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OFFICE OF INSPECTOR GENERAL
STATE OF HEALTH CARE FACILITIES
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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2014
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 OLD HIGHWAY 60 HARDINSBURG, KY 40143	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Health Survey was initiated on 03/05/14 and concluded on 03/07/14 with deficiencies cited at the highest scope and severity of an E. A Life Safety Code survey was initiated and concluded on 03/07/14 with deficiencies cited at the highest scope and severity of an F.	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to ensure housekeeping staff did not clean resident areas during two (2) of two (2) meals. Housekeeping were observed using chemicals, buffing floors and dusting on the residents' hallway. The findings include: Review of the facility's policy regarding Infection Prevention and Control (Nutritional Services), not dated, revealed all toxic cleaning products would be properly stored in a locked separate area from food products and toxic cleaning materials would be used in such a manner as not to contaminate food. A lunch meal observation (residents with lunch trays in their rooms with doors open), on 03/05/14	F 253	PLAN: Housekeeping will not be on the resident hallway performing job functions during meal times. PROCEDURE: Nutritional Services manager updated the policy on 3-23-14 to reflect that no cleaning or housekeeping will be done during meal times. Dietary staff, housekeeping staff, nurses and C.N.A.'s on the nursing facility will be educated on March 26 and 27, 2014 by Environmental Services Manager and Director of Nursing regarding changes to policy and job expectations. There is only one hallway of this facility of 18 beds therefore no other residents were affected that are not addressed by this intervention.	Completed: April 1, 2014

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

TITLE

(X6) DATE

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

Cynthia Pochman CNO, Interim CEO

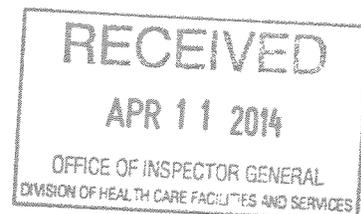
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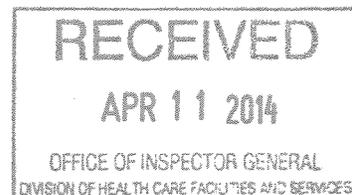
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F 253	<p>Continued From page 1</p> <p>at 12:20 PM, revealed housekeeping staff using a spray chemical on the resident hallway floor prior to buffing the floor. A breakfast meal observation, on 03/06/14 at 7:50 AM, revealed housekeeping staff using a dustmop and dusting cloth on the resident hallway when residents had trays in their rooms with the doors open.</p> <p>Interview with Housekeeper #1, on 03/06/14 at 10:12 AM, revealed she had been trained not to clean resident rooms while they were eating, but she was told it was okay to clean the common resident hallway or other rooms such as the activity room. She indicated she was not aware housekeeping chemicals, the buffer or the dustmop or dust cloth should not be used during a resident mealtime. Housekeeper #1 stated that using those items could contaminate the residents' food with chemicals or dust.</p> <p>Interview with the Housekeeping Supervisor, on 03/06/14 at 10:30 AM, revealed she had been trained it was okay to clean the resident hallway or common areas during the residents' mealtimes. She stated doing so could stir up dust which could get in the residents' food and contaminate the food. The Housekeeping Supervisor further stated the hallway and common rooms were cleaned during the residents' mealtimes because it was a small staff and a limited number of hours they worked.</p> <p>Interview with the Administrator, on 03/06/14 at 11:30 AM, revealed she had not noticed housekeeping cleaning the resident hallways during meal service. She indicated she was the acting Administrator but she knew that practice could cause a contamination concern with the residents' food. She stated there were no prior</p>	F 253	<p>MONITOR: Environmental Services Manager will monitor housekeeping staff at five meal passes a week for 90 days to ensure that no cleaning is done during meal times. This will be discussed and reviewed during Nursing Facility QA meetings and if 100% compliance is not met, plan will be re-evaluated and redesigned and then it will be continued for another 90 days if necessary.</p> <p>RESPONSIBLE PARTY: Director of Nursing, Environmental Services Manager and Nutritional Services Manager.</p>		



