

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

PRINTED: 10/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/05/2012
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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135
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F 000	INITIAL COMMENTS  An annual survey was conducted on 10/02/12 through 0/05/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E," with the facility having an opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined the facility failed to ensure policy and procedure were followed related to an injury of unknown origin that was not reported and investigated timely for one resident (#9) in a selected sample of eighteen (18). Resident #9 was observed on 10/02/12 to have a dark purple bruised area to his/her right hand. The bruised area was not reported to the nurse by the Certified Nurse Aide (CNA) resulting in an investigation not being initiated until 10/03/12.  Findings include:  Review of the facility policy and procedure titled Abuse/Neglect, no date, revealed Personnel,	F 226	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare requirements.	11/19/12

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

TITLE

(X6) DATE

*[Signature]*

*Administrator*

10/29/2012

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 226	<p>Continued From page 1</p> <p>residents and visitors were to promptly report incidents of suspected resident abuse or neglect to facility administration, including injuries of unknown origin such as bruising and/or skin tears and those incidents would be investigated by the Administrator and/or Director of Nursing.</p> <p>Resident #9 was admitted to the facility on 01/12/07 and had diagnoses to include Dementia with Behavior Disturbance, Muscle Weakness and Symbolic Dysfunction.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment, dated 08/28/12, revealed the facility had assessed the resident as severely cognitively impaired and required extensive assistance with activities of daily living.</p> <p>An observation on 10/02/12 at 11:35 AM revealed Resident #9 laying in bed. A dark purple discoloration covering a large portion of his/her right hand was observed. An interview with Resident #9 was attempted at this time but due to his/her severe cognitive impairment was unable to state how the injury to the right hand had occurred.</p> <p>An interview with Unit Manager #1 on 10/03/12 at 2:55 PM revealed all injuries identified by the CNAs were to be reported to the nurse immediately and the nurse was to assess the injury, notify all parties and place documentation on the Treatment Administration Record. Unit Manager #1 stated she was not made aware of the injury to Resident #9's right hand and that she had started an investigation on 10/03/12 when she had identified the injury. The Unit Manager said that CNA #1 had not reported the injury nor</p>	F 226	<p>F226</p> <ol style="list-style-type: none"> <li>1. A head to toe skin assessment of resident # 9 was completed by a staff nurse (LPN) on 10/03/2012 with no new skin impairments noted. The referred to bruise on the right hand was reported to the Administrator and Director of Nursing on 10/03/2012 and reported to the Office of Inspector General as a Injury of Unknown Origin on 10/03/2012.</li> <li>2. All current residents will have a head to toe skin assessment completed by Director of Nursing, Assistant Director of Nursing, and RN Unit Manager. The skin assessments will be completed by 11/18/2012 and any bruises or areas suspicious for abuse, neglect or Injuries of Unknown Origin will be immediately reported to the Office of Inspector General and other government agencies as required.</li> <li>3. All direct care staff will be re-educated by the Education and Training Director, the Director of Nursing, Assistant Director of Nursing or Unit Managers related to immediate reporting of bruises and the investigative and reporting process for Injuries of Unknown Origin. This training will be completed by 11/18/2012 with no direct care staff working after 11/18/2012 without having received this re-education.</li> <li>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will complete skin assessments on five (5) residents per week for twelve (12) weeks to assure that any bruises or skin impairments have been reported to the nurse and the Injury of Unknown Origin Process was followed. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months and until the Quality Assurance Committee feels that the deficiency is corrected. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</li> </ol> <p>Completion Date: November 19, 2012</p>	

11/19/12

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F 226	Continued From page 2 had she documented the injury in the kiosk and should have.  An interview on 10/03/12 at 3:00 PM with CNA #1 revealed she had been assigned to and provided care for Resident #9 on 10/02/12. CNA #1 stated she had observed the dark purple bruise on Resident #9's hand on 10/02/12 but had thought nothing about it and did not report it to the nurse. CNA #1 said injuries like skin tears and bruising was to be reported immediately to the nurse and was to be documented in the kiosk under body assessment.	F 226		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the resident environment was clean and comfortable related to a strong urine odor that was present in a common area of the facility on 10/02/12 and on 10/03/12. Findings include:  No policy was provided that addressed odors.  On 10/02/12 at 10:30 AM an observation of a common area and hall area located by the nursing station revealed a very strong odor of	F 252	F252  1. The carpet in the A wing lounge area next to the nurse's station will be replaced by the Maintenance Director before 11/18/2012. Soiled linens are bagged in the soiled linen room as observed by the Administrator on 10/26/2012.  2. The Housekeeping Supervisor and the Administrator will make a facility wide audit to identify any areas that are contributing to odors. Any identified areas will be corrected by 11/18/2012.  3. The housekeeping and laundry staff will be re-educated by the Housekeeping Supervisor on the cleaning of the soiled linen rooms and identification and reporting of chronic odors. Direct Care staff will be re-educated on bagging of soiled linen by the Director of Education, Director of Nursing, Assistant Director of Nursing or Unit Managers. All education will be completed by 11/18/2012.  4. The Housekeeping/Laundry supervisor and Administrator will make rounds five (5) times per week for four (4) weeks then weekly for eight (8) weeks to identify any unreported odor concerns. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months and until the Quality Assurance Committee deems appropriate. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12

