a clean, safe and sanitary manner following federal, state and local guidelines to minimize contamination and bacterial growth.</p> <p>Observations on 07/14/15 at 9:18 AM during the initial tour of the kitchen revealed the following: Twenty-seven (27) containers of applesauce with a use by date of 07/11/15, and twenty-one (21) containers of peaches with a use by date of 07/12/15 both located in the walk in cooler.</p> <p>Interview with the Dietary Manager on 07/15/15 at 4:09 PM revealed that the outdated peaches and applesauce should not have been in the walk in cooler. The Dietary Manager further stated that dietary staff would have "more than likely" found the outdated food when the grocery delivery came in, but there was "a chance" that the outdated food could have been used.</p> <p>Interview with the Registered Dietitian on 07/16/15 at 5:05 PM revealed that outdated food should not have been in the walk-in cooler and should have been discarded the day that it expired.</p> <p>Interview with the facility Administrator on 07/16/15 at 4:40 PM revealed that she did</p>	F 371	<p>2. Identification of other residents having the potential to be affected by the alleged same deficient practice.</p> <p>a. Residents that reside in the center have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures put into place or systemic changes made to ensure that the alleged deficient practice will not reoccur.</p> <p>a. Dietary staff were reeducated on storage, process of detecting out-of-date items, and disposal, on a consistent bases on 07-20-15.</p> <p>b. Dietary Manager will conduct weekly observation audits on storage room, walk-in cooler and freezer. The RD will perform monthly observation of the storage room, walk-in cooler and freezer. The results of the audit will be reviewed by the ED.</p>		

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F 371	Continued From page 7 inspections of the kitchen and checked for outdated food in the walk in cooler, and had not noticed a problem. The administrator admitted that the outdated applesauce and peaches should not have been in the walk in cooler.	F 371	4. How facility plans to monitor it's performance to ensure that solutions are sustained. a. The results of the audits will be communicated with the Quality Assurance Performance Improvement (QAPI) Team on a monthly basis. QAPI Team to review all audits and make recommendations related to findings weekly x 2 weeks beginning 08-7-15, then at least monthly until this issue is considered resolved. Continued QAPI monitoring of kitchen storage will be ongoing at least quarterly.		
F 372 SS=F	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined that the facility failed to dispose of garbage from the kitchen area properly. Observation of an uncovered dumpster on 07/14/15 revealed two (2) garbage bags containing food items from the kitchen to be present in the dumpster. Continued observation on 07/15/15 revealed the facility Dietary Manager and another staff member to throw eight (8) boxes of uneatable frozen food from the freezer into the uncovered dumpster. The findings include: Review of facility policy titled "Maintaining Food Waste (Garbage)," dated 10/25/10 revealed outdoor trash receptacles were to be kept covered at all times in order to avoid hazards from garbage or trash. Further review of the facility policy revealed garbage to be defined as wet waste matter that usually contained food and could not be recycled. Observation on 07/14/15 at 9:18 AM revealed two	F372	See attached page 8a. of 11 for F372 Disposal of Garbage and Refuge.	08-07-15	

F372

1. Corrective action for those residents found to have been affected by the alleged deficient practice.
 - a. No residents were cited in this alleged deficient practice.

2. Identification of other residents having the potential to be affected by the alleged same deficient practice.
 - a. No residents have the potential to be affected by the alleged deficient practice.

3. Measures put in to place or systemic changes made to ensure that the alleged deficient practice will not reoccur.
 - a. Dietary staff were reeducated on disposal of garbage and refuge on 07-20-15, including which dumpster disposable items were to be placed.
 - b. The facility ordered a replacement dumpster with a lid for cardboard only and the dumpster was delivered to the center on 07-31-15.
 - c. The Dietary Manager will perform observation audits weekly for continued compliance with appropriate refuge and disposal.
 - d. The RD will perform monthly Observation audits for continued compliance with appropriate refuge and disposal.
 - e. The results of the audit will be reviewed by the ED.

