

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

PRINTED: 03/22/2012

FORM APPROVED  
OMB NO. 0938-0391

RECEIVED  
MAR 30 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/08/2012
NAME OF PROVIDER OR SUPPLIER  RIDGEWAY NURSING & REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360 Division of Health Care Southern Enforcement Branch	

(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	F 000	Ridgeway Nursing and Rehabilitation does not believe nor does the facility admit that any deficiencies exist.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure services were provided in accordance with each resident's written Comprehensive Care Plan for one of fifteen sampled residents (Resident #7). According to Resident #7's written plan of care, when the resident experienced behaviors and agitation facility staff was to administer as needed anti-anxiety medications, attempt to put the resident in bed, reduce excessive stimulation by providing a quiet environment, and limit contact with others. Observations conducted on 03/06/12, revealed Resident #7 exhibited agitated behaviors while awaiting the evening meal. However, facility staff failed to provide interventions as outlined in Resident #7's written plan of care related to agitation.  The findings include:  A review of the facility's comprehensive care plan policy dated 01/09/03, revealed the resident's	F 282	Ridgeway Nursing and Rehabilitation reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Ridgeway Nursing and Rehabilitation reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Heather O'Banion* TITLE: *Administrator* (X5) DATE: *3/30/12*

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.

Received Time Mar. 30. 2012 12:35PM No. 6478

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NAME OF PROVIDER OR SUPPLIER  RIDGWAY NURSING & REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360
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F 000	INITIAL COMMENTS	F 000	Ridgeway Nursing and Rehabilitation does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action, or proceeding.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure services were provided in accordance with each resident's written Comprehensive Care Plan for one of fifteen sampled residents (Resident #7). According to Resident #7's written plan of care, when the resident experienced behaviors and agitation facility staff was to administer as needed anti-anxiety medications, attempt to put the resident in bed, reduce excessive stimulation by providing a quiet environment, and limit contact with others. Observations conducted on 03/06/12, revealed Resident #7 exhibited agitated behaviors while awaiting the evening meal. However, facility staff failed to provide interventions as outlined in Resident #7's written plan of care related to agitation.  The findings include:  A review of the facility's comprehensive care plan policy dated 01/09/03, revealed the resident's	F 282	Ridgeway Nursing and Rehabilitation offers its responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to residents.  Ridgeway Nursing and Rehabilitation strives to provide the highest quality care while assuring the rights and safety of all residents.  F282 It is and was on the day of survey the policy of Ridgeway to provide qualified persons in accordance to each resident's written POC.  1. Resident #7 has been reassessed and interventions have been updated on her care plan related to her agitation.	3/30/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Leather Okanaka* TITLE: *Administrator* (X6) DATE: *3/30/12*

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

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F 282	Continued From page 1 comprehensive care plan had been designed to identify problem areas and to build on the resident's strengths. Further review of the policy revealed the plan of care for the residents should identify the professional services that are responsible for each element of the resident's care and prevent declines in the resident's functional status and/or functional levels.  A review of the medical record for Resident #7 revealed the facility admitted the resident on 05/16/06, with diagnoses of Alzheimer's, Dementia, and Depression. Review of a quarterly Minimum Data Set (MDS) assessment dated 01/13/12, revealed the facility assessed the resident to be sometimes understood and sometimes understand others. Continued review of the MDS assessment revealed facility staff assessed Resident #7 to have other behavioral symptoms not directed toward others, to occur daily, during that assessment period. Further review of the MDS assessment revealed Resident #7 required extensive assistance from staff for transferring, dressing, bathing, and eating.  A review of the Comprehensive Care Plan for Resident #7 last updated 02/22/12, revealed facility staff had identified a focus area of concern related to Resident #7's anxiety, with behaviors and agitation. Further review of the care plan revealed facility staff had developed interventions for the resident's behaviors and agitation, repetitive verbalizations, and rapid pacing in wheelchair related to anxiety as follows: administer as needed medication as ordered, attempt to put the resident in bed when agitation occurs, and reduce excessive stimulation by	F 282	2. All residents who have agitated behaviors have been reassessed by the MDS Coordinator and interventions have been reviewed for those residents.  3. An in-service was conducted with all nursing staff (RN, LPN, CMT and CNA) by the Administrator and Director of Nursing on 3/29/12 reviewing following the care plan and implementing the appropriate interventions. CNA and CMTS have been instructed to communicate changes to registered staff.  4. As part of the facility's ongoing quality assurance program the Director of Nursing will audit 3 residents with anxiety symptoms per day to ensure that the care plan is being followed and interventions are being implemented appropriately for 6 months. The charge nurse will do weekend audits. Audits will be forwarded to QA committee for review.	

