

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

PRINTED: 05/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42056
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F 000	INITIAL COMMENTS A standard health survey was initiated on 05/14/13 and concluded on 05/16/13 and a Life Safety Code survey was conducted on 05/15-16/13. Deficiencies were cited at the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation interview record review and facility policy review it was determined the	F 279	F 279 The facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 1. Resident(s) affected by alleged deficient practice: <ul style="list-style-type: none"> MDS Coordinator immediately developed care plans for resident #2 to address behavior issues and the use of psychotropic medication. MDS Coordinator immediately developed care plans for resident #4 to address urinary tract infection and isolation precautions. 2. Residents with potential to be affected by alleged deficient practice: <ul style="list-style-type: none"> All resident care plans will be reviewed by the DON, ADON, MDS Coordinator and Interdisciplinary team with review of all physician orders completed in the last 30 days to ensure development of care plans related to resident needs. Completion date of 6/20/13. 3. Systems to ensure alleged deficient practice does not recur:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Singer Atkins TITLE: Executive Director (X6) DATE: 06/10/13

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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If continuation sheet Page 1 of 19
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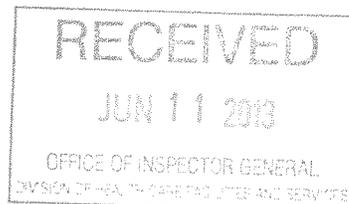
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F 279	<p>Continued From page 1</p> <p>facility failed to develop a care plan for two (2) of sixteen (16) sampled residents (#2 and #4). The facility failed to develop a plan of care to include a urinary tract infection and infection control/isolation precautions for Resident #4. The facility failed to develop a plan of care for behaviors and use of psychotropic medications for Resident #2.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Resident Care Plans, revised 12/08 revealed the care plan should reflect the resident's current needs, problems, goals, care, treatment and services. The care plan should include methods, approaches and plans of what is actually going to be done for, to, or with the resident in order to achieve the goals.</p> <p>Review of the clinical record revealed the facility re-admitted Resident #4 on 02/27/13 with diagnoses of Dementia, Shortness of Air and History of Urinary Tract Infection.</p> <p>Review of a lab report for a urinalysis collected on 04/09/13 revealed Resident #4 had Vancomycin Resistant Enterococcus (VRE) in the urine.</p> <p>Review of Physician Orders for Resident #4 dated 04/13/13 revealed Resident #4 was placed on contact precautions for VRE in the urine.</p> <p>Review of Physician Orders for Resident #4 dated 04/15/13 revealed the resident was placed on intravenous (IV antibiotic) therapy.</p> <p>Review of a Urinalysis collected on 04/20/13</p>	F 279	<ul style="list-style-type: none"> All MD orders will be reviewed daily Monday-Friday by DON, ADON, Unit Manger, MDS Coordinator to ensure care plans are developed to address resident needs. Director of Nursing will provide education by 06/14/13 to interdisciplinary team on developing and updating care plans for specific resident need. All noted education will be completed upon hire, annually and as needed. <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> DON, ADON, MDS Coordinator will audit 5 charts per week x 3 months, then 3 per week x 2 months, then 1 per week x 1 month to ensure care plans address resident needs. Results of audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	4/21/13
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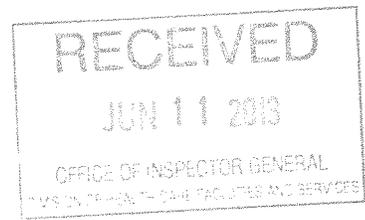
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F 279	<p>Continued From page 2 revealed Resident #4 had Klebsiella (a bacteria) in the urine.</p> <p>Review of Physician Orders for Resident #4 dated 04/26/13 revealed the resident was placed on oral (by mouth) antibiotic therapy.</p> <p>Interview on 05/15/13 at 8:30 AM with Resident #4's family member revealed the family member visited the resident almost every morning and did not wear a gown or gloves when entering the room.</p> <p>Interview on 05/15/13 at 10:40 AM with License Practical Nurse (LPN) #2 revealed she was unaware what bacteria was in Resident #4's urine. After checking with her unit manager, LPN #2 revealed the resident had VRE in the urine, and should have been care planned for isolation precautions and for a urinary tract infection.</p> <p>Interview on 05/15/13 at 10:45 AM revealed Certified Nursing Assistant (CNA) #5 did not know what bacteria Resident #4 had in the urine. Further interview revealed the Resident's family member did not wear a gown when entering the resident's room.</p> <p>Interview on 05/15/13 at 1:25 PM with the Assistant Director of Nursing (ADON) revealed a careplan should have been in place for isolation precautions and urinary tract infection for Resident #4. The ADON commented that somehow it had slipped through the cracks and admitted she was responsible to see that careplans were developed and updated as needed.</p>	F 279		
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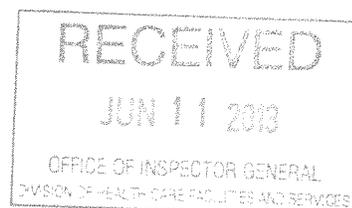
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F 279	<p>Continued From page 3</p> <p>Observation of Resident #2 on 05/14/13 at 10:55 AM revealed the resident up in a high back wheelchair. The resident was noted with right sided hemiparesis. The resident did not respond when greeted.</p> <p>Review of the clinical record for Resident #2 revealed the facility admitted the resident with diagnoses of Depression, Diabetes, Aphasia and Dementia. The facility completed an annual Minimum Data Set (MDS) assessment on 04/30/13 which revealed the resident was severely impaired cognitively. The resident was down, tired and easily annoyed. The resident required extensive assistance for all care needs. The resident received an anti-depressant.</p> <p>Review of the clinical record revealed the resident last had a psychological care visit on 05/14/13. The facility staff was to continue to provide the resident with supportive listening and positive redirection and use a soothing tone. The resident continued with anxiety, agitated mood, depression, grief and combativeness. The resident's medication for depression was to continue.</p> <p>Review of the clinical record revealed the care plan for Resident #2 did not contain documentation to address monitoring the resident for side effects and/or adverse drug reactions from the antidepressant. In addition, the care plan did not address how staff was to manage the resident's agitation, anxiety, or combativeness, should it occur.</p> <p>Interview with the Assistant Director of Nursing</p>	F 279		
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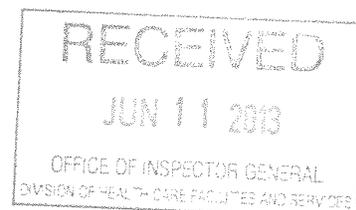
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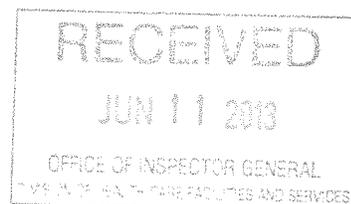
F 279	Continued From page 4 (ADON) on 05/16/13 at 1:10 PM revealed she was responsible for development of the comprehensive care plan based on the MDS assessments. She stated she could not locate Resident #2's care plan for the side effects and/or adverse drug effects which could potentially occur when antidepressant medication was administered. In addition, she stated she could not locate a care plan for managing anxiety and/or combativeness should it occur. She stated monitoring residents for adverse drug reactions and side effects was important.	F 279		
F 282 SS=D	Interview with the Director of Nursing (DON), on 05/16/13 at 2:10 PM, revealed she supervised the ADON; however, she had not reviewed Resident #2's care plan. She stated the care plans should be reviewed for accuracy and to ensure drugs were monitored. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to follow the comprehensive plan of care for one (1) of sixteen (16) sampled residents (Resident #1). The facility failed to ensure Resident #1 wore heel boots at all times.	F 282	F 282 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. 1. Resident(s) affected by alleged deficient practice. <ul style="list-style-type: none"> Education was provided 05/16/13 by the Director of Nursing to the caregivers of Resident #1 to ensure proper use of heel boots. Observation by the Director of Nursing confirmed immediate use of the boots. 2. Residents with potential to be affected by alleged deficient practice. <ul style="list-style-type: none"> 100% audit will be completed by Nursing Management on 06/07/13-06/14/13. Audit will focus on accuracy of all resident care guides to include use of any special equipment. Any discrepancies identified, Nursing administration will update patient care guides. 3. Systems to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> DON or Staff Development Coordinator initiated education on 06/03/13 to nurses and nurse aides on the use of special equipment and ensuring daily use in accordance with physician orders. Education will be completed on 06/20/13. DON, SDC, ADON, Charge Nurse will review all MD orders daily Monday-Friday to ensure any 	



