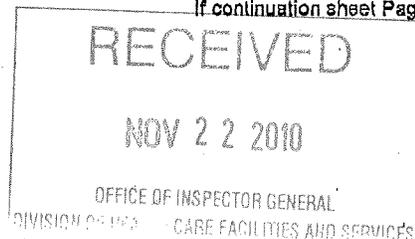


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/18/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2010
NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1166 EASTERN PARKWAY LOUISVILLE, KY 40217	
(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)
F 372	<p>Continued From page 1</p> <p>Observation of the dumpster area on 09/28/10 at 12:55pm revealed garbage piled above the opening of the trash compactor and uncovered. Observation at 1:45pm with the Dietary Manager revealed bags of garbage and pieces of cardboard in the opening of the compactor with shreds of plastic garbage bags and trash hanging over the side of the compactor. In addition, it was noted to have a dark liquid spilled down the side of the compactor that had pooled on the approximately 6 inch wide ledge and was on the ground approximately five feet long. There was a malodorous smell around the dumpster.</p> <p>Interview with the Dietary Manager (DM) on 09/28/10 at 1:45pm revealed housekeeping cleans at the end of the day. However, dietary is responsible for any spills as they bring the bin of garbage out and just lunge the bin so the garbage goes in the dumpster. This caused the spills down the side of the dumpster. The DM further stated this was the worse she had ever seen it.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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</p>	F 372	<p>Continued from page 1 F 372</p> <p>The Facility Manager and Dietary Manager are reviewing the daily checks for the garbage compactor and will take necessary actions for correction if any problems are noted. The Dietary manager will submit a report of the audits to the Performance Improvement Committee at the next two meetings at which time the continued frequency of the checks will be decided. The Compliance Officer will include monitoring of the dumpster area in her quarterly environmental audits.</p> <p>Completion Date: November 8, 2010</p> <p><i>F 441 D: Infection Control, Prevent Spread, Linens</i></p> <p>The medication carts and pitchers were immediately cleaned, during the survey. The masks for use with the mini-nebulizer in rooms 309 and 319 were replaced and stored in a plastic bag. The mini-nebulizer machines located in rooms 309, 315, 320 and 324 were cleaned.</p>
F 441 SS=D		F 441	



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NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217
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F 441	<p>Continued From page 2</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide routine drugs and pharmaceuticals to residents (including procedures that assure the accurate receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents. The medication carts on the third (3rd) and fourth (4th) floors were soiled inside and outside.</p> <p>The findings include:</p> <p>Observation of the Medication Cart (medications taken by mouth (PO) that supplied odd numbered</p>	F 441	<p>Continued from page 2</p> <p>F 441</p> <p>The staff nurses/CMTs thoroughly cleaned other medication carts that needed cleaning during the survey.</p> <p>The Respiratory Therapist checked mini-nebulizers and/or masks used for delivery of the mini-nebulizer treatment. Mini-nebulizer machines were cleaned. The masks that were not stored properly were replaced and plastic bags provided for use.</p> <p>The nurse educator conducted an inservice for nurses and CMTs and nursing assistants on the requirement to maintain resident equipment to help prevent the development and transmission of disease and infection. Special emphasis was placed on medication carts, mini-nebulizer machines and masks utilized for delivery of respiratory treatments.</p> <p>Nursing Administration is responsible to monitor the medication carts, nebulizers and masks weekly to ensure compliance with facility policy. Any concerns will be reported to the Assistant Director of Nursing.</p>	
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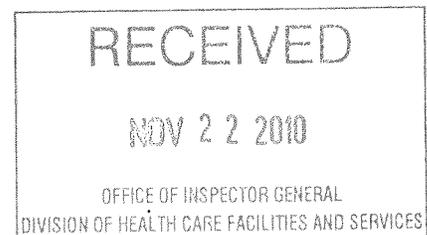
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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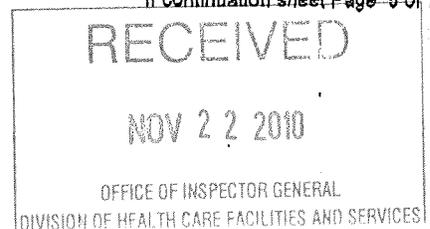
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F 441	<p>Continued From page 3</p> <p>rooms located on the 4th floor) on 09/28/10 at 10:55am revealed the cart drawers had loose brown, white, dusty, powdery substance in all the drawers. The exterior of the drawers had dried brown substance on the cart. The exterior pockets on the medicine carts had a loose white powdery substance. The water pitcher sitting on top of the medicine cart had a tan and pink substance dried and caked to the lower two inches of the pitcher and the base of the pitcher.</p> <p>Observation of the Medication Cart (medications taken by mouth (PO) that supplied even numbered rooms located on the 4th floor) on 09/28/10 at 11:08am revealed the cart drawers had loose brown, white dusty powdery substance in all the drawers. The exterior of the drawers had dried brown substance on the cart. The exterior pockets on the medicine carts had loose white powdery substance.</p> <p>Observation of the G-tube Cart located on the 4th floor on 09/28/10 at 11:08am revealed the cart drawers had loose brown, white dusty powdery substance in all the drawers. The exterior of the drawers had dried brown substance on the cart. The exterior pockets on the medicine carts had loose white powdery substance identified in them. The laminated sheet of paper on top of the cart had a thick brown, dried, caked substance around the borders and edges.</p> <p>Interview with Licensed Practical Nurse (LPN) #11 on 09/28/10 at 11:00am reported the night shift is suppose to clean the carts on nights, and each shift is suppose to clean after each shift. The LPN reported there is a cleaning schedule on the chart rack.</p>	F 441	<p>Continued from page 3 F 441</p> <p>The Assistant Director of Nursing will give a report at the Process Improvement quarterly meeting for the next 4 quarters. Changes will be made to the plan as indicated.</p> <p>Completion Date: November 8, 2010.</p>	



