STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185120	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on 06/18/13 through 06/20/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "D".	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the 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 provisions of federal and state law.*	
F 246 SS=D	483.15(c)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure; it was determined the facility failed to ensure each resident received reasonable accommodation of needs for one (1) resident (#13), in the selected sample of twenty-four (24) residents and two (2) residents (#26 and #27), not in the selected sample . The facility failed to provide bathing water at the appropriate temperature for one bed bath for Resident #13 and showers for Residents #26 and #27. Findings include:	F 246	F246 – Reasonable accommodation of needs/preferences 1. Corrective action for those residents found to have been affected: Residents #13, 26 and 27 received another bed bath on 6/20/13 with an acceptable water temp. 2. Corrective action for those with potential to be affected: All residents have potential to be affected. Mixing valve was immediately dialed up to ensure a higher amount of hot water came through the pipes. 3. Systemic changes to ensure the deficient practice will not recur: Nursing staff will be educated by the Staff Development RN or Director of Nursing on policy and procedure 6500 1on bathing and showers and water temps between 105-110 degrees. The education will include staff letting the water run to warm up prior to	8/2/13

Jan Lau, E.D. July 14/13

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

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F 246	Continued From page 1 A review of the facility Bed Bath policy/procedure revealed basin with water at 105-110 degrees Fahrenheit (F.). A review of the facility Shower policy/procedure revealed to adjust temperature of water to 105 -110 degrees F. 1. Observation of Resident #13's bed bath, on 06/19/13 at 9:37 AM, revealed Resident #13 had verbal and non-verbal expressions of discomfort throughout the bathing process related to the temperature of the water in the basin being cold. The resident verbally stated the water was cold, pulled away and exhibited gooseflesh on arms during the bathing process. The State Registered Nurse Aides (SRNA) failed to change the basin water to obtain an acceptable temperature and continued the bed bath until completion. An interview with Resident #13, on 06/19/13 at 10:05 AM revealed the basin water was cold during his/her bed bath. He/she stated the temperature of the water for his/her bed bath was generally uncomfortably cool. Interviews with Residents #26 and #27, on 06/19/13 at 1:37 PM and 1:39 PM respectively revealed the shower in their room and/or the resident shower down the hall had "not so hot water" and "even if they let it run for a while it still doesn't get warm enough for them most of the time. Observation, on 06/20/13 at 9:58 AM with the Maintenance Director, revealed twenty (20) resident bathing areas (five (5) showers and	F 246	filing the basin or showering residents. Also, what to do if the residents complain of the water temp. Any nursing staff that have not received the education prior to 8/2/13 will be removed from the schedule and not allowed to work until the education has been provided. Social workers/Program Director will interview 2 residents a week on each hall to ensure residents are not uncomfortable with water temps for the next three months and residents will be asked about water temps during the monthly resident council meeting for the next three months. Maintenance director will check mixing valve daily (Monday- Friday) to ensure temps leaving water heater to resident floors is maintained at 110 degrees. Maintenance director will log water temps in two rooms per unit weekly for resident areas 4. How the facility will monitor performance to ensure solutions are sustained: The results of the resident interviews and the water temps checked by maintenance will be tracked/trended and forwarded to the monthly PI meeting for three months or until compliance is achieved.	

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F 246	Continued From page 2 fifteen (15) resident rooms)and ten (10) of the twenty (20) areas revealed water temperatures below 100 degrees at the hot setting without cold blending. An interview with SRNA #11, on 06/19/13 at 1:30 PM, revealed the hot water takes a while to warm up, especially in the morning after the staff haven't used it all night, so staff have to turn it on and let it run for about 5 minutes to get it warm sometimes. An interview with SRNA #2, on 06/20/13 at 3:00 PM, revealed she would ensure the water temperature for a bed bath just like she would for kids, she would test the temperature on the wrist or elbow to make sure it was warm enough. The SRNA stated if the water was not warm enough she would throw it out and start over and let the water run for a while until it got warm. An interview with SRNA #5, on 06/20/13 at 3:06 PM, revealed she tests the water before starting a bath or shower. The SRNA stated she has to let the water run a minute to let it warm up, but if the resident complains the water is too cool, more water can be added to warm it up.	F 246		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the	F 280	F280 – Right to participate Planning Care-Revise CP 1. Corrective action for those residents found to have been affected: Resident #8's care plan was immediately reviewed by the Interdisciplinary Team and updated on 6/20/13 to reflect that there was no longer a need for a bed sensor alarm.	8/2/13