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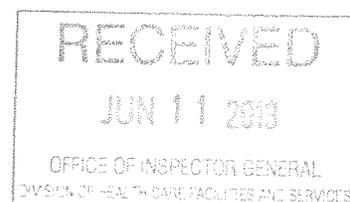
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F 282	Continued From page 5 The findings include: Review of the facility's policy regarding Resident Care Plans, revised 12/08, revealed the care plan should reflect the resident's current needs, problems, goals, care, treatment and services. The care plan should include methods, approaches and plans of what is actually going to be done for, to, or with the resident in order to achieve the goals. Review of the clinical record revealed the facility re-admitted Resident #1, on 02/28/13, with diagnoses of Bipolar Disorder, Diabetes, Multiple Sclerosis and recent Bowel Perforation and Colostomy. The facility assessed the resident utilizing a Minimum Data Set (MDS) assessment, on 03/07/13, as having a brief interview of mental status (BIMS) score of 14, which indicated the resident was cognitively intact. Review of Resident #1's comprehensive plan of care revealed the facility had identified a risk for alteration in skin integrity and determined a goal of no skin breakdown through the next review. One of the approaches listed was to apply blue heel lift boots to bilateral feet and to check skin integrity once daily. Observation of Resident #1, on 05/14/13 at 11:47 AM revealed the resident did not have on blue heel lift boots. Observation of Resident #1, on 05/15/13 at 9:05 AM, 10:50 AM, 11:40 AM and 12:20 AM, revealed Resident #1 sitting in a wheelchair wearing multicolored fuzzy socks. There were no blue lift	F 282	change in devices need is captured and care guides are updated, devices are put in place, and staff is aware of needed devices. 4. Monitoring to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> DON, ADON, MDS Coordinator will audit 5 residents per day Monday-Friday x 2 months, then 5 residents per week x 2 months, then 5 residents per month x 2 months to ensure use of special equipment. Nursing Administration will provide on-going education as indicated for non-compliance, as well as upon initiation of new equipment, upon hire, annually, and PRN. Results of audits will be brought to the monthly Performance Improvement committee to determine the need for further monitoring and updated the plan as needed. Appropriate actions plans will be reviewed and revised as needed. 	6/21/13	