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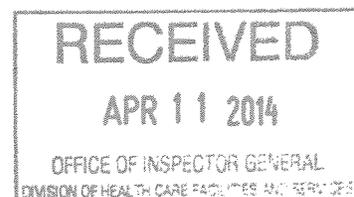
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F 253	Continued From page 2	F 253		Completed by: April 2, 2014	
F 323 SS=D	<p>concerns in the facility with food contamination to her knowledge.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy Resident Safety Plan, it was determined the facility failed to maintain an environment as free of accidents/hazards as possible for one (1) of two (2) unit elevators. The facility utilized an unsecured elevator on the resident living unit which went to the basement with access to a steep unlit stairway of greater than ten (10) steps.</p> <p>The findings include: Review of the facility's policy regarding Resident Safety Plan, dated 12/12/13, revealed the purpose of the plan was to improve resident safety and reduce resident risk. The policy revealed recognition and acknowledgment of risks to resident safety was encouraged. The facility provided no policy regarding the use of the unsecured elevator.</p> <p>Observation, on 03/05/14 at 9:30 AM, revealed an</p>	F 323	<p>IMMEDIATE ACTION: Stop signs were placed on elevator doors on the Nursing Facility Unit on March 6, 2014.</p> <p>PLAN: Furthermore, a key only access mechanism will replace the basement button in the elevator so that you will have to have a key to get to the basement of the building. Also, a key pad lock will be placed on the entrance to the stairway to the basement beside the kitchen from the first floor level. This facility only has 18 residents all located on the same hallway. There are no other elevators or unidentified exits on the resident hallway. Other exits have keypad coded locks and code alert alarms on them.</p>		



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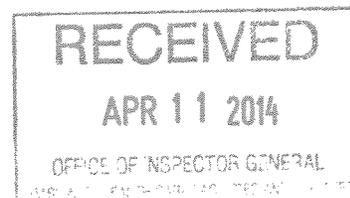
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F 323	Continued From page 3 unsecured elevator which opened onto the resident living unit accessible to ambulatory or mobile ambulatory residents without a roam alert device. Observation at that time also revealed the unsecured elevator went to the basement of the building with access to stairs with greater than ten (10) steps which were unlit with an unlocked door at the top of the stairs that led into the first (1st) floor of the building near the kitchen. Interview with the Safety and Compliance Officer, on 03/06/14 at 11:00 AM, revealed the ambulatory and mobile ambulatory residents could ride the unsecured elevator to the basement. He stated the basement room with access to a steep unlit stairway could be a potential danger to those residents and he had not recognized the potential danger of the unsecured elevator previously. The Safety and Compliance Officer stated there had been no incidents of residents riding the unsecured elevator alone either to the first (1st) floor or to the basement to his knowledge. Interview with the Director of Nursing (DON), on 03/06/14 at 11:20 AM, revealed the ambulatory and mobile ambulatory residents on the living unit could access the unsecured elevator, but none had done so to her knowledge. She stated she had not recognized the unsecured elevator as a potential hazard before. Interview with the Acting Administrator, on 03/06/14 at 11:40 AM, revealed the unsecured elevator going to the basement with access to a steep unlit stairway was a potential hazard to the residents.	F 323	PROCEDURE: Plant Operations Manager will obtain and install basement key lock mechanism onto elevator as well as keypad lock on stairwell doorway. Both locks were installed on 4-1-14. Life Safety Director will monitor for function weekly during safety monitor rounding on an ongoing basis. Compliance will be taken before quarterly QA meetings for 2 quarters. RESPONSIBLE PARTY: Plant Operations Manager/Life Safety Director		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441			



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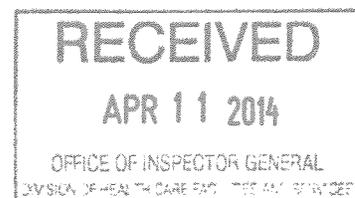
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F 441 SS=E	Continued From page 4 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and 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 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	PLAN: Residents in rooms 210 A & B, 212 A & B, 213 A & B were deemed no longer ill related to the virus in question and were taken out of any form of isolation precautions. Also, no other residents showed indications of being ill at this time. Director of Nursing and Infection Control Nurse reviewed Resident Isolation Precaution policy on 3-25-14 and no changes to the policy were made. Education was provided to nursing facility staff (Nurses, C.N.A.'s, Housekeeping, Dietary and Maintenance) on the above policy to include the posting of signage regarding isolation precautions and the use of PPE when a resident is in isolation on 3-26 & 27, 2014. PROCEDURE: Facility in services was provided March 26 and 27, 2014 by the Director of Nursing and the Infection Control Nurse jointly.	Completed by: April 1, 2014