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F 441	<p>Continued From page 4</p> <p>Interview with LPN #10 on 09/28/10 at 11:08am reported the night shift is suppose to clean the carts on nights, and each shift is suppose to clean after each shift. The LPN reported there is a cleaning schedule on the chart rack.</p> <p>Interview with Unit Manager on 09/28/10 at 10:30am reported the night shift is suppose to clean the carts on nights, and each shift is suppose to clean after each shift. The Unit Manager reported there is a cleaning schedule on the chart rack and staff are to sign off on the schedule when the cleaning has been completed. She reported the cart (odd PO) was scheduled last week and she reported that it had not been signed off by the staff.</p> <p>Observation of the third (3rd) floor on 09/23/10 at 9:00am revealed the medication cart for the odd numbered resident rooms was heavily soiled on the outside and the inside. The medication cart outside was stained with an orange substance, white drips, and a brown build-up in the corners. The inside drawers of the medication cart were also soiled with tan and white particles, red and brownish dried drips, and bits of torn paper.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 09/23/10 at 9:30am, revealed the medication cart on the third (3rd) floor was soiled inside and outside and had not been cleaned recently. She stated the medication carts were to be cleaned by the night shift nurses.</p> <p>Observation of the third (3rd) floor on 09/26/10 at 10:00am revealed mini-nebulizers located in rooms 309, 315, 320, 324 that were soiled with brown dried substances and particles of debris. The masks used to deliver the mini-nebulizer</p>	F 441		



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F 441	Continued From page 5 treatments were not covered in rooms 309 and 319.	F 441		
F 465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain services necessary keep a sanitary, orderly, and comfortable interior for the residents. There were seven (7) wheelchairs and Geri-chairs with torn, worn and frayed upholstery.</p> <p>The findings include:</p> <p>Observation on 09/26/10 at 10:00am revealed torn, worn and frayed upholstery material on the arms of the wheelchairs for residents assigned to room 312B, 320B, 322A and 322B.</p> <p>Observation on 09/27/10 at 8:50am revealed the back of the Geri-chair for the resident in room 320B has torn upholstery material on the back of</p>	F 465	<p><i>F465: Environment - Wheelchairs/Geri-chairs</i></p> <p>The therapy assistant repaired the arms of the wheelchairs for residents assigned to rooms 312B, 320B, 322A, 322B and 413A by October 22nd. The therapy assistant repaired the Geri-chair for the residents in rooms 320B and 315B by October 15th.</p> <p>A review of wheelchairs and Geri-chairs was conducted by nursing staff by October 21st. A list of those needing repairs was given to the therapy department. The therapy department completed the replacement or repair of most of these chairs by Nov 8th. Parts have been ordered for chairs needing repair that could not be repaired with facility resources.</p> <p>The system for checking for needed repairs for resident equipment has been revised. The Unit Secretary for</p>	