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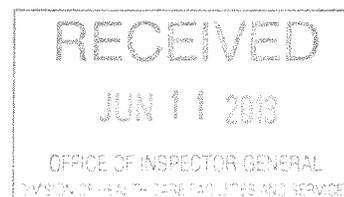
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F 282	Continued From page 6 heel lift boots in place. Interview with CNA #2, on 05/16/13 at 10:45 AM, revealed Resident #1 was supposed to wear blue heel lift boots every day, all day to prevent pressure sores on his/her heels. She stated Resident #1 had a skin breakdown on his/her heel in the past which was now healed. CNA #2 stated if the boots were not kept on as ordered Resident #1 could get another breakdown. Interview with LPN #3, on 05/16/13 at 10:34 AM, revealed the purpose of the blue heel lift boots for Resident #1 was to keep pressure off his/her heels and prevent skin breakdown. If the boots were not worn as ordered Resident #1 could develop pressure sores.	F 282			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation interview and facility policy review it was determined the facility failed to maintain water temperatures at 100 to 110 degrees Farenheit in two (2) of three (3) Resident Shower Rooms. The facility failed to ensure it	F 323	F 323 The facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. Resident(s) affected by alleged deficient practice: <ul style="list-style-type: none"> No residents were affected by the water temperatures. Shower rooms were taken out of service until temperatures could be maintained within 100-110 degrees. Maintenance Director contacted local plumbing contractor on 05/14/13, to perform maintenance necessary to correct water temperatures. 2. Residents with potential to be affected by alleged deficient practice: <ul style="list-style-type: none"> All residents utilizing the shower rooms have the potential to be affected by improper temperatures. All residents who received a shower on 5/14/2013 were assessed by the Director of Nursing and ADON to ensure no harm had occurred. No residents had any adverse effect from showering on 05/14/13. 3. Systems to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> Facility procedures were updated to include weekly checks of the shower room temperatures by the Maintenance Director . 		



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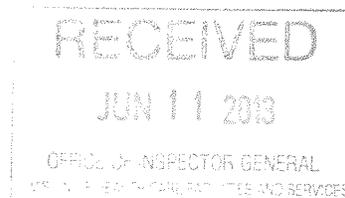
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F 323	<p>Continued From page 7</p> <p>maintained a policy that reflected accurate regulatory specifications for staff to follow for guidance.</p> <p>The findings include:</p> <p>Review of the facility's Water Temperature Inspection policy revision date 03/15/04 revealed once a month temperatures were taken in the bathing area. Faucet temperatures will be recorded on a temperature log sheet and should range from 100 to 120 degrees Farenheit. Shower Room temperatures for the two (2) North Wing and the one (1) one South Wing Shower Room were not mentioned in the the policy. The facility was unable to provide a temperature log for the three (3) shower rooms by the end of the survey.</p> <p>Observation on 05/14/13 at 1:45 PM during the initial environmental tour with the Director of Maintenance (DM) revealed the shower water temperature was 116 degrees and the sink water temperature was 90 degrees in the North Wing #1 Shower Room. The shower water temperature was 114 degrees and the sink water temperature was 80 degrees in the North Wing #2 Shower Room during the initial tour with the DM.</p> <p>Interview on 05/14/13 at 2:45 PM with the DM revealed he was unaware of what the actual shower room water temperatures should be and questioned the surveyor for the correct temperature parameters. The DM revealed he did not check the shower room water temperatures with a thermometer but depended on the the temperature gauge on the shower</p>	F 323	<ul style="list-style-type: none"> Education provided to staff to report any abnormalities to water temperatures and to immediately remove residents from the area until issues resolved. Education was initiated on 06/03/13 by Executive Director and will be completed on 06/20/13. The Executive Director provided education to the Maintenance Director on 06/03/13 regarding obtaining temperatures of showers when obtaining other water temps. <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> Director of Maintenance will audit water temperatures including shower rooms on a weekly basis. This will be an on-going procedure. Executive Director will perform random water temps of showers 2 x week, x 4 weeks. Results of the audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	06/21/13	



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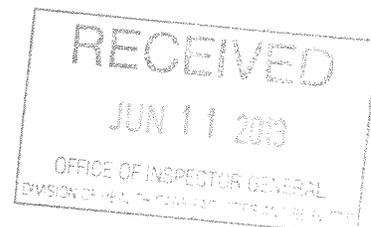
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F 323	Continued From page 8 head and depended on the staff to report if water temperature seemed too hot or cold. The DM also revealed he did not keep a temperature log on the water temperature in the Shower Rooms. The DM commented the bath aides are always with the residents in the shower room and they informed the DM if there was any problems with the water temperature being too hot or cold. Interview with the Facility Administrator on 05/14/16 at 3:00 PM revealed the DM should be keeping a temperature log for the Residents' Shower Rooms. The Administrator was unaware the water temperatures for the shower rooms should be between 100 to 110 degrees Fahrenheit and changed the Facility's policy from 100 to 110 degrees to 100 to 120 degrees and initialed the changes. The Administrator revealed The DM should not depend on the bath aides to report problems with the water temperature and there should be a system in place.	F 323	F 371 The facility must (1)Procure food considered satisfactory by Federal, State, or Local authorities; and (2)Store, prepare, distribute and serve food under sanitary conditions. 1. Residents affected by alleged deficient practice. <ul style="list-style-type: none"> Dietary services manager provided immediate education to the dietary staff members for maintaining cleanliness of uniforms and handling soiled linens. Registered Dietitian and Staff Development coordinator will provide education to all staff on proper food handling. Education initiated on 06/07/13 and will be completed by 06/20/13. 2. Residents with potential to be affected by alleged deficient practice: <ul style="list-style-type: none"> All residents benefit from sanitary food storage and preparation. No residents were affected by alleged deficient practice. 3. Systems to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> Registered Dietitian to provide inservice to Dietary Manager and dietary staff on sanitary procedures for handling food as well as clean and soiled linens used in the dining room on 06/11/13. Education will be provided upon hire, annually and PRN. Registered Dietitian and Staff Development Coordinator will 		
F 371 SS=F	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, interview and facility	F 371			