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F 280	Continued From page 3 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the comprehensive care plan was reviewed and revised for one resident (#6), in the selected sample of twenty-four (24) residents. Findings include: A review of the facility's Care Plans policy/procedure, dated 01/07/12, revealed the team of qualified persons monitored the patients' condition and effectiveness of the care plan interventions and revised the care plan quarterly, annually, with a significant change assessment, or more frequently as needed with the input of the patient and/or the representative, to the extent possible. Record review revealed Resident #6 was	F 280	2. Corrective action for those with potential to be affected: House wide audit was conducted by nursing management on residents that were readmitted within the last three months to ensure physician orders, care plans and SRNA assignment sheets were correct. Audit will be completed before July 26. Any concerns will be corrected at that time. 3. Systemic changes to ensure the deficient practice will not recur: MDS nurses will close the care plan when they are completing the discharge assessment. When a resident is re-admitted the Interdisciplinary Team will open the care plan and update as needed based on the MD orders and resident assessments. 4. How the facility will monitor performance to ensure solutions are sustained: MDS nurses will maintain a log with discharged and re-admitted residents which will be turned in to the DNS/ADNS weekly. This information will be tracked and trended by the DNS to identify any further education or actions needed. Results will be presented to the PI Meeting monthly for three months or longer until compliance is sustained.	

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F 280	Continued From page 4 admitted to the facility on 02/28/13 with diagnoses to include Chronic Pancreatitis, Congenital Anomaly of the Heart, and Congested Heart Failure. A review of the quarterly Minimum Data Set (MDS), dated 05/17/13, revealed the facility assessed the resident as cognitively intact and independent with transfer and ambulation. A review of the Fall Evaluations, dated 06/02/13, 06/04/13, and 06/06/13, revealed the resident sustained a fall while ambulating without assistance. A review of the Physician's Orders, dated 06/06/13, revealed an order for a sensor pad at all times due to decreased safety awareness. Further record review revealed the resident was transferred to the hospital, on 06/07/13, with an infection. A review of the Admission Orders Record, dated 06/13/13, revealed the resident was re-admitted to the facility on this date. A review of the State Registered Nurse Aide (SRNA) assignment sheet, updated 06/18/13, and the Risk for Falls Care Plan, revised 06/07/13, verified the sensor pad at all times. Observations, on 06/19/13 at 8:40 AM, 10:20 AM, 12:00 PM, 3:10 PM, and 06/20/13 at 9:30 AM, revealed Resident #8 was in the bed with no sensor alarm visualized. Observation, on 06/20/13 at 10:15 AM, revealed the resident ambulated to the bathroom without assistance and no alarm sounded. Interview with Resident #8, on 06/19/13 at 3:10 PM, revealed he/she gets up without assistance and did not have an alarm to the bed. Interview with Unit Manager #1, on 06/20/13 at	F 280		

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F 280	Continued From page 5 10:55 AM, revealed the sensor alarm was ordered after a fall, on 06/06/13. She revealed the resident was sent to the hospital on 06/07/13, and returned on 06/13/13. The resident did not need the alarm upon return to the facility; however, the care plan was not updated. She revealed it was her responsibility to update the care plans/SRNA assignment sheets upon re-admission. Interview with the Assistant Director of Nursing (ADON), on 06/20/13 at 1:55 PM, revealed Resident #8 was cognitively intact and independent, unless he/she had an infection. The resident was sent out for an infection, on 06/07/13. The resident did not require an assistive device upon return, 06/13/13. She revealed Unit Manager #1 did the chart review upon the resident's re-admit to the facility and was responsible to update the care plans/SRNA assignment sheet at that time. Interview with the Director of Nursing (DON), on 06/20/13 at 2:15 PM, verified Unit Manager #1 was responsible for updating the care plan/SRNA assignment sheets upon the resident's re-admission.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by. Based on observation, interview, record review	F 281	F281 – Services Provided Meet Professional Standards 1. Corrective action for those residents found to have been affected: Resident #5 was supplied with ear protectors for the oxygen tubing on 6/20/13. Care plan was updated by the DNS to show potential behavior for resident taking off the car protectors.	8/2/13