4. How facility plans to monitor it's performance to ensure that solutions are sustained.
 - a. The results of the audits will be communicated with the QAPI Team on a monthly basis. The QAPI Team to review all audits and make recommendations related to findings weekly x 2 weeks beginning 08-07-15, then at least monthly until the issue is considered resolved. Continued QAPI monitoring of refuge and disposal will be ongoing at least quarterly.

08-07-15

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F 372	Continued From page 8 (2) bags of garbage containing food items to be present in the uncovered dumpster located behind the facility near the outside kitchen entrance. Continued observation on 07/15/15 at 11:30 AM revealed the facility Dietary Manager and another kitchen staff member to throw eight (8) boxes of various uneatable frozen foods into the uncovered dumpster located behind the facility. Interview with the facility Dietary Manager on 07/15/15 at 11:30 AM revealed the dumpster she used had been uncovered for as long as she had worked at the facility (for approximately thirteen [13] years) and that she did not know the reason why the dumpster was uncovered. Interview with the facility Maintenance Director on 07/15/15 at 11:35 AM revealed the uncovered dumpster behind the facility was to be used for "boxes only." Interview with the facility Administrator on 07/16/15 at 5:46 PM revealed the uncovered dumpster located behind the facility was to be used for boxes only and that nothing else was to be placed in that dumpster. Continued interview with the facility Administrator revealed she made rounds to check the dumpster two (2) to three (3) times a week and had not noticed any garbage to be in the dumpster in the past.	F 372		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F468	1. Corrective actions for those residents found to have been affected by alleged deficient practice. a. No individual residents were cited on this alleged deficient practice. b. Items that contained ice build-up were removed and discarded on 07-16-15 by the Dietary Manager and Dietary staff.	

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F 456	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to assure that a walk-in-freezer was in safe operating condition. Observation on 07/14/15 revealed a walk-in-freezer that was in use that was not in safe operating condition with a severe ice buildup.</p> <p>The findings include:</p> <p>Interview with the facility Administrator on 07/16/15 at 4:40 PM revealed the facility did not have a policy regarding maintenance of equipment.</p> <p>Observations on 07/14/15 at 9:18 AM revealed a walk-in freezer with a major ice build-up running from behind the freezer to the inside of the unit. Observations further revealed there was ice on the shelf covering several boxes of food including: one (1) case of vegetable egg rolls, two (2) cases of omelets with ham, two (2) cases of okra, one (1) case of sweet corn, two (2) cases of yellow squash, one (1) bag of green peas, one (1) bag of broccoli, and four (4) other brown bags of unknown food items with no labels. The ice was inside a box of yellow squash.</p> <p>Interview on 07/16/15 at 4:40 PM with the Dietary Manager revealed that the ice build-up had been there at least two (2) weeks at the current severity and stated, "It had built up before but not this bad." The Dietary Manager stated she sent a work order two (2) weeks ago to the repair person and the repair person said we needed new hinges on the freezer door and needed insulation around the drainpipe going to the outside. The Dietary</p>	F 456	<p>2. Identification of other residents having the potential to be affected by the alleged same deficient practice.</p> <p>a. No residents have the potential to be affected by the alleged deficient practice.</p> <p>3. Measures put in to place or systemic changes made to ensure that the alleged deficient practice will not reoccur.</p> <p>a. Maintenance Director communicated to contractor and contractor arrived at the facility on 07-17-15 to begin repairs to the Walk-in freezer.</p> <p>b. The walk-in freezer repairs will be completed by 08-07-15.</p> <p>c. The Dietary Manager was reeducated by the ED and Maintenance Director on the work order process for Dietary repairs on 07-17-15.</p> <p>d. The ED will monitor work order process for Dietary requested repairs weekly for 4 weeks, then monthly.</p>	