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F 371	<p>Continued From page 9</p> <p>policy review, it was determined the facility failed to distribute and serve food under sanitary conditions. Two staff were observed handling food with their bare hands and one staff member was seen gathering soiled linen and placing that soiled linen against her uniform. One dietary staff member was kneeling on the floor in the dining room cleaning.</p> <p>The findings include:</p> <p>Review of the Dining Policy, revised 03/01/13, revealed any associate serving food would use utensils when handling ready-to-eat food.</p> <p>Observation of the 200 hallway during lunch tray pass, on 05/15/13 at 11:54 AM, revealed CNA #3 picked up with bare hands a piece of bread for a resident and made a sandwich out of the resident's ground meat and bread, then handed the sandwich to the resident.</p> <p>Observation of lunch service in the main dining room, on 05/15/13 at 12:45 PM, revealed LPN #2 picked up hot dog pieces with her bare hands and placed them on the hot dog bun of a resident she was assisting with feeding.</p> <p>Interview with CNA #3, on 05/16/13 at 9:33 AM, revealed she was aware you should not touch a resident's food with bare hands. She had been trained not to touch food with bare hands and stated she just made a mistake.</p> <p>Interview with LPN #2, on 05/16/13 at 1:27 PM, revealed a resident's food should not be touched with bare hands because of spreading germs. She stated she did not remember touching a</p>	F 371	<p>provide education to all staff on proper food handling techniques. Education will be initiated on 06/11/13 with completion date 06/20/13.</p> <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> Weekly sanitation audits will be conducted by the dietary manager, with a monthly audit being completed by the Consultant RD. Audit will include visual observation of handling of linen and maintenance of clean uniforms, as well as proper handling of food items. On-going. Director of Nursing, SDC, ADON, Unit Manager will audit food handling in 5 resident rooms per week x 2 months, then 3 per week x 2 months, then 1 per week x 2 months. Results of the audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	06/21/13	



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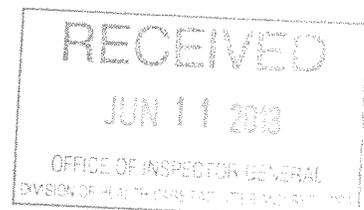
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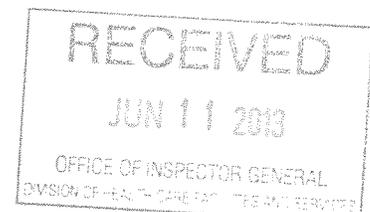
F 371	<p>Continued From page 10</p> <p>resident's hot dog and stated she guessed she just slipped up like she was at home.</p> <p>Observation of the dining room on 05/15/13 at 11:50 AM revealed Dietary Aide (DA) #1 clearing tables as the meal was completed. She was observed removing soiled napkins from the resident dining tables and tucking them under her arm. In addition, she was observed kneeling down on the dining room floor in her uniform and cleaning up a spill.</p> <p>Interview with DA #1 on 05/15/13 at 12:05 PM revealed DA #1 attended a training on infection control several weeks ago. She stated she did not realize she was contaminating her uniform by holding soiled napkins against her uniform or by kneeling on the floor in the dining room in her uniform. She stated she could spread germs working in the kitchen with contaminated clothing.</p> <p>Interview with the Dietary Manager on 05/15/13 at 12:10 PM revealed the DA should have used gloves to collect soiled napkins into a bag. She stated the DA should not have knelt on the floor in her uniform and then returned to the kitchen. She stated the DA 's uniform was contaminated and could spread germs to food. She stated she did supervise the dietary staff and had not observed this prior to today.</p> <p>Interview with the Director of Nursing (DON), on 05/16/13 at 12:55 PM, revealed all staff receive training on food serving which includes not touching food with bare hands. There is a risk for contamination if food is touched with bare hands.</p>	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		



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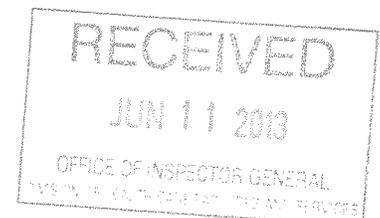
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F 441	Continued From page 11 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1. Resident(s) affected by alleged deficient practice: <ul style="list-style-type: none"> Housekeeper #1 and the Housekeeping Supervisor were re-educated on 06/06/13 by Infection Control Nurse related to wearing protective equipment ie: gown/gloves when cleaning resident rooms that are contact isolation. Resident #11's MD was notified on 06/15/13 by the DON related to staff entering the room and failing to wear glove and gown. No new orders were obtained. Resident #5's MD was notified on 06/05/13 by the DON related to WCN not washing hands between glove changes. No new orders were obtained. WCN was re-educated on 06/06/13 by the Infection Control Nurse on the importance of proper hand hygiene when performing wound care to decrease the risk of infection to the resident. Resident #4's MD was notified on 06/05/13 by DON related to residents family not wearing gloves or gown during family visits. No new orders were obtained. 		



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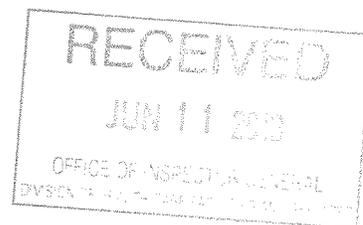
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F 441	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy it was determined the facility failed to ensure proper handwashing was completed during a dressing change and that Contact Precautions were followed for four (4) of sixteen (16) sampled residents (Residents #4, #5 #6 and #11). Residents #4, #6 and #11 were in Contact Precautions and the facility failed to ensure these precautions were followed. Resident #5 had a dressing change during which the nurse failed to practice proper handwashing techniques.</p> <p>The findings include:</p> <p>Review of the facility policy for Contact Precautions, dated 07/18/2011, revealed no policy was in place to address environmental precautions in the isolation room. The policy revealed residents were to be transported only for essential purposes.</p> <p>Observation of Resident #6, on 05/15/13 at 10:00 AM, revealed Housekeeper #1 inside the resident's room cleaning and mopping. A sign on the resident's door advised anyone entering the room to see the nurse. There were no other instructions posted.</p> <p>Observation of Resident #6, on 05/14/13 at 12:00 PM, and on 05/15/13 at 12:00 PM, revealed the resident propelling self about the facility in a wheelchair and going to the dining room for meals.</p> <p>Review of the clinical record for Resident #6</p>	F 441	<ul style="list-style-type: none"> • Resident #6 was educated by the Infection control nurse on 06/06/13 of the requirement to remain confined to her room until 3 negative cultures have been obtained. Two cultures are clear, third scheduled for 06/10/13. <p>2. Residents with potential to be affected by alleged deficient practice:</p> <ul style="list-style-type: none"> • All residents have the potential to be affected by this practice. The DON, Infection Control Nurse completed an observation of all residents requiring isolation to ensure all isolation measures were in place and being completed per expectations. No other residents required isolation at this time. Completed 06/07/13 <p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> • The policy for contact isolation was revised on 06/06/13 to include the CDC recommendation as they relate to contact isolation. • The policy for Hand Hygiene was revised on 06/06/13 to include washing of hands after each change of gloves during a procedure. • Education will be provided to all staff on 06/11/13 by the Infection Control Nurse to ensure education of revisions to the Contact Isolation Policy and Hand Hygiene Policy were communicated. • Licensed Nurses will provide education to any family member that visits residents in isolation to ensure decrease risk of transmission of 		