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F 252	<p>Continued From page 3</p> <p>urine. Large areas of unidentified stains were observed over much of the carpet surfact. The strong odor and stain areas were present at 1:30 PM and at 4:00 PM.</p> <p>An interview conducted with the area Ombudsman on 10/01/12 at 11:30 AM revealed she had a concern with odor of urine in the facility on visits to the facility recently.</p> <p>An interview with the House Keeping Supervisor on 10/02/12 at 4:00 PM revealed there had been a problem with a urine odor in that area and felt the odor was coming from a small carpeted area that was frequently soiled with spills and urine. He stated he spot cleaned the rug area two or three times a week due to odor and spills and did an extraction cleaning when needed. The House Keeping Supervisor stated there had been discussion in the past about removing the carpet but no definite plans had been determined.</p> <p>Interviews with Certified Nurse Aide (CNA) #2, Unit Manager #1 on 10/03/12 at 9:30 PM and 9:40 PM, revealed the urine odor was "strong" and air freshener sprayed by staff "did not cover up the odor". The Unit Manager and CNA were unable to identify the source of the strong urine odor.</p> <p>An interview with the Administrator on 10/03/12 at 9:45 AM revealed housekeeping staff had been struggling with cleaning of two male rooms located off the hall near the common area and thought that might be a contributing factor to the strong urine odor. An observation of a dirty linen room at the time of the interview (also located close to common area), revealed soiled items in</p>	F 252		
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F 252	Continued From page 4 the soiled linen room that were not bagged. There was a very strong odor of urine in the dirty linen room. The Administrator stated more frequent rounds might be needed and dirty linens should be bagged. Staff that handle soiled linens were responsible to ensure proper bagging.	F 252		
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS  The facility must provide for the maintenance of comfortable sound levels.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure sound levels were comfortable for residents. Observations on 10/02/12 through 10/05/02 revealed loud and frequent use of overhead announcements through the facility intercom. Residents and staff revealed frequent overhead paging through the facility intercom occurred daily.  Findings include:  No facility policy related to noise levels was provided.  On 10/02/12, numerous overhead pages were heard for staff. The pages requested staff presence or notified particular staff of incoming phone calls. Some of the pages requested certain staff to be present at a certain nursing station or the reception desk. The overhead	F 258	1 On 10/24/2012, the Administrator observed the facility to be at a comfortable sound level with no overhead paging noted.  2. On 10/26/2012, the Administrator observed the facility to be at a comfortable sound level with no overhead paging noted.  3. The facility has a new system that was started on 10/08/2012 which will help to reduce the number of overhead pages in the building. One of the advantages of the new system is that the staff have the ability to communicate directly with other staff via wireless headsets. The system's capabilities will help to reduce the number of overhead pages heard throughout the building. All staff will be re-educated on the requirement for a comfortable sound level in the facility. This education will be completed by the Administrator, Education and Training Director, Director of Nursing, or Assistant Director of Nursing by 11/18/2012.  4. The Administrator will make observations of the noise level twice a day five (5) times per week for twelve (12) weeks. The Administrator will review the sound level audits with the Resident Council monthly for three (3) months for their input and recommendations. The results of these audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months and until the Quality Assurance Committee deems corrected. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12