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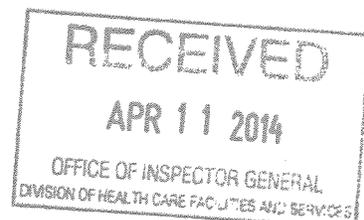
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F 441	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure staff were following standard precautions and procedures related to an outbreak of a viral illness for three (3) of twelve (12) resident rooms.</p> <p>The findings include:</p> <p>Review of the Infection Prevention Plan, effective December 2012, revealed an outbreak was defined by the occurrence of more cases among a specific group of people during a particular period of time. When an outbreak was suspected, the outbreak control measures of: re-education on hand hygiene practices; staff restriction from working in patient care or food handling duties until 48 hours after symptoms end; patient restrictions such as stopping group activities and keeping patients in their rooms until 48 hours after symptoms end; education of visitors and staff with posted signage for isolation, respiratory hygiene/cough etiquette, and hand hygiene measures and cleaning/disinfecting increase and vigilance by staff would be instituted and an investigation of the occurrence would be completed.</p> <p>Observation made during tour, on 03/05/14 at 8:20 AM, revealed Rooms 210 A and B, Rooms 212 A and B and Rooms 213 A and B had residents who had viruses that caused nausea and vomiting. No signage was observed to be on the doors to inform staff or visitors of infection control practices. Further observations revealed, no Personal Protective Equipment (PPE) on</p>	F 441	<p>MONITOR: Competency was evaluated by written exam administered by the Director of Nursing after education was provided. Compliance will be verified through ongoing observation of the proper use of PPE and Isolation Precaution policy adherence by the DON as well as the Infection Control Nurse as isolation circumstances arise. Noncompliance will be addressed through immediate re-education of staff and annually through competency training to ensure continued compliance. QA committee will be updated quarterly for 2 quarters on staff education and adherence to policy.</p> <p>RESPONSIBLE PARTY: Director of Nursing and Infection Control Nurse</p>		



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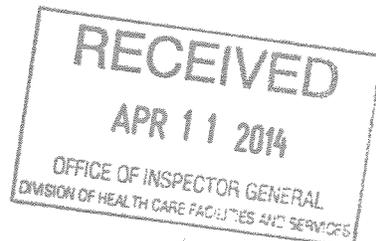
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F 441	<p>Continued From page 6 doors of resident rooms.</p> <p>Observations during the lunch service, on 03/05/14 at 12:00 PM, revealed staff entering room 212 donning gloves, but not putting on masks.</p> <p>Observation during the lunch service, on 03/06/14 at 12:00 PM, revealed staff entering rooms 210, 212, and 213 without putting on masks.</p> <p>Interview with the Director of Nursing (DON), on 03/05/14 at 11:27 PM, revealed visitors should go into infected rooms with a mask if not providing direct care, but the Certified Nursing Assistants (CNA's) and the nurses should wear PPE to include mask, gown and gloves if providing direct care.</p> <p>Interview with CNA #2, on 03/06/14 at 2:21 PM, revealed residents started getting sick about two (2) weeks ago. CNA #2 stated room 209 came down with the virus first and the majority of the residents had been "touched" with the virus. CNA #2 stated that the facility had given some training on infection control by reminding the staff to wash their hands and to use sanitizer when walking in and out of resident rooms. The Infection Control Nurse informed the staff to don gowns and wear a mask if they thought the resident would breath on them. CNA #2 stated she was to practice good hygiene and to remind the family when they came to the facility.</p> <p>Interview with CNA #1, on 03/06/14 at 2:33 PM, revealed the virus had been going around for a week. The Infection Control Nurse informed staff to wear gowns and gloves when the residents were sick and vomiting and to wipe off resident</p>	F 441			