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F 261	Continued From page 6 and a review of the facility policy, it was determined the facility failed to ensure services meet professional standards of quality related to the failure to carry out the physician orders for one (1) resident (#5), in the selected sample of twenty four (24) residents. The facility failed to follow the physician's orders for foam ear padding around the oxygen (O2) nasal cannula tubing for Resident #5. Findings include: Review of the facility policy titled, Oxygen Therapy and dated 8/31/12, revealed procedure #1 "Verify physician order or implement per approved facility protocol". A record review revealed Resident #5 was admitted to the facility with diagnoses to include Senile Dementia, Glaucoma, Psychosis and Depression. Review of the quarterly Minimum Data Set (MDS) assessment, dated 05/03/13, revealed the facility had assessed Resident #5 as cognitively impaired and required extensive assistance with all activities of daily living. Review of the Physician's orders, dated 06/01/13 through 06/30/13, revealed Resident #5 was to have O2 at two (2) liters per minute (l/m) per nasal cannula continuous and foam ear protectors on oxygen tubing. Observations on 06/19/13 at 8:30 AM revealed Resident #5 was in a wheelchair in the lobby area with O2 per nasal cannula from a portable oxygen tank attached to the back of the wheel chair.	F 281	2. Corrective action for those with potential to be affected: All residents on oxygen were checked by nursing management to ensure they had ear protectors for their tubing and that they were in place on 6/20/13. Any residents with identified behavior of picking at their ear protectors will have this noted by the interdisciplinary team on their behavior sheets, aide assignment sheets and included in their care plan as of July 19, 2013. 3. Systemic changes to ensure the deficient practice will not recur: New orders for oxygen will be reviewed daily (M-F) at standup meetings. Weekend Supervisor will review MD orders on the weekend for any new orders to ensure the oxygen foam ear protectors are on the Treatment Administration Record (TAR). All nursing staff will be in serviced by the Staff Development RN or DNS on importance of placement of ear protectors at all-staff meetings the week of July 15th. Any nursing staff that have not received the education prior to 8/2/13 will be removed from the schedule and not allowed to work until the education has been provided. Weekly audits of tubing changes and audits of all residents with oxygen will be done by the Unit Managers.	

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F 281	Continued From page 7 Additional observations at 9:30 AM, 10:30 AM, 12:00 PM, 1:00 PM, 2:00 PM and 3:15 PM on 06/19/13 revealed Resident #5 in the lobby area with peers with O2 per nasal cannula and no foam ear protectors in place. Observation, on 06/20/13 at 9:25 AM during a skin assessment being provided by Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1, revealed Resident #5 with O2 per nasal cannula but no foam ear protectors were in place on the oxygen tubing. RN #1 and LPN #1 verified there were no foam ear protectors in place on the oxygen tubing. Observation on 06/20/13 at 12:55 PM revealed Resident #5 resting in bed with O2 per nasal cannula and there was still no foam ear protectors in place. Interviews on 06/20/13 with RN #1, LPN #1 and the Corporate Compliance Officer at 1:00 PM, 1:05 PM and 1:15 PM respectively, revealed foam ear protectors come with the O2 tubing and Resident #5 often picks them off. They additionally stated nurses were to check every day to ensure the foam ear protectors were in place and were to document on the Medication Administration Record (MAR). Interviews with the Director of Nursing and the Assistant Director of Nursing, on 06/20/13 at 1:20 PM and 2:30 PM respectively, revealed they expected the nurse to ensure Resident #5 was provided the foam ear protectors as prescribed by the physician.	F 281	4. How the facility will monitor performance to ensure solutions are sustained: TARS will be monitored monthly by the Unit Managers during changeover to ensure that each resident has their oxygen tubing on the TAR. Results of the weekly audits by the Unit Managers will be forwarded to the DNS to be tracked and trended and reviewed at the monthly PI meeting for three months or until compliance is achieved.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282	F282 – Services by Qualified Persons/Per Care Plan	8/2/13

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F 282	Continued From page 8 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/procedure review it was determined the facility failed to ensure care was provided in accordance to the resident's care plan for one (1) resident (#8), in the selected sample of twenty four (24) residents. Resident #8 had no safety alarm in place as per the care plan. Findings include: Review of the facility policy titled "Care Plans, dated 01/07/12, revealed documentation under Rationale: "Plan of care is developed on the patient's individual needs as identified by assessments. The care plan includes a treatment plan, patient's preferences, patient goals that are measurable and contain a schedule to evaluate the patient's progress of lack of progress toward his/her goals". Record review revealed Resident #8 was admitted to the facility on 02/28/13 with diagnoses to include Chronic Pancreatitis, Congenital Anomaly of the Heart, and Congested Heart Failure. A review of the quarterly Minimum Data Set (MDS) assessment, dated 05/17/13, revealed the facility assessed the resident as cognitively	F 282	1. Corrective action for those residents found to have been affected: Resident #8's care plan was immediately reviewed by the Interdisciplinary Team and updated on 6/20/13 to reflect that there was no longer a need for a bed sensor alarm. 2. Corrective action for those with potential to be affected: House wide audit was conducted by nursing management on residents that were readmitted within the last three months to ensure physician orders, care plans and SRNA assignment sheets were correct. Audit will be completed by July 26. Any concerns will be corrected at that time. 3. Systemic changes to ensure the deficient practice will not recur: MDS nurses will close the care plan when they are doing the discharge assessment. When a resident is re-admitted they will open the care plan and ensure orders match. DNS/ADNS will conduct weekly observation rounds of at least 5 residents per hall to validate that care plan interventions match the assignment sheet and are being implemented. Any identified concerns will be immediately addressed.	