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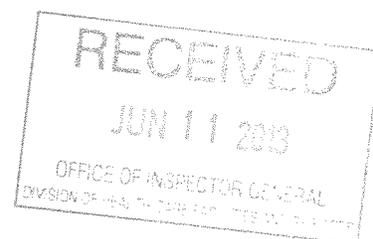
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F 441	<p>Continued From page 13</p> <p>revealed the resident was admitted to the facility with diagnoses of Diabetes and Hypertension. The facility completed a quarterly Minimum Data Set (MDS) assessment on 04/23/13 which revealed the resident required extensive assistance with care and was frequently incontinent of urine. The resident was cognitively intact. Review of laboratory testing completed on 04/26/13 revealed the resident had acquired a vancomycin resistant enterococcus urinary tract infection. The physician ordered contact precautions on 04/30/13.</p> <p>Observation of Resident #11, on 05/15/13 at 12:15 PM, revealed a sign on the door frame requesting persons entering the room to talk to the nurse. A staff member entered the resident's room and cleared the over bed table of personal items and positioned the table to receive the resident's lunch tray. The staff member was noted not to be gowned or gloved while performing this task.</p> <p>Review of the clinical record for Resident #11 revealed the facility admitted the resident with a diagnoses of Clostridium Difficile Colitis and a Urinary Tract Infection with Extended Spectrum Beta-Lactamase (ESBL) producing Eschericia Coli. The physician ordered Contact Precautions for the resident. The resident was placed on intravenous antibiotics.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/15/13 at 12:20 PM, revealed Resident #11 was in isolation with Contact Precautions for urine and stool infections. She stated that as long as the staff did not touch the resident, there was no need for gloves or a gown. She stated she did</p>	F 441	<p>infection to resident and/or family members.</p> <ul style="list-style-type: none"> • Education of Contact Isolation and Hand Hygiene policy will occur upon hire, annually, and PRN. <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> • DON, Infection Control Nurse, ADON will audit residents requiring isolation daily Monday-Friday x 6 months to ensure gloves and gowns are being worn when providing resident care or family is visiting. • DON, Infection Control Nurse, ADON will audit WCN or any Licensed Nursing performing wound care daily Monday-Friday x 6 months ensure handwashing is occurring between changing of gloves • Results of audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	06/21/13	



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F 441	<p>Continued From page 14</p> <p>not know of any precautions that should be taken for contact with surfaces or items in the resident's room. She stated she had received training on management of residents requiring isolation precautions for infections.</p> <p>Interview with the Health Information Nurse, on 05/16/13 at 1:40 PM, revealed the facility did not require staff to gown or glove when entering isolation for Contact Precautions as long as no resident contact was made. She stated Resident #6 wore an adult brief to contain the infection in the urine and could be up and out of the room as desired. She stated Resident #11 also wore an adult brief and the stool and urine infections were contained. She stated residents on Contact Precautions were treated case by case. She stated she had provided training for housekeepers and the housekeeper should have been gowned and gloved while cleaning a room where contact precautions were in effect as they were at a high risk of spreading infection.</p> <p>Interview with Housekeeper #1, on 05/16/13 at 1:50 PM, revealed she had been trained on cleaning a room where the resident was on contact precautions. She stated she should have been wearing gloves and a gown while cleaning Resident #6's room. She thought she should wear the gloves and gown to prevent infection to her. She stated she had no explanation for cleaning an isolation room without personal protective equipment.</p> <p>Interview with the Housekeeping Supervisor, on 05/16/13 at 2:05 PM, revealed the housekeeping staff were never told anything regarding residents with isolation/precautions. She stated the staff</p>	F 441			