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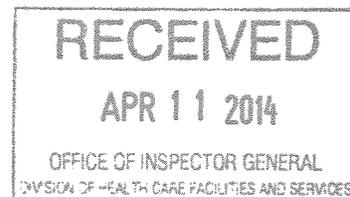
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F 441	Continued From page 7 items in resident rooms to ensure cleanliness. CNA #1 stated when she walked in resident rooms she utilized her own judgement for putting on PPE. CNA #1 stated she knew which residents were sick by the report that was given by the CNA staff. CNA #1 also stated that she would obtain her PPE from the nourishment room. Interview with the Infection Control Nurse, on 03/06/14 at 2:59 PM, revealed a virus had been going on for about 2 weeks. Eight (8) out of eighteen (18) residents had been infected with the virus. She stated if there had been any sick residents she tried to isolate those residents and ceased doing group dining and group activities. The Infection Control Nurse stated she educated staff on hand hygiene. The nursing staff were encouraged to inform the physicians that there were multiple residents who had the virus and the physicians decided to treat the symptoms only. No residents were observed to have had any fevers. The Infection Control Nurse stated that the virus was something that had been spread through out the community. The Infection Control Nurse stated that nursing staff were to wear PPE when caring for those residents who were ill and the staff were to place PPE in the resident's personal garbage cans, bagged up and then disposed of in the soiled utility room. The Infection Control Nurse stated she began to notify families and to limit visitors by placing signs at the elevator. The Infection Control Nurse stated that the staff policed people and she educated them as she saw them sporadically. The Infection Control Nurse stated that she was under the impression that she should not post resident rooms with a sign (i.e. come see nurse before entering) because this would not make the environment homelike. The Infection Control	F 441			



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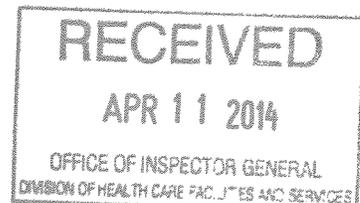
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F 441	<p>Continued From page 8</p> <p>Nurse stated that she has had no residents on Clostridium-Difficile precautions, but if this was the case she would isolate the resident and put the resident on contact isolation with no sign on the door. The Infection Control Nurse stated that she agreed there should be signage to alert maintenance, housekeeping etc. The Infection Control Nurse stated she did have a system for tracking and trending infections, which met quarterly.</p> <p>Interview with the DON, on 03/06/14 at 3:30 PM, revealed the first signs of diarrhea and vomiting occurred the week before. The DON stated she monitored the diarrhea and encouraged fluids. When the virus got to the third (3rd) resident, she began to isolate the residents. About eight (8) residents were infected in all. The virus had a twenty-four (24) to thirty-four (34) hour time frame. The DON stated she encouraged the staff to wash their hands and made phone calls to Physicians. The DON stated no residents were observed to have fever. The DON stated the infection had progressed to each room and the staff starting utilizing PDI (disinfecting) wipes for hand rails and wiping down bedside tables. The staff were also using PPE such as gowns, gloves and masks when providing care. The DON stated if she had an isolation, she would isolate the resident or co-hort with like residents and hang supplies on the door with signage. The DON stated she would have corrected the Infection Control Nurse immediately, if she had been aware the Infection Control Nurse was not placing signs on the resident's doors. The DON stated when she reported the first case of the virus, she was not expecting the Infection Control Nurse to ask her if she was to isolate residents. The DON stated she would isolate the residents herself.</p>	F 441			



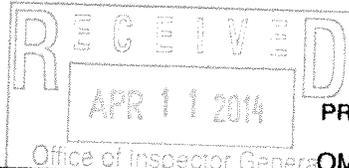
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F 441	Continued From page 9 The DON stated she had signage on the elevators, but no signage on the resident's door specifying staff and visitors to come see the nurse before entering. The DON stated she should have put signage on the doors to alert the visitors and staff of the infection and what personal PPE to put on. The DON stated she did not monitor the staff to ensure the staff were putting on the appropriate PPE. The DON stated she did have a system for tracking and trending infections.	F 441			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2014
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NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1011 OLD HIGHWAY 60 HARDINSBURG, KY 40143
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964, 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type I (222)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/07/14. Breckenridge Memorial Nursing Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has eighteen (18) certified beds with a census of seventeen (17) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Angela Padman CNO, Antoinette CEO