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F 282	<p>Continued From page 2 providing a quiet environment and limit contact with others.</p> <p>Observations of Resident #7 during the evening meal on 03/06/12, from 5:30 PM to 6:30 PM, in the dining room, revealed the resident was crying and moaning repetitively, rocking back and forth in his/her wheelchair, and making loud gasping noises with breathing, while awaiting the evening meal on 03/06/12. Further observations revealed facility staff was present in the dining room and would occasionally approach the resident and ask the resident what was wrong and "pat" the resident on his/her back. Resident #7 continued to display behaviors and facility staff was not observed to implement other interventions to address the resident's behavior symptoms.</p> <p>An interview with Certified Nursing Assistant (CNA) #1 on 03/07/12, at 6:10 PM, revealed she was assigned to the dining room during the evening meal on 03/06/12. Continued interview with CNA #1 confirmed Resident #7 was in the dining room on 03/06/12, and was agitated, made repetitive crying and moaning sounds, and displayed loud gasping noises with breathing, while awaiting the evening meal. CNA #1 stated she did not report the resident's agitated behaviors to the nurse because being agitated was the resident's normal behavior. Further interview with the CNA revealed Resident #7 "is agitated a majority of the time," and that the resident's behavior observed on 03/06/12, was how he/she is "normally." CNA #1 stated she would have removed the resident from the dining room and taken the resident to his/her room if she was more agitated than normal, however, behaviors displayed on 03/06/12, were the</p>	F 282			

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F 282	<p>Continued From page 3 resident's normal behavior.</p> <p>An interview with CNA #3 on 03/07/12, at 8:40 PM, revealed Resident #7 had behaviors of making loud repetitive noises while breathing and "cries and moans all the time." CNA #3 stated she didn't always report the resident's behavior because that's the way the resident is all the time.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 03/07/12; at 5:00 PM, confirmed she had not been notified of Resident #7's agitated behaviors on the evening of 03/08/12. Further interview with the LPN revealed she should have been notified if a resident was observed to be crying, moaning repetitively, and rocking back and forth while sitting in a wheelchair. Continued interview revealed Resident #7 had as needed medications that could have been administered for agitated behaviors.</p> <p>An interview with the Care Plan Coordinator on 03/08/12, at 12:30 PM, confirmed she had identified anxiety with behaviors as a focus area of concern for Resident #7. Further interview with the Care Plan Coordinator revealed facility staff should have taken Resident #7 out of the dining room and provided the resident with a quiet environment when the resident experienced periods of agitation. Continued interview with the Care Plan Coordinator revealed she ensured care plan interventions were followed by making rounds daily but stated she did not observe Resident #7's behavior during the evening meal on 03/08/12.</p> <p>An interview with the Director of Nursing (DON) on 03/08/12, at 4:30 PM, revealed she ensured</p>	F 282			

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F 282	Continued From page 4 care planned interventions were being provided to the residents by reviewing shift reports and making rounds daily. Further interview with the DON revealed she was unaware staff had failed to provide care plan interventions as indicated for Resident #7's behavior during the evening meal on 03/06/12.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of fifteen sampled residents (Resident #7). Observations conducted on 03/06/12; during the evening meal revealed the resident to have repetitive behaviors of crying, moaning, rocking his/her upper body back and forth while in the wheelchair, and to remove the table linen while awaiting the evening meal. However, interview and record review on 03/07/12, revealed the facility failed to provide interventions for Resident #7's behavior as outlined in the comprehensive plan of care.  The findings include:	F 309	F309 It is and was on the day of survey the policy of Ridgeway that each resident receive the necessary care and services to attain physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  1. Resident #7 has been reassessed and interventions have been updated on her care plan related to her agitation.  2. All residents who have agitated behaviors have been reassessed by the MDS Coordinator and interventions have been reviewed for those residents.	3/30/12