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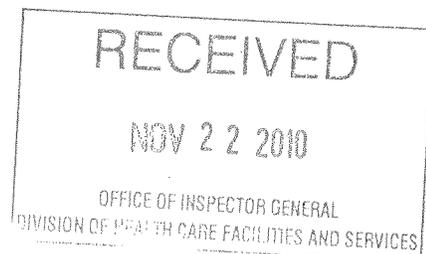
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NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217
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F 465	<p>Continued From page 6 the resident's Geri-chair.</p> <p>Observation on 09/27/10 at 9:02am, revealed torn, worn and frayed upholstery material on the arms of the wheelchair for the resident assigned to room 413A.</p> <p>Observation on 09/27/10 at 11:30am revealed the seat of the Geri-chair for the resident in room 315B has torn upholstery material on the seat of the resident's Geri-chair.</p> <p>Interview with the Director of the Therapy Department (DOT) on 11/28/10 at 4:30pm revealed the arms on the wheelchairs are repaired or changed out by the therapy department. She reported they do not have a system in place to routinely check on the resident's equipment, but when staff notifies the department for an equipment repair, then the therapy technician works from that list to repair. During the facility tour concurrently with the interview she reported the wheelchairs and Geri-chairs identified for 312B, 315B, 320B, 322A, 322B and 413A were not properly maintained and would not be able to be easily cleaned and sanitized for resident use.</p>	F 465	<p>Continued from page 6 F 465</p> <p>each floor is now responsible to conduct weekly rounds to determine any needed repairs of wheelchairs or geri chairs. She will communicate any needed repairs to the therapy department who will in turn repair or replace the equipment. The unit secretary will sign once the repair is completed.</p> <p>Nursing and housekeeping staff has been inserviced by the nurse educator to notify the Unit Secretary of any problems they observe related to resident equipment.</p> <p>The Therapy Manager will monitor the resident equipment repair requests to verify that the therapy assistant has completed the repairs.</p> <p>The Therapy Manager will report at the Process Improvement quarterly meeting for the next 4 quarters. Changes will be made to the plan as indicated.</p> <p>November 8, 2010</p>	
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NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217
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K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on September 29, 2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".</p> <p>K 038 SS=D NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors were maintained, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 09/29/10 at 10:45am revealed that a door located at the rear loading dock did not have a means of delayed egress or a way to override the magnetic lock on the door other than a coded key pad. The doors were located in an area that was not observable from a nurse's station. The observation was confirmed with the Director of Environmental Services.</p> <p>Interview on 09/29/10 at 10:45am, with the Director of Environmental Services, revealed that</p>	K 000	<p>K038: Exit Egress Doors</p> <p>The Facility Manager has contracted with an outside audio-video technician to upgrade the door located at the rear loading dock. Currently the door releases when the fire alarm sounds.</p> <p>The upgrade includes a mechanism that will disable the magnetic lock and allow the door to open immediately when the emergency button is pulled. In addition an alarm will be sounded at the 4th floor nurses station as well as at the receptionist area indicating the door has been opened.</p> <p>The Facility Manager will test this new device monthly for the next three months, then routinely on a quarterly basis. Any problems noted will be addressed immediately.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Barbara Schmitt RN Nursing Administrator 10/21/10

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 038	Continued From page 1 in order to exit the facility one must use a code. Further interview revealed the door releases when the fire alarm activates. Reference: NFPA 101 (2000 edition) 19.1.1.1.5 It shall be recognized that, In buildings housing certain types of patients or having detention rooms or a security section, it might be necessary to lock doors and bar windows to confine and protect building inhabitants. In such instances, the authority having jurisdiction shall make appropriate modifications to those sections of this Code that would otherwise require means of egress to be kept unlocked.	K 038	Continued from page 1 K 038 The Facility Manager will give a report at the Performance Improvement meeting quarterly for the next 4 quarters. This plan will be revised as needed. Completion Date: November 8, 2010 K048 F: Evacuation Plan	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure that a fire safety plan was followed, according to NFPA standards. The findings include: Interview on 09/29/10 at 12:08pm, with the Maintenance Director and the Director of Environmental Services, revealed the facility does	K 048	The facility's Fire and Evacuation Plan has been reviewed and revised. The revisions include the relocation of residents from one smoke compartment to another smoke compartment. An inservice was held for employees regarding the Fire and Evacuation Plan changes. Future fire drills will include testing staffs' knowledge and performance regarding relocation of residents from one smoke compartment to another.	