4-10-14

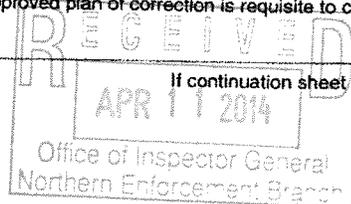
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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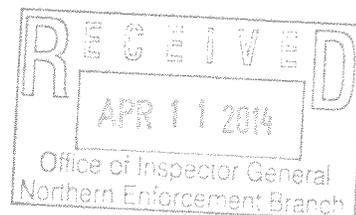


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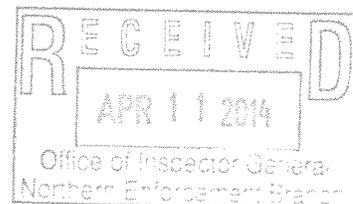
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K 000	Continued From page 1	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>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 one (1) of two (2) smoke compartments, eighteen residents (18) residents, staff and visitors. The facility is certified for</p>	K 018	<p>Action: On March 25, 2014 Plant Operations Manager, in rooms 204 and 210, installed metal strip with manufacturer approved material to meet smoke barrier requirements. Door knobs were also adjusted so that the doors open and close easily. The rest of the resident room doors were opened and closed without difficulty and therefore not noted to be out of compliance with this regulation. Life Safety Officer and Infection Control Nurse were educated about the regulation by the Life Safety Inspector onsite the day of survey. This information was shared with the Plant Operations Manager through verbal education by the Life Safety Officer on March 25, 2014.</p>	Completed by: March 26, 2014



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K 018	<p>Continued From page 2 eighteen (18) beds with a census of seventeen (17) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/07/14 between 10:00 AM and 1:00 PM, with the Safety Director and the Infection Control Officer revealed the corridor doors to room's 204 and 210 had of gap greater than one half inch from the door to the door stop and would not resist the passage of smoke. Further observation revealed the door to room 210 would not latch.</p> <p>Interview, on 03/07/14 between 10:00 AM and 1:00 PM, with the Safety Director and the Infection Control Officer revealed they were not aware the doors identified would not latch or had too large of a gap to resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and 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.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or</p>	K 018	<p>MONITOR: Life Safety Officer will monitor doors during monthly life safety rounds and report in QA quarterly meetings for 2 quarters. Doors found to be out of compliance will be fixed immediately. Door inspections will be added to monthly life safety rounding on a routine, continual basis.</p> <p>RESPONSIBLE PARTY: Plant Operations Manager/Life Safety Officer.</p>	



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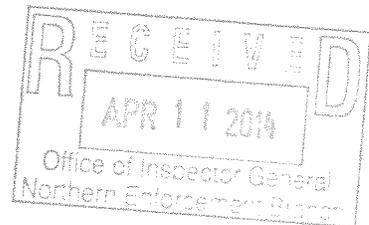
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K 018	Continued From page 3 combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke	K 025	ACTION: Penetration wall in beauty shop area was replaced by a concrete board and 3 hour fire caulking on March 25, 2014 by Plant Operations Manager. No other penetrations were identified by Plant Operations Manager during visual inspection.	Completed by: March 26, 2014



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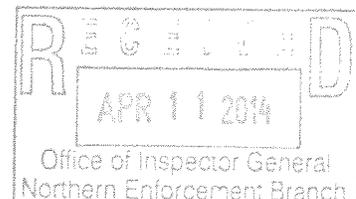
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K 025	<p>Continued From page 4</p> <p>barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, eighteen (18) residents, staff and visitors. The facility is certified for eighteen (18) beds with a census of seventeen (17) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/07/14 at 10:45 AM, with the Safety Director and the Infection Control Officer revealed the smoke barrier extending above the ceiling located in the Beauty Shop was penetrated and would not resist the passage of smoke.</p> <p>Interview, on 03/07/14 at 10:45 AM, with the Safety Director and the Infection Control Officer revealed they were not aware of the penetration.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3 SMOKE BARRIERS 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.</p>	K 025	<p>MONITOR: Life Safety Officer will perform visual inspection of a different fire wall each month during monthly safety rounds to detect new firewall penetrations. This will be taken to the QA committee for 2 quarters to determine continued compliance. Any areas found to be out of compliance will be fixed immediately. Once 100% compliance is noted than inspections will be changed to quarterly on an ongoing basis.</p> <p>RESPONSIBLE PARTY: Plant Operations Manager/Life Safety Officer</p>	