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F 282	Continued From page 9 intact and independent with transfer and ambulation. A review of the Fall Evaluations, dated 06/02/13, 06/04/13, and 06/06/13, revealed the resident sustained a fall while ambulating without assistance. A review of the Physician's Orders, dated 06/06/13, revealed an order for a sensor pad at all times due to decreased safety awareness. A review of the State Registered Nurse Aide (SRNA) assignment sheet, updated 06/18/13, and the Risk for Falls Care Plan, revised 06/07/13, verified the sensor pad at all times. Observations, on 06/19/13 at 8:40 AM, 10:20 AM, 12:00 PM, 3:10 PM, and 06/20/13 at 9:30 AM, revealed Resident #8 was in the bed with no sensor alarm visualized. Observation, on 06/20/13 at 10:15 AM, revealed the resident ambulated to the bathroom without assistance and no alarm sounded. An interview with Resident #8, on 06/19/13 at 3:10 PM, revealed he/she gets up without assistance and did not have an alarm to the bed. Interview with SRNA #4, on 06/20/13 at 12:55 PM, revealed she was the aide for Resident #8, on 06/19/13. She revealed the resident went to the bathroom without assistance and did not have an alarm to the bed. She verified the SRNA assignment sheet indicated a sensor alarm; however, she revealed it was not noticed on 06/19/13. Interview with SRNA #3, on 06/20/13 at 10:40 AM, revealed she was the aide for Resident #8, on 06/20/13. She verified the resident did not	F 282	4. How the facility will monitor performance to ensure solutions are sustained: MDS team will fill out a log with discharged and re-admitted residents which will be turned in to the DNS/Designee weekly. This log and the results of the DNS/ADNS weekly observation rounds will be reviewed at the PI Meeting monthly for three months or until compliance is achieved.	

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F 282	Continued From page 10 have an alarm on the bed. She verified the SRNA assignment sheet indicated a sensor alarm at all times, and revealed she was supposed to check the assignment sheet prior to providing care. Interview with the Director of Nursing (DON), on 06/20/13 at 2:15 PM, revealed she expected staff to follow the SRNA assignment sheets.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to consistently implement the care plan to prevent pressure sores for one resident (#5) in the selected sample of twenty four (24) residents. The facility failed to ensure ear protectors were in place on Resident #5's oxygen tubing to prevent pressure sores. Findings include: Resident #5 was admitted to the facility with diagnoses to include Senile Dementia, Glaucoma, Psychosis and Depression. Review	F 314	F314 – Treatment/Svcs to prevent/heal pressure Sores 1. Corrective action for those residents found to have been affected: Resident #5 was supplied with ear protectors for the oxygen tubing on 6/20/13. Care plan was updated by the DNS to show potential behavior for resident taking off the ear protectors. 2. Corrective action for those with potential to be affected: All residents on oxygen were checked by nursing management to ensure they had ear protectors for their tubing and that they were in place on 6/20/13. Any residents with identified behavior of picking at their ear protectors will have this noted by the interdisciplinary team on their behavior sheets, aide assignment sheets and included in their care plan as of July 19, 2013. All current residents were reviewed by Licensed Nurses to validate risk factors for skin breakdown are addressed on the care	8/2/13

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	185120	A. BUILDING _____ B. WING _____	06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

(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 314	Continued From page 11 of the quarterly Minimum Data Set (MDS), dated 05/03/13, revealed the facility had assessed Resident #5 as cognitively impaired and required extensive assistance with all activities of daily living. Review of Physician's Orders, dated 06/01/13 through 06/30/13, revealed Resident #5 was to have oxygen at 2/L per minute per nasal cannula continuous and foam ear protectors on oxygen tubing. Review of Resident #5's care plan for shortness of breath, dated 06/2013, revealed an intervention to use foam ear protectors on line of tubing. Observations on 06/19/13 at 8:30 AM, 9:30 AM, 10:30 AM, 12:00 PM, 1:00 PM, 2:00 PM and 3:15 PM revealed Resident #5 with oxygen per nasal cannula and no foam ear protectors in place at the time. Observation on 06/20/13 at 9:25 AM during a skin assessment with Registered Nurse (RN) #1 and Licensed Practical Nurse (LPN) #1 revealed Resident #5 had oxygen per nasal cannula but there were no foam ear protectors in place on the oxygen tubing. RN #1 and LPN #1 verified there were no foam ear protectors in place on the oxygen tubing. Further observation on 06/20/13 at 12:55 PM revealed Resident #5 was resting in bed and there was still no foam ear protectors on the resident's oxygen tubing. Interviews on 06/20/13 with RN #1, LPN #1 and the Corporate Compliance Officer at 1:00 PM, 1:05 PM and 1:15 PM respectively, revealed foam ear protectors come with the oxygen tubing and	F 314	plan with interventions to prevent pressure sores implemented. 3. Systemic changes to ensure the deficient practice will not recur: New orders for oxygen will be reviewed daily at standup meetings (M-F). Weekend Supervisor will review MD orders on the weekend for any new orders to ensure the oxygen foam ear protectors are on the TAR. All nursing staff will be in serviced by the Staff Development RN or DNS on importance of placement of ear protectors at all-staff meetings the week of July 15th. Any nursing staff that have not received the education prior to 8/2/13 will be removed from the schedule and not allowed to work until the education has been provided. Weekly audits of tubing changes and audits of all residents with oxygen will be done by the Unit Managers. DNS/ADNS will conduct weekly observation rounds of at least 5 residents per hall to validate that care plan interventions to reduce pressure sores match the assignment sheet and are being implemented. Any identified concerns will be immediately addressed. 4. How the facility will monitor performance to ensure solutions are sustained: TARS will be monitored monthly by the Unit Managers during changeover to ensure that each resident has their oxygen tubing on the TAR.	