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NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40862	
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F 456	<p>Continued From page 10</p> <p>Manager stated they usually throw the food away when it got ice built up on it, but was waiting for the freezer to be fixed before she threw the food away. The Dietary Manager stated that the food should not have been in the freezer with the ice buildup on it.</p> <p>Interview with the Maintenance Director on 07/16/15 at 4:00 PM revealed that he was not sure if the Dietary Manager had sent a work order or not and that he first saw the ice buildup on Tuesday 07/14/15. The Maintenance Director stated there should not have been an ice buildup like that in the freezer.</p> <p>Interview on 07/16/15 at 5:05 PM with the Registered Dietitian revealed that she was not aware of an ice buildup in the walk-in freezer.</p> <p>Interview with the facility Administrator on 07/16/15 at 4:40 PM revealed she was not aware of the ice buildup in the walk-in freezer, and there should not have been ice buildup on the food items.</p>	F 456	<p>4. How facility plans to monitor it's performance to ensure that solutions are sustained.</p> <p>a. The results of the audits will be communicated with the Quality Assurance Performance Improvement (QAPI) team on a monthly bases. QAPI team (consisting of ED, DON, ADON, MDS Coord., Dietary Manager, Activity Director and the Medical Director) to review all audits and make recommendations related to findings weekly x 2 weeks beginning 08-07-15, then at least monthly until this is considered resolved. Continued QAPI monitoring of Essential Equipment, Safe Operating conditions will be ongoing at least quarterly.</p>	08-07-15

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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: 1976</p> <p>SURVEY UNDER: 2000 Existing (Short Form)</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type V(000)</p> <p>SMOKE COMPARTMENTS: Five</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey using a 2786S (Short Form) was initiated and concluded on 07/14/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred six (106) residents, with a census of eighty-three (83) residents on the day of the survey.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Claudia E. George* TITLE *Supv. Director* (X8) DATE *08/05/15*

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 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 review of the fire drill records, it was determined the facility failed to ensure fire drills were conducted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, one hundred six (106) residents, staff and visitors.</p> <p>The findings include:</p> <p>Review of the facility's fire drill records on 07/14/15 at 3:00 PM, with Maintenance Director, revealed all 3rd shift fire drills were conducted between 6:00 AM and 6:30 AM. All 2nd shift fire drills were conducted between 3:00 PM and 4:00 PM. Interview, with Maintenance Director, revealed Maintenance Director, was not aware the fire drills had to be conducted at unexpected times and varying conditions.</p> <p>The Administrator acknowledged the findings</p>	K 050	<p>1. Corrective action for those residents found to have been affected by alleged deficient practice.</p> <p>a. No residents were cited in alleged deficient practice.</p> <p>2. Identification of other residents having the potential to be affected by the alleged same deficient practice.</p> <p>a. All residents have the potential to be affected by the alleged practice.</p> <p>3. Measures put in to place or systemic changes made to ensure that the alleged deficient practice will not reoccur.</p> <p>a. Maintenance Director will continue to perform quarterly unannounced Fire Drills on each shift. The fire drills will occur at various time of shifts and days of the week.</p>		

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K 050	Continued From page 2 during the exit conference. Reference: NFPA 101 (2000 Edition) 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 4.7.5* Simulated Conditions. Drills shall be held at expected and unexpected times and under varying conditions to simulate the unusual conditions that can occur in an actual emergency.	K 050	b. Upon completion of each drill the Maintenance Director will complete and review the Drill Report with the ED who will monitor various times and days of the week. 4. How facility plans to monitor it's performance to ensure that solutions are sustained. a. The results of the quarterly drills will be communicated with the QAPI Team on a quarterly basis. QAPI Team to review all audits and make recommendations related to findings weekly x 2 weeks beginning 08-07-15, then at least monthly until the issue is considered resolved. Continued QAPI monitoring of Essential Equipment, Safe Operation Conditions will be ongoing at least quarterly.	08-07-15
K 062 SS=D	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 automatic sprinkler heads were maintained according to			