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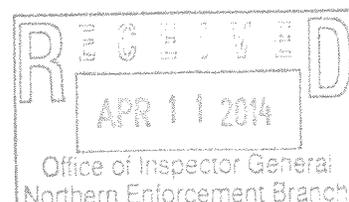
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K 025	<p>Continued From page 5</p> <p>Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be</p>	K 025		



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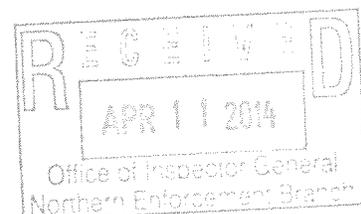
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K 025	Continued From page 6 solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 029 SS=F	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 two (2) smoke compartments, eighteen (18) residents, staff and visitors. The facility is certified for eighteen (18) beds with a census of	K 029	ACTION: On March 25, 2014, Plant Operations manager installed Self-closure devices on doors to rooms 218, 219, Activities storage and soiled linen room. Life Safety Inspector educated facility Life Safety Officer and Infection Control Nurse on day of survey (March 7, 2014) on doors that required self-closures. No other doors were noted to need self-closures during this survey by Life Safety Inspector who evaluated all doors on this unit. Life Safety Director provided education to Plant operations manager about regulation requirements for compliance on March 25, 2014. PLAN: Doors with self-closure devices will be monitored during	Completed by: March 26, 2014



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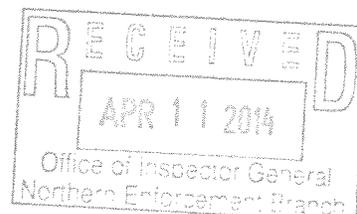
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K 029	<p>Continued From page 7</p> <p>seventeen (17) on the day of the survey. The facility failed to maintain self-closing doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 03/07/14 between 11:00 AM and 1:00 PM, with the Safety Director and the Infection Control Officer revealed rooms 218, 219, Activities Storage, and the Soiled Linen Room had hazardous combustible storage and did not have a self-closing device installed on the door.</p> <p>Interview, on 03/07/14 between 11:00 AM and 1:00 PM, with the Safety Director and the Infection Control Officer revealed they were not aware of the requirements for hazardous rooms.</p> <p>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 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</p>	K 029	<p>monthly unit safety inspections to verify function. Inspections will be taken before QA quarterly for 2 quarters to show compliance. Any doors found to be out of compliance will be fixed immediately.</p> <p>RESPONSIBLE PARTY: Plant Operations Manager/Life Safety Officer</p>		



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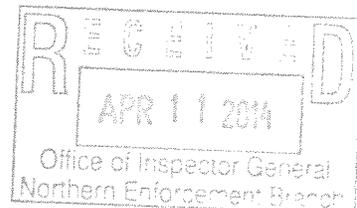
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K 029	Continued From page 8 (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous 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. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 038 SS=D	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, one (1) of four (4) exits, eighteen (18) residents, staff and visitors. The facility is certified for eighteen (18) beds with a	K 038	ACTION: On March 24, 2014, Plant Operations Manager adjusted magnet closure device so that adequate magnet contact would allow release within 15 seconds meeting regulation. All other doors on the nursing facility unit are in working order through testing of wander guard alert system as well as keypad locking device to allow entrance and exit to the facility. All doors released in the allotted amount of time and found to be functional during Life Safety Inspection rounding done by Life Safety Officer.	Completed by: March 25, 2014