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F 314	Continued From page 12 Resident #5 often picks them off. Resident #5 had a care plan intervention for foam ear protectors to prevent skin breakdown. They additionally stated nurses were to check every day to ensure the foam ear protectors were in place and were to document on the Medication Administration Record (MAR). Interviews with the Director of Nursing and the Assistant Director of Nursing, on 06/20/13 at 1:20 PM and 2:30 PM respectively, revealed they expected the nurse to ensure Resident #5 was provided the foam ear protectors as prescribed by the physician and per the resident's plan of care.	F 314	Results of the weekly audits by the Unit Managers will be forwarded to the DNS to be tracked and trended and reviewed at the monthly PI meeting for three months. DNS/ADNS will conduct weekly observation rounds of at least 5 residents per hall to validate that care plan interventions match the assignment sheet and are being implemented. Any identified concerns will be immediately addressed. Results of weekly observation rounds will be reviewed at the monthly PI meeting for three months or until compliance is achieved.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and a review of the facility policy, it was determined the facility failed to ensure the medication administration rate was less than five (5) percent. A review of 25 medication administration opportunities revealed three medication errors, for a medication administration error rate of 16 percent, related to an incorrect medication dose, a medication not administered with food and two medications that were crushed and on the "Medications Not To Be Crushed" list. Findings include:	F 332	F332 – Free of Medication Error Rates of 5% or More 1. Corrective action for those residents found to have been affected: Resident #17 and #25 had a medication error documented with the Medical Director notified. Resident #25's order for enteric coated aspirin was discontinued. 2. Corrective action for those with potential to be affected: A house wide audit of residents with diabetes will be done by nursing management by July 19 to ensure timing of oral medications is being done according to manufacturer's recommendation.	8/2/13

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F 332	Continued From page 13 A review of the facility policy, "Medication Administration," dated 06/15/12, revealed medications were to be administered within 60 minutes of the schedules time of administration, except for before and after meals, which are based on scheduled meal times and administered within 30 minutes of the meal. The medications were to have been prepared using the five rights of medication administration: The right resident, right medication and strength, the right time of administration, the right frequency and route of administration. 1. An observation of a medication administration pass, on 06/19/13 at 8:45 AM, revealed Amaryl, a Diabetic medication, was administered to Resident #17. A review of the Medication Administration Records (MARs,) dated 06/2013 and the Admission Orders Record, revealed the Amaryl was scheduled to have been administered at 7:00 AM, "before breakfast." An interview with Certified Medication Assistant (CMA) #1, on 06/19/13 at 8:50 AM, revealed the Amaryl should have been administered with the breakfast meal, which was delivered at approximately 7:20 AM. 2. An observation of a medication administration pass, on 06/19/13 at 9:05 AM, revealed CMA #1 administered Enteric Coated Aspirin and Lanoxin that were crushed and placed in applesauce to Resident #25. In addition, one tablet of Calcium 500 mg was administered. A review of the MARs and physician orders, for	F 332	A med cart to medication record/MD orders audit will be done by Nursing managers and CMTs by August 2nd. to ensure correct medications are on hand as ordered by the physician. Residents with orders for crushed medications will be reviewed by the pharmacist to determine appropriate medication has been ordered. Medication pass times will be reviewed by the DNS/ADNS for each hall to ensure appropriate time frames by July 19th. Education to be completed for all CMT's and licensed nurses regarding med pass to include timing of diabetic medications and crushing meds per DO NOT CRUSH guidelines. Education scheduled for July 25 per pharmacy consultant/ DNS. Any licensed nursing staff that have not received the education prior to 8/2/13 will be removed from the schedule and not allowed to work until the education has been provided. 3. Systemic changes to ensure the deficient practice will not recur: Timing for medication will be reviewed during daily standup meeting with order changes. Pharmacy review of crushed medications will be done monthly. The monthly report will be forwarded to the monthly PI committee for review for the next three months.	