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F 309	Continued From page 5  A review of the facility's comprehensive care plan policy dated 01/09/03, revealed the resident's comprehensive care plan had been designed to identify problem areas and to build on the resident's strengths. Further review of the policy revealed the plan of care for the residents should identify the professional services that are responsible for each element of the resident's care and prevent declines in the resident's functional status and/or functional levels.  A review of the facility's Behavior Tracking Protocol (not dated) revealed facility staff was to monitor each resident daily for certain behavior indicators as determined by the Minimum Data Set Process. Further review of the policy revealed a Behavior Tracking Flowsheet, which included specific behavior indicators, would be kept in the resident's record and completed as the resident's behaviors were observed to occur.  A review of the medical record for Resident #7 revealed the facility admitted the resident on 05/16/06, with diagnoses of Alzheimer's, Dementia, and Depression. Review of a quarterly Minimum Data Set (MDS) assessment dated 01/13/12, revealed the facility assessed the resident to be sometimes understood and sometimes understand others. Further review of the MDS assessment revealed Resident #7 required extensive assistance from staff for transferring, dressing, bathing, and eating. Continued review of the MDS assessment revealed facility staff assessed Resident #7 to have other behavioral symptoms not directed toward others, to occur daily, during that assessment period.	F 309	3. An in-service was conducted with all nursing staff (RN, LPN, CMT and CNA) by the Administrator and Director of Nursing on 3/29/12 reviewing the behavior protocol and behavior monitoring tracking sheets for each residents. Licensed staff have been instructed on proper documentation as it pertains to behaviors. Certified nurse aides and certified medication technicians have been instructed to inform the nurse if behaviors exist and instructed to follow the care plan and implementing the appropriate interventions.  4. As part of the facility's ongoing quality assurance program the Director of Nursing will audit 10% of all residents behavior tracking sheets on a weekly basis to ensure behaviors are being monitored appropriately. These audits will be performed weekly for the next six months. Audits will be forwarded to QA committee for review.		

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F 309	Continued From page 6  Observations of Resident #7 during the evening meal on 03/06/12, from 5:30 PM to 6:30 PM, in the dining room, revealed the resident was crying and moaning repetitively, rocking back and forth in his/her wheelchair, and making loud gasping noises with breathing, while awaiting the evening meal on 03/06/12. Further observations revealed facility staff was present in the dining room and would occasionally approach the resident and ask the resident what was wrong and "pat" the resident on his/her back. Resident #7 continued to display behaviors and facility staff was not observed to implement other interventions to address the resident's behavior symptoms.  A review of the Comprehensive Care Plan for Resident #7 last updated 02/22/12, revealed facility staff had identified a focus area of concern related to Resident #7's anxiety, with behaviors and agitation. Further review of the care plan revealed facility staff had developed interventions for the resident's behaviors as follows: administer as needed medication as ordered, attempt to put the resident in bed when agitation occurs, and reduce excessive stimulation by providing a quiet environment and limit contact with others.  A review of the Behavior Tracking record for Resident #7 revealed no behaviors had been documented for the resident as observed to have occurred on 03/06/12.  A review of Resident #7's Medication Administration Record (MAR) for the month of March 2012 for any prn anti-anxiety medications administered revealed the resident had two different anti-anxiety medications ordered to be	F 309			