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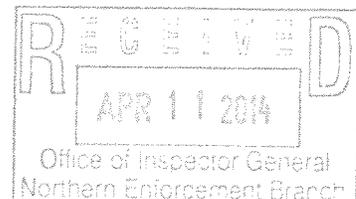
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2014
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 OLD HIGHWAY 60 HARDINBURG, KY 40143	
(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 038	<p>Continued From page 9</p> <p>census of seventeen (17) on the day of the survey. The facility failed to ensure doors with delayed egress locks were operational.</p> <p>The findings include:</p> <p>Observation, on 03/07/14 at 11:40 AM, with the Safety Director and the Infection Control Officer revealed the exit door located at the Patient Hall End Stairwell was equipped with a delayed egress lock that failed to release when tested. The door would release with the fire alarm and with the keypad. Staff members were asked to open the door with a 100% success rate and the code to the keypad was posted.</p> <p>Interview, on 03/07/14 at 11:40 AM, with the Safety Director and the Infection Control Officer revealed they were not aware the delayed egress door was not functioning properly.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided</p>	K 038	<p>MONITOR: Life Safety Officer will monitor on a weekly basis to verify functioning of alarms and door locking devices as well as automatic releasing within the allotted time. These monitors will be reported in QA on a quarterly basis for 2 quarters. Any doors found to be out of compliance will be fixed immediately and monitor will continue for another 6 months.</p> <p>RESPONSIBLE PARTY: Plant Operations Manager/Life Safety Officer</p>	



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K 038	Continued From page 10 that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters	K 038			



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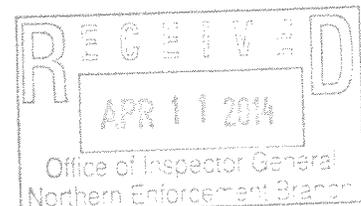
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K 038	Continued From page 11 not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent	K 038		



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K 038	Continued From page 12 hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged	K 038			
K 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, eighteen (18) residents, staff and visitors. The facility is certified for eighteen (18) beds with a census of seventeen (17) on the day of the survey. The findings include: Observation, on 03/07/14 between 11:00 AM and 1:00 PM, with the Safety Director and the	K 047	ACTION: On March 21, 2014, Plant Operations Manager posted installed exit signs on the 3 stairwells leading from the second floor to the ground floor which did not previously have exit signs noted during survey to mark paths of egress. The exits found on survey of facility by state Life Safety Inspector were only paths of egress from facility not marked since all paths of egress were surveyed during inspection. Life Safety Officer will continue to monitor signs for existence and proper functioning during monthly safety rounds. Monthly monitor logs will be reported in QA on a quarterly basis for 2 quarters. Any exit signs to be found out of	Completed March 22, 2014	



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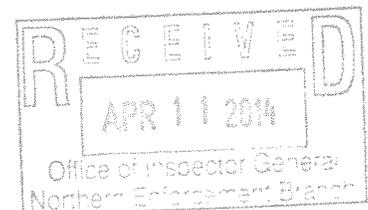
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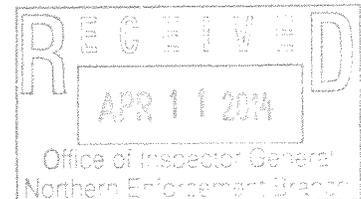
K 047	<p>Continued From page 13</p> <p>Infection Control Officer, revealed three (3) of the four (4) stairwells leading from the second floor to ground floor did not have exit signage inside the stairwell on the ground floor, making the path of egress clearly recognizable. The stairwells had multiple doors on the ground level, but only one was in the path of egress.</p> <p>Interview, on 03/07/14 between 11:00 AM and 1:00 PM, with the Safety Director and the Infection Control Officer revealed they were not aware the stairwells did not have the required exit signage.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.2.10 Marking of Means of Egress. 19.2.10.1 Means of egress shall have signs in accordance with Section 7.10. Exception: Where the path of egress travel is obvious, signs shall not be required in one-story buildings with an occupant load of fewer than 30 persons.</p> <p>7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall</p>	K 047	<p>compliance will be fixed immediately.</p> <p>RESPONSIBLE PARTY: Plant Operations Manager/Life Safety Officer</p>	
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K 047	Continued From page 14 read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. 7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame. 7.10.1.6* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and	K 047		