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F 332	Continued From page 14 06/2013, revealed an order "May crush all crushable meds." There was no indication on the MARs of what may or may not be crushed. However, a review of the facility's "Medications Not To Be Crushed List," dated 12/2010, revealed the Enteric Coated Aspirin and the Lanoxin were not to be crushed. In addition, the Calcium 500 milligrams was ordered for two tablets, to equal 1000 milligrams. An interview with CMA #1, on 06/19/13 at 9:20 AM, revealed she should have checked the facility's "Medication Not To Be Crushed List," prior to crushing the medications and should have administered two of the Calcium tablets. An interview with the DON and the ADON, on 06/20/13 at 2:40 PM, revealed the Amaryl should have been given with meals and the physician orders for the right dosage of the Calcium, should have been administered.	F 332	Med Pass observations will be done by nursing management for all CMT's and nurses to validate learning by August 2nd. 4. How the facility will monitor performance to ensure solutions are sustained: Med pass competencies will be done by SDC on 3 nurses or CMT's per month for the next three months. The results of these checks will be reviewed at the monthly PI committee meeting. Pharmacy consultant will receive a list of residents with crushed meds and he will review with the monthly drug regimen review. This information will be reviewed at the monthly PI meeting for the next three months or until compliance is achieved.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441	F441 – Infection Control, Prevent Spread, Linens 1. Corrective action for those residents found to have been affected: SRNA #1 and #2 were re-in serviced on appropriate hand washing on 6/19/13 by the SDC. Both employees were observed doing a return demonstration by the SDC to ensure accuracy. LPN#3 was re-educated regarding the requirements to disinfect the glucometer after each use by the DNS on 6/19/13 .	8/2/13

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F 441	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate hand washing when indicated by accepted professional practice for one resident (#1) in the selected sample of twenty-four (24) residents. In addition, the facility failed to ensure a glucometer was cleansed after use. Findings include: 1. Review of the Hand Hygiene/Handwashing policy/procedure, dated 08/31/11, revealed hand hygiene was to be performed in the following	F 441	2. Corrective action for those with potential to be affected: Re-education was started by the SDC with all SRNA's on hand washing techniques on 6/19. All nursing employees will be re-trained by 7/15/13. Nurses will be re-in serviced on the disinfection of glucometers at the nurses meeting on July 25th by the DNS. Any nursing staff that have not received the education prior to 8/2/13 will be removed from the schedule and not allowed to work until the education has been provided. 3. Systemic changes to ensure the deficient practice will not recur: SDC will check hand washing competencies upon hire, annually and during weekly infection control rounds. All nursing staff will be reinserviced quarterly at all-staff meetings.. A spot was designated for each med cart where bleach wipes are to be kept on June 20th. Extra wipes will be in Central Supply with 24 hour access by nursing staff. 4. How the facility will monitor performance to ensure solutions are sustained:	

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F 441	Continued From page 16 situations: 1. After touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves were worn. 2. Between tasks and procedures on the same patient when contaminated with body fluids to prevent contamination of different body sites. 3. Intermittently after gloves were removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments. Additionally, the procedure revealed to change gloves during patient care if moving from a contaminated body site to a clean body site. Observation of Resident #1, on 06/19/13 at 2:30 PM, revealed State Registered Nurse Aide (SRNA) #1 and #2 performed incontinent care on the resident. SRNA #1 cleansed and rinsed the resident's perineal area, then SRNA #2 cleansed the buttocks and applied a barrier cream. After care, both SRNA's repositioned the resident in bed and placed a wedge behind him/her while wearing soiled gloves. SRNA #1 then removed her gloves; however, SRNA #2 covered the resident with a blanket and gathered supplies from the resident's bedside table wearing the soiled gloves. SRNA #2 removed the soiled gloves and left the resident's room with a bag of dirty linen. She did not wash her hands prior to leaving the resident's room. She took the bag to the soiled utility room, then came out and used hand sanitizer in the hallway. Interview with SRNA #1, on 06/19/13 at 2:52 PM, revealed she should have removed the soiled gloves immediately after providing incontinent care. She should have washed her hands and	F 441	Availability of bleach wipes will be checked through infection control rounds by the SDC and reported at the weekly Infection Control Meeting. SDC will conduct observations of at least 3 employees weekly to validate correct infection control techniques with resident care and hand washing. Any identified concerns will be addressed immediately. Results of SDC employee observations and Infection Control rounds will be tracked and trended and reported to the monthly PI meeting for the next three months or until compliance is achieved.	