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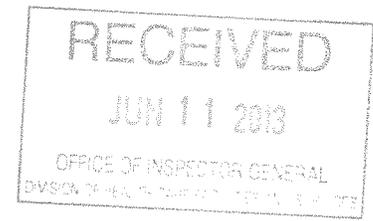
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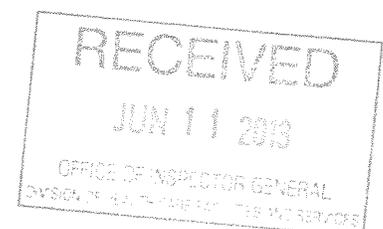
F 441	<p>Continued From page 15</p> <p>just did as they were told by the Health Information Nurse. She stated they had attended one in-service on bloodbourne pathogens and infection control in regards to housekeeping.</p> <p>Interview with the Administrator, on 05/16/13 at 2:10 PM, revealed a search of the Centers for Disease Control revealed the facility policy was not up to date with recommendations on contact precautions.</p> <p>Review of facility Hand Hygiene policy, revised 05/01/13, revealed the purpose of hand hygiene was to decrease the risk of transmission of infection by appropriate hand hygiene. The policy did not address washing hands after glove changes.</p> <p>Review of the clinical record revealed the facility admitted Resident #5 on 04/30/13 with diagnoses of Aftercare for Healing Pathologic Fracture of Hip and Post Operative Infection of Hip.</p> <p>Observation of Resident #5's dressing change, on 05/15/13 at 10:20 AM, revealed the Wound Care Nurse (WCN) placed gloves on her hands and removed the old wound vacutainer and dressing and threw the dressing away and removed her gloves and did not wash her hands. She then applied new gloves and removed the packing from the wound, discarded the packing, removed her gloves and did not wash her hands. She applied new gloves, irrigated the wound with normal saline and repacked the wound with gauze and again removed her gloves and reapplied new ones without washing her hands. The WCN then packed the wound with a black sponge and applied the new wound vacutainer.</p>	F 441		
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F 441	Continued From page 16 Interview with the WCN, on 05/16/13 at 1:15 PM, revealed handwashing should occur during dressing changes before the procedure is started, after you remove soiled gloves and after finishing the dressing change. The purpose of washing hands after removing gloves is to prevent infection. She stated the wound dressing was very complicated and some of the times she changed her gloves were for her convenience and she thought is was okay not to wash her hands when it was only done for her convenience. Interview with the Infection Control Nurse (ICN), on 05/16/13 at 12:43 PM, revealed handwashing should be done before care, after care, before and after meals, after bathroom break and anytime they are soiled. She stated gloves should be worn during patient care and if they become soiled or contaminated they should be removed and hands washed between glove changes. The ICN stated staff were trained on hand washing every year and she was shocked to learn that any nurse did not wash hands after removing gloves during a dressing change. That is basic wound care and was covered in the inservice every year. Hands should be washed anytime gloves are removed to prevent spread of any kind of organism or bacteria. Interview with the Director of Nursing (DON), on 05/16/13 at 12:55 PM, revealed there was training every year on hand washing and wound care which included washing hands between glove changes. She further stated there was a risk of contamination if not done properly.	F 441			



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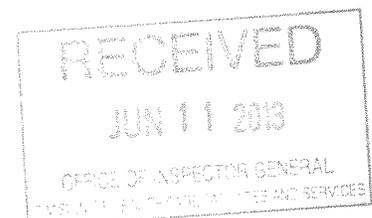
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F 441	<p>Continued From page 17</p> <p>Review of the clinical record revealed the facility re-admitted Resident #4 on 02/27/13 with diagnoses of Dementia Shortness of Air and History of Urinary Tract Infection.</p> <p>Review of a lab report for a urinalysis collected on 04/09/13 revealed Resident #4 had Vancomycin Resistant Enterococcus (VRE) in the urine.</p> <p>Review of Physician Orders for Resident #4 dated 04/13/13 revealed Resident #4 was placed on contact precautions for VRE in the urine.</p> <p>Review of Physician Orders for Resident #4 dated 04/15/13 revealed the resident was placed on intravenous (IV) antibiotic therapy.</p> <p>Review of a Urinalysis collected on 04/20/13 revealed Resident #4 had Klebsiella (a bacteria) in the urine.</p> <p>Review of Physician Orders for Resident #4 dated 04/26/13 revealed the resident was placed on oral (by mouth) antibiotic therapy.</p> <p>Interview on 05/15/13 at 8:30 AM with Resident's #4 family member revealed the family member visited the resident almost every morning and did not wear a gown or gloves when entering the room.</p> <p>Interview on 05/15/13 at 10:45 AM revealed Certified Nursing Assistant (CNA) #5 did not know what bacteria Resident #4 had in the urine. Further interview revealed the Resident's family member did not wear a gown when entering the resident's room. The CNA was uncertain the reason the family member did not wear a gown</p>	F 441		
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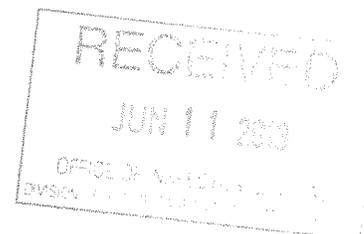
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42056
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F 441	Continued From page 18 when entering the resident's room.	F 441		
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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: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 24 smoke detectors and 6 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 2006. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/15/13 and 05/16/13. Life Care Center of La Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Seventy (70) beds with a census of Sixty-Five (65) 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>"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."</p> <p>K 025 Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3.</p> <ol style="list-style-type: none"> The smoke partitions extending above the ceiling located at rooms 211 and 307 were repaired by the maintenance director to correct any penetrations. Completed 05/16/13. Smoke barrier at room 201 will be repaired by a contracted company to ensure complete extension of the smoke wall. Work to be completed by 06/28/13. All other facility smoke barriers were observed during the survey, no other problems were identified. The Maintenance Department was inserviced by the Administrator to monitor the integrity of smoke barriers 06/03/2013. The Maintenance Department will audit smoke barriers after any outside contract work is done to ensure the integrity has been maintained. Ongoing. Maintenance Department will audit all smoke barriers 1 x per month, x 6 months with results reported to PI committee for further recommendations. 	06/29/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dinger Atkins</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>06/10/13</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

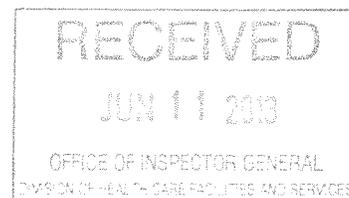
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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K 000	Continued From page 1 Fire).	K 000		
K 025 SS=F	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 four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy (70) beds with a census of Sixty-Five (65) on the day of the survey. The facility failed to ensure three (3) smoke barriers were sealed around pipes and wires to resist the passage of smoke. The findings include: Observations, on 05/15/13 between 3:15 PM and	K 025		