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K 047	Continued From page 15 approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. 7.10.1.7* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted. 7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.3* Sign Legend. Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters. 7.10.4* Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in	K 047			



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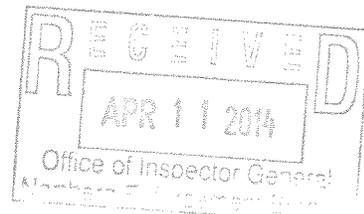
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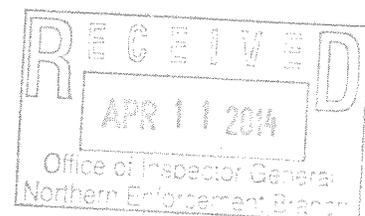
K 047	Continued From page 16 accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration. 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.6 Externally Illuminated Signs. 7.10.6.1* Size of Signs. Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter I, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height. Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high.	K 047		
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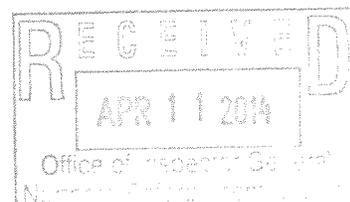
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K 047	<p>Continued From page 17</p> <p>Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5.</p> <p>7.10.6.2* Size and Location of Directional Indicator. The directional indicator shall be located outside of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated. Exception: This requirement shall not apply to approved existing signs. Figure 7.10.6.2 Chevron-type indicator.</p> <p>7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5.</p> <p>7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5.</p> <p>7.10.7.2* Photoluminescent Signs. The face of a photoluminescent sign shall be continually illuminated while the building is occupied. The illumination levels on the face of</p>	K 047			



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K 047	Continued From page 18 the photoluminescent sign shall be in accordance with its listing. The charging illumination shall be a reliable light source as determined by the authority having jurisdiction. The charging light source shall be of a type specified in the product markings. 7.10.8 Special Signs. 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs. 7.10.8.2 Elevator Signs. Elevators that are a part of a means of egress (see 7.2.13.1) shall have the following signs, with minimum letter height of 5/8 in. (1.6 cm), in every elevator lobby: (1) * Signs that indicate that the elevator can be used for egress, including any restrictions on use (2) * Signs that indicate the operational status of elevators 7.10.9 Testing and Maintenance. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days. 7.10.9.2 Testing. Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and	K 047			



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185285	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/07/2014
NAME OF PROVIDER OR SUPPLIER BRECKINRIDGE MEMORIAL NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 OLD HIGHWAY 60 HARDINSBURG, KY 40143	
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K 047	Continued From page 19 maintained in accordance with 7.9.3.	K 047		
K 130 SS=D	<p>7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a means of egress, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, eighteen (18) residents, staff and visitors. The facility has eighteen (18) certified beds with a census of seventeen (17) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/07/14 at 11:37 AM, with the Safety Director and the Infection Control Officer revealed an unapproved lock [slide bolt type] was installed on the egress side of the door to the Activities Office.</p> <p>Interview, on 03/07/14 at 11:37 AM, with the Safety Director and the Infection Control Officer</p>	K 130	<p>ACTION: On March 21, 2014 Plant Operations Manager removed slide bolt lock from Activity Director's office door. This lock was not in use on the door in question and no other nursing facility office doors were found to have slide bolt locks on them during Life Safety Inspectors survey of facility. Life Safety Inspector educated Life Safety officer and Infection control nurse on date of survey (March 7, 2014). Life safety officer will monitor during monthly life safety inspections for any further slide bolt lock use in facility. Any locks found to be in use will be removed immediately. Monthly monitor will be reported to QA for 2 quarters. Inspections will continue on an ongoing basis.</p>	Completed by: March 22, 2014



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K 130	Continued From page 20 revealed they were not aware the slide bolt lock was prohibited and could be a deterrent to exiting the room in the event of an emergency. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	RESPONSIBLE PARTY: Plant Operations Manager/Life Safety Officer.	