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F 309	Continued From page 7 administered as needed for anxiety. However, further review of the MAR for March 2012 revealed the facility failed to administer the medications for Resident #7's anxiety on 03/06/12.	F 309			
	An interview with Certified Nursing Assistant (CNA) #1 on 03/07/12, at 6:10 PM, revealed she was assigned to the dining room during the evening meal on 03/06/12. Continued interview with CNA #1 confirmed Resident #7 was in the dining room on 03/06/12, and was agitated, made repetitive crying and moaning sounds, and displayed loud gasping noises with breathing, while awaiting the evening meal. CNA #1 stated she did not report the resident's agitated behaviors to the nurse because being agitated was the resident's normal behavior. Further interview with the CNA revealed Resident #7 "is agitated a majority of the time," and that the resident's behavior observed on 03/06/12, was how he/she is "normally." CNA #1 stated she would have removed the resident from the dining room, and taken the resident to his/her room, if she was more agitated than normal, however, behaviors displayed on 03/06/12, was the resident's normal behavior.  An interview with CNA #3 on 03/07/12, at 6:40 PM, revealed Resident #7 had behaviors of making loud repetitive noises while breathing and "cries and moans all the time." CNA #3 stated "she didn't always report the resident's behavior because that's the way the resident is all the time."  An interview with Licensed Practical Nurse (LPN) #1 on 03/07/12, at 5:00 PM, confirmed she had				

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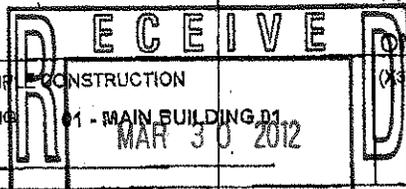
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F 309	Continued From page 8 not been notified of Resident #7's agitated behaviors on the evening of 03/06/12. Further interview with the LPN revealed she should have been notified if a resident was observed to be crying, moaning repetitively, and rocking back and forth while sitting in a wheelchair. Continued interview revealed Resident #7 had as needed medications that could have been administered for agitated behaviors.  An interview with the Director Of Nursing (DON) on 03/08/12, at 4:30 PM, revealed she monitored residents' behaviors and ensured care planned interventions were being provided to the residents by reviewing shift reports, making rounds, and reviewing behavior monitoring sheets daily. Further interview with the DON revealed she was unaware the behavior monitoring sheet for Resident #7 was incomplete, and was not aware of Resident #7 's behavior on 03/06/12, and that staff had failed to provide care plan interventions as indicated for the resident.	F 309		

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1978 Facility type: SNF/NF Type of structure: Type III unprotected Smoke Compartments: Three Fire Alarm: Fire alarm installed in 1978 Smoke detectors in corridors Heat detectors in kitchen/attic Sprinkler System: Complete sprinkler system (dry) installed 1978 Generator: Natural gas installed 2005  A standard Life Safety Code survey was conducted on 03/07/12. Ridgeway Nursing and Rehabilitation Facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 58. The facility is licensed for 60 beds. The highest scope and severity identified was at "F" level.	K 000		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in	K 045	K045 It is and was on the day of survey the policy of Ridgeway to provide qualified persons in accordance to each resident's written POC.	3/27/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Heather Okanow* TITLE *Administrator* (X5) DATE *3/28/12*

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.

Received Time Mar. 30. 2012 12:35PM No. 6478

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185254	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  03/07/2012
NAME OF PROVIDER OR SUPPLIER  RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
(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 045	Continued From page 1 darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency lighting for exits was according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two of three smoke compartments, thirty-five residents, staff, and visitors.  The findings include:  Observation on 03/07/12, at 11:05 AM, with the Maintenance Director, revealed the emergency illumination for Hallway A was provided by a lighting fixture with a single bulb. Exits must be provided with emergency illumination with more than one bulb. Further observation revealed the exit from Hallway B did not have any emergency lighting.  Interview on 03/07/12, at 11:05 AM, with the Maintenance Director, revealed he was unaware of the requirements for the emergency illumination of the exits.  Reference: NFPA 101 (2000 Edition).  7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	1. The emergency lighting for exits has been corrected to ensure proper illumination of means of egress.  2. All exits were examined and now are properly illuminated.  3. The maintenance director has been in-serviced by the administrator on 3/26/12 related to the required exit lighting.  4. As part of the facility's ongoing quality assurance the Director of Maintenance will monthly check all exit lighting to ensure bulbs are functioning properly. Audits will be forwarded to QA committee for review.		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062			