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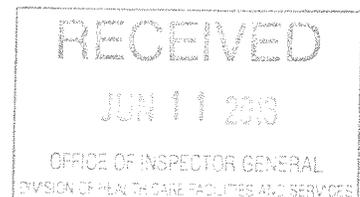
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K 025	<p>Continued From page 2</p> <p>4:30 PM with the Director of Maintenance, revealed the smoke partitions, extending above the ceiling located at rooms# 211 and 307, were penetrated by pipes and wires. Further observation revealed the smoke barrier at room #201 did not extend to an exterior wall.</p> <p>Interview, on 05/15/13 between 3:15 PM and 4:30 PM with the Director of Maintenance, revealed he was unaware of the penetrations in the smoke barriers as they have been inspected several times since the last survey. Further interview revealed he was unaware the smoke barrier located at room # 201 did not extend properly to an outside wall.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. 	K 025		
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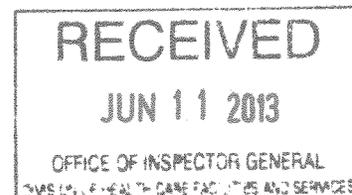


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K 025	Continued From page 3 (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025	K 056 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. 1. Private contractor will be hired to expand existing sprinkler system to cover areas of Wing 1 air locks, resident closets on the 300 hall, and the treatment room #1 in rehab. Work to be completed by 06/28/13. 2. Maintenance, Life Safety Inspector, and Administrator inspected all other areas of the facility during survey rounds to ensure proper coverage. 3. The Maintenance Department was inserviced on the requirements for complete sprinkler coverage in accordance with NFPA standards by the Administrator on 06/03/13. 4. The Maintenance Director will ensure all areas of sprinkler coverage will be maintained within NFPA standards. Outside licensed providers will be utilized for inspection of sprinkler system to meet compliance with NFPA standards on a routine basis, ongoing. Any structure changes will be reviewed by PI committee to ensure compliance with sprinkler coverage.		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056			

06/29/13



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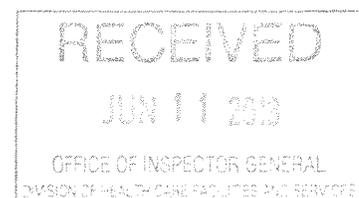
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K 025	Continued From page 3 (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K 056 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. 1. Private contractor will be hired to expand existing sprinkler system to cover areas of Wing 1 air locks, resident closets on the 300 hall, and the treatment room #1 in rehab. Work to be completed by 06/28/13. 2. Maintenance, Life Safety Inspector, and Administrator inspected all other areas of the facility during survey rounds to ensure proper coverage. 3. The Maintenance Department was inserviced on the requirements for complete sprinkler coverage in accordance with NFPA standards by the Administrator on 06/03/13. 4. The Maintenance Director will ensure all areas of sprinkler coverage will be maintained within NFPA standards. Outside licensed providers will be utilized for inspection of sprinkler system to meet compliance with NFPA standards on a routine basis, ongoing.	06/29/13



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K 056	<p>Continued From page 4</p> <p>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 four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy (70) beds with a census of Sixty-Five (65) on the day of the survey. The facility failed to ensure all areas of the building had proper sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 05/15/13 between 3:15 PM and 4:30 PM with the Director of Maintenance, revealed the air locks at room's# 101,113, the resident closets on the 300 hall, and the treatment room# 1 closet did not have proper sprinkler protection.</p> <p>Interview, on 05/15/13 between 3:15 PM and 4:30 PM with the Director of Maintenance, revealed he was unaware that the areas listed did not have proper sprinkler protection.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1</p> <p>Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in</p>	K 056		
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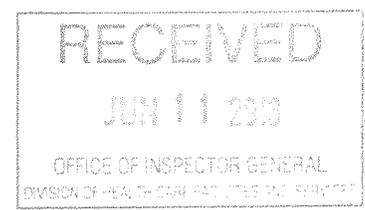
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K 056	<p>Continued From page 5 accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p> <p>S&C Letter stating all Long Term Facilities must be fully sprinkler protected by August 2013.</p>	K 056	<p>K 062 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <ol style="list-style-type: none"> 1. Private contractor will be hired to replace all sprinkler heads that have any paint on them. Escutcheon rings will be replaced on all sprinkler heads. Work will be completed by 06/28/13. 2. A facility walk-through was completed by the administrator, Director of maintenance and outside contractor to determine sprinkler heads altered by paint damage. 3. Maintenance Department was educated by Administrator on need to maintain integrity of sprinkler heads and escutcheon rings, completed 06/03/13. 4. Maintenance Department will audit 10 sprinkler heads per monthly x 6 months, to ensure proper maintenance. Results of audit will be reviewed by PI committee. 	
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by:</p>	K 062		06/29/13



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K 062

Continued From page 6

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 four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy (70) beds with a census of Sixty-Five (65) on the day of the survey. The facility failed to ensure the sprinkler heads on 300 hall were free of paint and were equipped with an escutcheon ring.

The findings include:

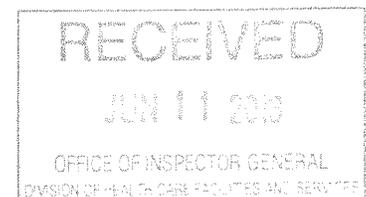
Observations, on 05/16/13 between 8:45 AM and 10:30 AM with the Director of Maintenance, revealed sprinkler heads located throughout the 300 hall were missing the escutcheon rings. Further observation revealed sprinkler heads were painted throughout the facility.

Interview, on 05/16/13 between 8:45 AM and 10:30 AM with the Director of Maintenance, revealed he was unaware the sprinkler head escutcheon rings were missing and was unaware sprinkler heads could not be painted in any way.