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K 062	<p>Continued From page 3</p> <p>National Fire Protection Standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, thirty-two (32) residents, staff and visitors.</p> <p>The findings included:</p> <p>Observation on 07/14/15 at 2:03 PM, with the Maintenance Director, revealed the automatic sprinkler head in the freezer was obstructed by a build-up of ice. Further observation with the Maintenance Director, revealed a build-up of dust on the automatic sprinkler head for the refrigerator. Interview, with the Maintenance Director at the time of observation revealed, no inspections were conducted for automatic sprinkler heads in the kitchen area for dirt or obstruction such as ice by facility staff. Further interview, with the Maintenance Director, revealed the facility does not have an outside contractor perform an annual internal visual inspection for dry system piping that pass through the freezer and refrigerator areas.</p> <p>Observation on 07/14/15 at 2:14 PM with the Director of Maintenance, revealed the automatic sprinkler head in the Linen Room for the Short West Wing Hall was obstructed by a light fixture located below the automatic sprinkler head deflector. Interview, with Maintenance Director, at the time of observation revealed, the facility had an outside contractor perform quarterly inspection to ensure automatic sprinkler heads were maintained, and the outside contractor had never made the facility aware of the light fixture being located below the automatic sprinkler deflector.</p> <p>The Administrator acknowledged the findings</p>	K 062	<ol style="list-style-type: none"> 1. Corrective action for those residents found to have been affected by alleged deficient practice. <ol style="list-style-type: none"> a. No residents were cited in alleged deficient practice. 2. Identification of other residents having the potential to be affected by the alleged same deficient practice. <ol style="list-style-type: none"> a. All residents have the potential to be affected by the alleged practice. 3. Measures put in to place or systemic changes made to ensure that the alleged deficient practice will not reoccur. <ol style="list-style-type: none"> a. Maintenance Director has secured outside contractor to repair the sprinkler head in the walk-in refrigerator/freezer. Repairs will be completed by 08-07-15. b. The light fixture below the automatic sprinkler deflector will be repaired by 08-07-15 by the Maintenance Director. c. Weekly compliance rounds will be conducted by assigned Dept. Heads that include observation of sprinkler heads in the center. 		

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K 062	<p>Continued From page 4 during the exit conference.</p> <p>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.</p> <p>Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection.</p> <p>Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.</p> <p>10-3 Prevention of Ice Obstruction. Dry pipe or preaction sprinkler system piping that protects or passes through freezers or cold storage rooms shall be visually inspected internally on an annual basis for ice obstructions at the point where the piping enters the refrigerated area. All penetrations into the cold storage areas shall be inspected, and, if an ice obstruction is found, additional pipe shall be examined to ensure no ice blockage exists.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2.1 Continuous or non-continuous obstructions less than or equal to 18 in. (457 mm) below the sprinkler deflector that prevent the pattern from fully developing shall comply with</p>	K 062	<p>d. Results of weekly compliance rounds audits will be communicated and reviewed by the ED.</p> <p>4. How facility plans to monitor it's performance to ensure that solutions are sustained.</p> <p>a. The results of the quarterly audits will be communicated with the QAPI Team on a quarterly basis. QAPI Team to review all audits and make recommendations related to findings weekly x 2 weeks beginning 08-07-15, then at least monthly until the issue is considered resolved. Continued QAPI monitoring of Essential Equipment, Safe Operation Conditions will be ongoing at least quarterly.</p>	08-07-15

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K 062	Continued From page 5 5-5.5.2. 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. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) Distance from Sprinklers to side of Obstruction (A). Maximum Allowable Distance of Deflector above Bottom of Obstruction (in.) (B) 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 2 ft to less than 2 ft 6 in. 5 1/2 2 ft 6 in. to less than 3 ft 7 1/2 3 ft to less than 3 ft 6 in. 9 1/2 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 16 1/2 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). NFPA 101 LIFE SAFETY CODE STANDARD	K 062		
K 072 SS=D	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	K 072	1. Corrective action for those residents found to have been affected by alleged deficient practice. a. No residents were cited in alleged deficient practice. 2. Identification of other residents having the potential to be affected by the alleged same deficient practice. a. All residents have the potential to be affected by the alleged practice. 3. Measures put in to place or systemic changes made to ensure that the alleged deficient practice will not reoccur.	