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F 441	Continued From page 17 donned a new pair of gloves to reposition the resident. Interview with SRNA #2, no 06/18/13 at 2:50 PM, revealed she should have put a new pair of gloves on after providing incontinent care. She did not wash her hands prior to leaving the resident's room as she had soiled linen bags in her hand. SRNA #2 revealed she should have washed her hands before leaving the room. Interview with the Director of Nursing (DON), on 06/20/13 at 2:15 PM, revealed she expected staff to follow the policy related to handwashing. She expected staff to take off soiled gloves and wash their hands after providing incontinent care. Staff should also wash their hands before exiting a resident's room. 2. A review of the policy for "Blood Glucose Monitoring Using A Glucometer," dated 08/31/12, revealed, after obtaining the glucometer reading and discarding the test strip, the glucometer was to be cleaned, using a 10 percent (%) bleach wipe solution moistened wipe, between each patient. An observation of blood glucose level monitoring for Resident #11, on 06/19/13 at 3:20 PM, revealed Licensed Practical Nurse (LPN) #3 failed to disinfect the glucometer after obtaining the reading and left the glucometer on the top of the chart while administering medications to two other residents. An interview with LPN #3, on 06/19/13 at 3:50 PM, revealed the nurse was aware the glucometer had to be cleaned with bleach wipes	F 441		

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F 441	Continued From page 18 and had "just forgot" to clean the glucometer. However, there were no bleach wipes on the cart and the LPN had to go and obtain these from a locked shower room. An interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON,) on 06/20/13 at 2: 40 PM, revealed they would have expected the glucometer to have been cleaned, with bleach wipes, after each use.	F 441		

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1964 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type I (222) SMOKE COMPARTMENTS: Seven (7) smoke compartments FIRE ALARM: Complete fire alarm system with heat detectors . SPRINKLER SYSTEM: Complete automatic wet and dry sprinkler system. GENERATOR: Type II generator. Fuel source is diesel. A standard Life Safety Code survey was conducted on 06/19/13. Kindred Transitional Care Center-Owensboro was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred fifty six (156) beds with a census of one hundred thirty three (133) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the 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 provisions of federal and state law.* RECEIVED JUL 2013 OFFICE OF INSPECTOR GENERAL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

John Kerr, ED — 7/23/13

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

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K 000	Continued From page 1 Fire) Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, residents, staff and visitors. The	K 018	K018 1. Corrections to doors on rooms #11, 52, 58 and 68 have been corrected as of 7/12/13. 2. All other doors were audited to ensure compliance. 3. Weekly door audits will be conducted and documented with corrections made immediately to ensure compliance. 4. Door audits will be reported to monthly PI committee for three months to ensure continued compliance.	7/13/13

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KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

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K 018	Continued From page 2 facility is certified for one hundred fifty six (156) beds with a census of one hundred thirty three (133) on the day of the survey. The findings include: Observation, on 06/19/13 between 9:30 AM and 3:00 PM, with the Director of Maintenance revealed the corridor doors to room's #11, 52, 58, and 68 would not latch when tested. Interview, on 06/19/13 between 9:30 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware the doors would not latch. Reference: NFPA 101 (2000 edition) 18.3.6.3.1* Doors protecting corridor openings shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. 18.3.6.3.2 Doors shall be provided with positive latching hardware. Roller latches shall be prohibited. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. 18.3.6.3.3* Hold-open devices that release when the door is	K 018		

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	185120	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/19/2013

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KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

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K 018	Continued From page 3 pushed or pulled shall be permitted.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, patients, staff and visitors. The facility is certified for one hundred fifty six (156) beds with a census of one hundred thirty three (133) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas. The findings include: Observation, on 06/19/13 between 9:00 AM and 3:00 PM, with the Director of Maintenance revealed rooms required being self-closing or containing a hazardous amount of combustibles	K 029	K029 1.Door closer was initiated on Housekeeping closet on Unit 6 on 7/10/13. Door closer installed on Nutritional Services Office on 7/11/13. 2. All other doors were audited to ensure compliance. 3. Weekly door audits will begin week of July 15 and documented with corrections made immediately if needed. 4. Door audits will be reported to monthly PI committee for three months to ensure continued compliance.	7/12/13

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KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORO RD OWENSBORO, KY 42303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4 did not have self-closing device to keep the door closed. The rooms identified as hazardous requiring a rated door with a self-closing device were located in the following areas: 1) The Housekeeping Closet located in Unit 6, opened outward into the egress path and was greater than seven inches from the wall when fully opened. 2) The Nutritional Services Office had hazardous amounts of combustibles and the door did not have a self-closing device. Interview, on 06/19/13 between 9:00 AM and 3:00 PM, with the Director of Maintenance revealed he was not aware the doors to these rooms did not meet the requirements for protection from hazards. 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic	K 029		