OCT 21 2010

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K 048	Continued From page 2 not practice relocation of residents from one smoke compartment to another smoke compartment. Further interview, with the Maintenance Director and the Director of Environmental Services, revealed that the facility was not aware that a fire safety plan should address relocation from one smoke compartment to another smoke compartment. Record review at 2:00pm, with the Director of Environmental Services, revealed that the facility's fire safety plan did not address the relocation of residents from one smoke compartment to another smoke compartment. Reference: NFPA 101 (2000 edition) Reference: NFPA 101 (2000 edition) 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.2.2 A written health care occupancy fire safety plan shall	K 048	Continued from page 2 K 048 The Facility Manager will give the Administrator results of staff performance during fire drills. The Administrator will review and take any action if deemed appropriate. The Facility Manager will give a report at the Performance Improvement meeting quarterly for the next 4 quarters. Revisions to the plan will be made as indicated. Completion Date: November 8, 2010	

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K 048	Continued From page 3 provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire	K 048		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained, according to NFPA standards. The findings include: Observation on 09/29/10 at 10:30am revealed that a sprinkler head located in a basement computer room was located too close to the wall. Further observation revealed paint and drywall mud was found to be on the sprinkler head. The observations were confirmed with the Maintenance Director. Interview on 09/29/10 at 10:30am, with the Maintenance Director, revealed the facility had constructed the Computer Room due to	K 062	<i>K062 Sprinkler System</i> The telephone room had just been installed prior to the survey and the final inspection had not yet been completed. The sprinkler head was relocated on September 30 and cleaned of paint and drywall mud. Maintenance and housekeeping checked sprinkler heads throughout the facility to ensure they were free of dust and debris. This was completed the week of October 4 th . The Facility Manager has revised the monthly preventive maintenance audit to include observation of cleanliness of sprinkler heads.	

OCT 21 2010

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

PRINTED: 10/12/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185122	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/29/2010
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NAME OF PROVIDER OR SUPPLIER PARKWAY MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1155 EASTERN PARKWAY LOUISVILLE, KY 40217
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K 062	Continued From page 4 computers located in the basement getting to hot and had not considered that the sprinkler head was too close to the wall of the Computer Room. Further interview revealed the Maintenance Director was unaware of the paint and drywall mud being on the sprinkler head. Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall. 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. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062	Continued from page 4 K 062 The Facility Manager will submit a report to the Performance Improvement meeting quarterly for the next year. Revisions to the plan will be made as needed. Completion Date: October 8, 2010 <i>K072 Egress free from obstruction</i>	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No	K 072	The items noted were removed from the corridors when brought to the attention of the staff.	

OCT 21 2010

ORIGINAL
DATE RECORDED

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K 072	Continued From page 5 furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that corridors were maintained free from obstructions in the case of fire or other emergencies, according to NFPA standards. The findings include: Observation on 09/29/10 at 12:30pm, revealed two residents using a card table for dining in the corridor next to resident room #620 on the sixth floor. Further observation at 12:45pm, revealed Hoyer Lifts in the corridor on the seventh floor next to resident rooms numbered 703, 715, and 718. Interview with the Maintenance Director on 09/29/10 at 12:30pm, indicated they had been using the card table for some time. Further interview indicated that the Hoyer Lifts would be moved from the corridors.	K 072	Continued from page 5 K 072 Nursing staff have been instructed to store resident lifts and other resident-care equipment in designated areas when not in use. These areas do not block corridors for means of egress. Nursing Administration is responsible to see that the units are free of obstructions or impediments that may obstruct egress. Problems will be addressed or referred to the Assistant Director of Nursing. The Assistant Director of Nursing will give a report at the Performance Improvement meeting quarterly for the next 4 quarters. The plan will be revised as indicated. Completion Date: November 8, 2010.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a linen	K 130	K130 Linen Chute In accordance with NFPA Standards the string has been removed and a wire with a fusible link was installed on October 19 th .	

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K 130	<p>Continued From page 6 chute discharge was protected according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 09/29/10 at 10:00am revealed that a linen chute located in the basement did not have an approved self closing device on the linen chute discharge. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 09/29/10 at 10:00am, with the Maintenance Director, revealed that the linen chute discharge door was held open with a string.</p> <p>Reference: NFPA 82 (1999 edition)</p> <p>3-2.2.9 Chute Discharge Doors. Gravity chutes shall be constructed so that the base opening of the chute or shaft, or both, shall be protected by an approved automatic-closing or self-closing 1-hour fire door suitable for a Class B opening.</p>	K 130	<p>Continued from page 6 K 130</p> <p>The Facility Manager will inspect the wire with a fusible link monthly for 3 months. The Fire Protection Agency that monitors all other fusible links in the facility on a yearly basis will monitor the new fusible link.</p> <p>The Facility Manager will give a report at the Performance Improvement meeting quarterly for the next 4 quarters.</p> <p>Completion Date: October 19th, 2010.</p>	

OCT 21 2010

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