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



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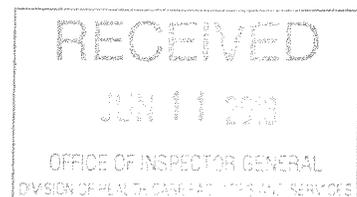
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K 069 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the cooking appliances in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, forty-two (42) residents, staff, and visitors. The facility is certified for Seventy (70) beds with a census of Sixty-Five (65) on the day of the survey. The facility failed to ensure the grease fryer was properly separated from stove top.</p> <p>The findings include:</p> <p>Observation, on 05/16/13 at 10:00 AM with the Director of Maintenance, revealed the grease fryer did not have the proper separation from the cooking surface.</p> <p>Interview, on 05/16/13 at 10:00 AM with the Director of Maintenance, revealed he was unaware the grease fryer did not have proper separation from the cook top.</p> <p>Reference: NFPA 96 (1998 Edition) 9-1.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed</p>	K 069	<p>K 069 Cooking facilities are protected in accordance with 9.2.3.19.3.2.6, NFPA 96</p> <ol style="list-style-type: none"> 1. Private contractor has been contacted by facility to install steel baffle plate between fryer and stove. Work will be completed by 06/28/13. 2. All cooking facilities were audited during annual life safety survey, no other issues identified. 3. The Maintenance Department was inserviced by the Administrator on 06/03/13 on the standard for protection of cooking facilities. 4. Dietary Manager will ensure maintenance of steel baffle plate between cooking surfaces during monthly sanitation audit. Ongoing. Results will be reported to PI committee for recommendations. 	06/29/13
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2013
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K 069 Continued From page 8
at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.

K 076 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.

(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.

(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, thirty-two (32) residents, staff and visitors. The facility is certified for Seventy (70) beds with a census of Sixty-Five (65) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles and ignition sources were located five (5) feet from the floor.

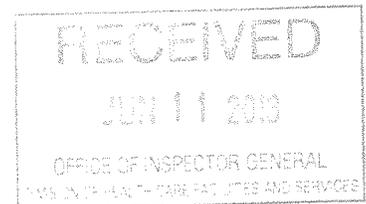
The findings include:

K 069

K 076 **Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.**

1. The facility will purchase a non-combustible cabinet for storage of items within the oxygen storage closet. Work will be completed by 06/28/13.
2. The facility currently has only the 1 oxygen storage unit.
3. Maintenance Director and Director of Nursing inserviced by Administrator on 06/03/13 on proper storage of oxygen.
4. Director of maintenance will complete visual audit of oxygen storage space weekly to ensure compliance. On-going. Results of audit will be reported to Safety committee, then to PI Committee for recommendations.

06/29/13



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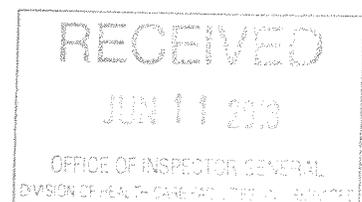
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K 076	<p>Continued From page 9</p> <p>Observation, on 05/16/13 at 10:58 AM with the Director of Maintenance, revealed thirty-six (36) oxygen tanks in the oxygen storage room. The oxygen tanks were being stored within five (5) feet of combustible items.</p> <p>Interview, on 05/16/13 at 10:58 AM with the Director of Maintenance, revealed they were unaware oxygen tanks could not be stored within five (5) feet of combustible materials once the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid</p>	K 076		
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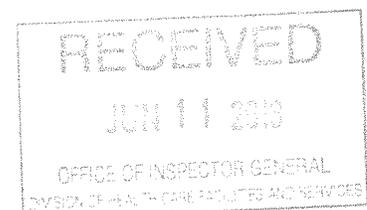
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<p>K 076</p>	<p>Continued From page 10 storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.</p>	<p>K 076</p>	<p>K 147 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code.9.1.2</p> <ol style="list-style-type: none"> 1) Medical equipment was unplugged from power strip in treatment room #1. 2)Extension cord has been removed and replaced with a power strip in the ADON office for computer equipment. Coffee pot was unplugged. 3) Bone stimulator was unplugged from power strip and moved to outlet. 4)Coffee pot was removed from treatment room #2. 5) Extension cord was removed from the Business office. Professional Contractor was hired for installation of additional electrical wiring for the removal of power strips. Completed 05/30/13. ED provided education to Department Heads on proper use of power strips on 06/06/13. Education to be provided by Executive Director, to all staff on 06/11/13. Maintenance Director and safety committee will audit 5 resident rooms/offices per week x 6 months to ensure compliance. Results of audits will be reported to Safety committee for additional recommendations. Results will be reported to PI committee as well for any recommendations. 	<p></p>
<p>K 147 SS=D</p>	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>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 one (1) of four (4) smoke compartments, eighteen (18) residents, staff and visitors. The facility is certified for Seventy (70) beds with a census of Sixty-Five (65) on the day of the</p>	<p>K 147</p>	<p></p>	<p>06/29/13</p>



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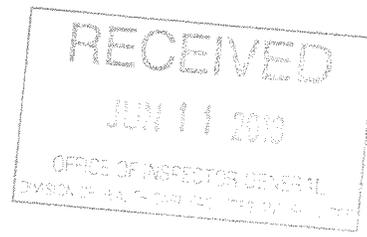
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K 147	<p>Continued From page 11 survey. The facility failed to ensure power strips were being used properly.</p> <p>The findings include:</p> <p>Observations, on 05/16/13 between 8:45 AM and 11:00 AM with the Director of Maintenance, revealed:</p> <ol style="list-style-type: none"> 1) Medical equipment was plugged into two (2) separate power strips located in Treatment room #1. 2) An extension cord was plugged into computer equipment and a coffee pot was plugged into a power strip located in the Assistant Director of Nursing Office. 3) A bone stimulator was plugged into a power strip located in room# 111. 4) A coffee pot was plugged into a power strip in Treatment room #2. 5) An extension cord was plugged into computer equipment located in the Business Office. <p>Interview, on 05/16/13 between 8:45 AM and 11:00 AM with the Director of Maintenance, revealed he was unaware of the items being improperly plugged into power strips and the two extension cords in use.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of 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.</p>	K 147		
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K 147	Continued From page 12 Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147		
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