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K 029	Continued From page 5 extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 18.3.2 Protection from Hazards. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated.	K 029		

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K 029	Continued From page 6 Table 18.3.2.1 Hazardous Area Protection Hazardous Area Description Separation/Protection Boiler and fuel-fired heater rooms 1 hour Central/bulk laundries larger than 100 ft2 (9.3 m2)1 hour Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4 Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour Physical plant maintenance shops 1 hour Soiled linen rooms 1 hour Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) storing combustible material See 18.3.6.3.4 Storage rooms larger than 100 ft2 (9.3 m2) storing combustible material1 hour Trash collection rooms 1 hour	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056	K056 1. The 155 degree sprinkler heads located in the dining room and Unit 5 conference room have been replaced with new 165 degree sidewall sprinkler heads. The work was completed by Tri-State Fire Protection on 7/3/13.	7/4/13

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K 056	Continued From page 7 supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system installed, in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred fifty six (156) beds with a census of one hundred thirty three (133) on the day of the survey. The facility failed to ensure the facility sprinkler heads were of the same temperature rating in a compartment. The findings include: Observation, on 06/19/13 between 9:30 AM and 3:00 PM, with the Director of Maintenance revealed sprinkler heads were installed within the same compartment that were not of the same temperature rating. The sprinkler heads were mixed ratings of 155 degree F, and 165 degree F. The mixed rating sprinkler heads were located in the Dining Room, and the Unit 5 Conference Room. Interview, on 06/19/13 between 9:00 AM and 3:00 PM, with the Director of Maintenance revealed they were not aware of the mixed sprinkler heads	K 056	2. House wide building audit conducted to ensure compliance 3. Weekly sprinkler audits will be conducted and documented with corrections made immediately to ensure compliance. 4. Sprinkler audits will be reported to monthly PI committee for three months to ensure continued compliance.	

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K 056	Continued From page 8 located within the same compartment. Reference: NFPA 13 (1999 Edition) 5-13 8.1 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 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. Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from	K 056		

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K 056	Continued From page 9 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)	K 056		

Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B	Maximum Allowable Distance of Deflector Obstruction (in.)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	21/2
1 ft 6 in. to less than 2 ft	31/2
2 ft to less than 2 ft 6 in.	51/2
2 ft 6 in. to less than 3 ft	71/2
3 ft to less than 3 ft 6 in.	91/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	161/2
5 ft and greater	18

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).
Reference: NFPA 13 (1999 ed.)
5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.

Reference: NFPA 13 (1999 Edition)

7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the

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K 056	Continued From page 10 density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met: (a) The roof covering meets Class C	K 056		

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K 056	Continued From page 11 requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings. (b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 21/2 in. (6.4 cm) of concrete or gypsum fill. (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.	K 056		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on fire damper testing record review, and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for one hundred fifty six (156) beds with a census of one hundred thirty three (133) on the day of the survey. The facility failed to provide documentation that the smoke/fire dampers were tested within the last four (4) years. The findings include: Fire damper testing record review, on 06/19/13 at	K 104	K104 1. Fire Damper testing is scheduled week of 7/15/13 by Vanguard of Evansville. 2. A survey of entire building was done to ensure all fire dampers were identified, tested and documented on 7/19/13. 3. Monthly fire damper audits will be conducted and documented with corrections made immediately to ensure compliance. 4. Fire Damper audits will be reported to monthly PI committee for three months or until compliance is reached.	7/22/13

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K 104	Continued From page 12 10:30 AM, with the Director of Maintenance revealed the facility did not have documentation that fire/smoke dampers had been tested within the last four (4) years. Interview, on 06/19/13 at 10:30 AM, with the Director of Maintenance revealed he was not aware of the requirements for fire/smoke damper testing. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred fifty six (156) beds with	K 147	K147 1. Power strip was removed and a hardwired receptacle was installed. Stat strips are plugged into permanent hired wired receptacle as of 7/1/13. 2. An audit of entire building was done on 7/1/13 to ensure compliance. 3. All areas will be monitored through monthly room audits. 4. The results of the audits will be forwarded to the monthly PI committee for the next three months to ensure compliance.	7/2/13

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K 147	Continued From page 13 a census of one hundred thirty three (133) on the day of the survey. The facility failed to maintain proper use of power strips. The findings include: Observations, on 06/19/13 at 1:21 PM, with the Director of Maintenance revealed three (3) stat-strip chargers plugged into a power strip located in the Copy Room. Interview, on 06/19/13 at 1:21 PM, with the Director of Maintenance revealed he was not aware medical equipment outside of a resident room could not be plugged into a power strip. 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. Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring end equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K 147		