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NAME OF PROVIDER OR SUPPLIER  RIDGEWAY NURSING & REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 406 WYOMING ROAD #38 OWINGSVILLE, KY 40360		
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K 062 SS=D	Continued From page 2  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 cleared of obstructions according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of three smoke compartments, twenty-four residents, staff, and visitors.  The findings include:  Observation on 03/07/12, at 10:31 AM, with the Maintenance Director revealed one sprinkler head located in the attic area of Hallway A was covered with blown-in insulation. Sprinkler heads must be maintained clear of obstruction to ensure their reliability during a fire.  Interview on 03/07/12, at 10:31 AM, with the Maintenance Director revealed the facility inspects sprinkler heads on a monthly basis to ensure sprinkler heads are not obstructed and was not aware the sprinkler head was obstructed with blown-in insulation.  Reference: NFPA 25 (1998 Edition).  2-2.1.2* Unacceptable obstructions to spray patterns shall be corrected.	K 062	K062 It is and was on the day of survey the policy of Ridgeway to provide qualified persons in accordance to each resident's written POC.  1. The sprinkler head which was obstructed was in the attic in the pitch of the roof. It was corrected immediately.  2. All sprinkler heads are clear and meet NFPA standards.  3. An in-service was conducted on 3/27/12 with all maintenance staff by the Maintenance Director on NFPA standards related to sprinkler heads.  4. As part of the facility's ongoing quality assurance program the Maintenance Director will monthly review all sprinkler heads to ensure they meet NFPA requirements. Audit will be forwarded to QA committee for review.	3/28/12	

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K 064 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure fire extinguishers were maintained according to National Fire Protection Association (NFPA) standards. Observations revealed four facility fire extinguishers did not have a six-year service collar indicating the required maintenance inspection. The deficiency had the potential to affect three of three smoke compartments, fifty-two residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 03/07/12, at 11:22 AM, with the Maintenance Director, revealed the fire extinguisher in the Laundry Department did not have a six-year service collar indicating the required maintenance or inspection. Fire extinguishers must be maintained and inspected to ensure their reliability. During the survey three additional fire extinguishers were found not to have the required six-year service collar. The fire extinguishers were found near the exits of Hallways A, B, and C.</p> <p>Interview on 03/07/12, at 11:22 AM, with the Maintenance Director, revealed he believed all fire extinguishers in the facility had been replaced</p>	K 064	<p>K064</p> <p>It is and was on the day of survey the policy of Ridgeway to provide qualified persons in accordance to each resident's written POC.</p> <p>1. The four fire extinguishers have been serviced on 3/13/12 and the collar indicating proper maintenance inspection is in place.</p> <p>2. All fire extinguishers now comply with 19.3.5.3, NFPA 10.</p> <p>3. A letter of concern was issued to the company which provides our fire protection service concerning the fire extinguishers lack of collar indicating proper maintenance inspection.</p> <p>4. As part of the facility's ongoing quality assurance program the Director of Maintenance will monitor yearly for any extinguisher that requires service.</p>	3/14/12	

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K 064	<p>Continued From page 4 with new extinguishers the previous year.</p> <p>Record review on 03/07/12, at 1:19 PM, of the fire extinguisher inspection report dated 10/18/11, indicated the fire extinguishers were new in 1999 and required a six-year inspection and maintenance of the extinguishers located in the laundry, and the exits of Hallways A, B and C.</p> <p>Interview on 03/07/12, at 1:19 PM, with the Maintenance Director, revealed he was unaware the fire extinguisher report indicated the four (4) extinguishers needed the 6-year maintenance and inspection.</p> <p>Reference: NFPA 10 (1998 Edition).</p> <p>4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.</p> <p>Exception: Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3.</p> <p>4-4.4.2* Verification of Service (Maintenance or Recharging).</p>	K 064			

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K 064	<p>Continued From page 5</p> <p>Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.</p> <p>Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.</p> <p>Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.</p>	K 064		