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F 258	Continued From page 5 pages were heard throughout the day.  On 10/03/12 at 10:30 AM, a resident group interview was conducted. During the interview overhead paging disrupted the interview multiple times. The residents participating in the interview revealed overhead paging went on constantly for everything and was intrusive. The residents in the group said no one had ever complained to administration about the paging but it did get on their "nerves".  An interview with the receptionist on 10/03/12 at 1:35 PM revealed the phone "rings off the hook" and she transferred all of the calls via the intercom system or she would have to go and physically locate the person the call was for.  An interview with the Administrator on 10/05/12 at 4:30 PM revealed there were "new people" working the phones and he had asked them on 10/04/12 to call on the phone to the nursing stations to locate staff as needed and refrain from paging.	F 258	F323  1. The resident identified as resident A was observed by the Administrator to be wearing a smoking apron as assessed and careplanned on 10/19/2012. The Administrator observed staff to be transfilling a portable oxygen tank with the door closed on 10/26/2012. The Administrator observed on 10/26/2012 that all liquid oxygen tanks to be functioning and stored appropriately.  2. A review of all residents who wish to smoke was completed by the Activities Director, Social Services Director, and Director of Nursing on 10/03/2012 to assure that all interventions for safe smoking that were needed were also careplanned. No other concerns were identified. The Administrator observed staff to be transfilling a portable oxygen tank with the door closed on 10/29/2012. The Administrator observed on 10/29/2012 that all liquid oxygen tanks to be functioning and stored appropriately.  3. All identified smoking equipment will be listed on a guide placed in the smoking box that accompanies staff on smoke breaks. This list will be updated by the Activity Director when smoking careplans change. The Activities Director will be re-educated by the Director of Nursing on assessment and careplanning of smoking interventions and updating of the smoking equipment list by 11/18/2012. All direct care staff and Department Heads will be re-educated on following careplan interventions for smoking and smoking equipment list for safe smoking while supervising smoking breaks. All staff who transfill liquid oxygen (licensed staff) will be re-educated on how to fill a portable liquid oxygen tank to include keeping the door closed as well as procedure to follow if a valve sticks during filling. This education will be provided by the Director of Education, Director of Nursing, Assistant Director of Nursing or Unit Managers by 11/18/2012.  4. The Administrator, Director of Nursing or Assistant Director of Nursing will observe smoke breaks five (5) times per week for four (4) weeks followed by three (3) times per week for eight (8) weeks to assure that the staff are providing needed smoking equipment. The Director of Nursing, Assistant Director of Nursing, or Unit Managers will observe transfilling of liquid oxygen as well as appropriate storage five (5) times per week for four (4) weeks followed by three (3) times per week for eight (8) weeks to assure appropriate safety precautions are in place. The results of the observations will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months and when the Quality Assurance Committee feels that the deficiency is corrected. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly  Completion Date: November 19, 2012	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced	F 323		11/19/12

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F 323	<p>Continued From page 6</p> <p>by:</p> <p>Based on observation, interviews, record reviews, policy reviews, and Material Safety Data Sheet (MSDS) review, it was determined the facility failed to ensure the resident environment was free from accident hazards. The facility failed to ensure their smoking policy and cautions and fall/injury care plans were implemented to ensure residents' safety when smoking. The facility assessed Resident A as requiring supervision during smoking and to have a safety smoking apron applied. On 10/02/12 one resident (A), not in the selected sample of 18, was observed smoking with peers in the smoking area near the front entrance of the facility without a safety smoking apron in place and multiple burn holes were observed in the resident's blanket covering his/her lap.</p> <p>Additionally, the facility failed to ensure staff was trained and knowledgeable regarding the safe use and transport of a liquid oxygen tank. On 10/03/12, staff was observed propping the oxygen storage room door open while completing the transfill process. Additionally, on 10/03/12 staff observed the Maintenance Supervisor moving a leaking liquid oxygen tank through the facility to the outside of the facility and the Housekeeping Supervisor was then observed, by the survey team to transport the same leaking tank outside to the far side of the property.</p> <p>The Findings Include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility SMOKING POLICY, dated effective July 01,2012, revealed all residents would be screened using the Safe Smoking Evaluation form upon admission,</li> </ol>	F 323		
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F 323	<p>Continued From page 7</p> <p>quarterly and with a significant change in condition to determine any special smoking needs. Additionally, the policy stated Residents may be required to wear smoking aprons or to adhere to other safety requirements as determined by the Safe Smoking Evaluation form.</p> <p>Resident A was admitted to the facility on 07/16/10 with diagnoses to include Dementia, Late Effect Hemiplegia Dominant Side, Lack of Coordination, Abnormal Posture and Muscle Weakness. A quarterly Minimum Data Set assessment, dated 08/10/12 revealed the facility had assessed the resident having no cognitive impairment and requiring extensive assistance with activities of daily living. A review of an Activity's of Daily Living Plan of Care revealed the following under the CAUTIONS section: "Resident smokes. Do not let resident smoke unattended". Review of Resident A Plan of Care titled Fall/Injury Assessment revealed interventions, dated 12/15/11, to include "Ensure resident safety by use of apron and monitor compliance to smoking policy."</p> <p>On 10/02/12 at 9:30 AM, an observation of several residents smoking on the front porch area near the facility entrance revealed Resident A, seated in a wheel chair and holding a cigarette with his/her left hand. Resident A had a green blanket across his/her lap that had numerous burn holes it. The resident was observed again at approximately 2:30 PM smoking with peers with a green blanket across the lap that had numerous visible burn holes.</p> <p>An interview conducted on 10/03/12 at 2:25 PM</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>with Resident A revealed he/she had used a smoking apron in the past but had not utilized one for a while. The resident stated she had burned self in the past and showed areas on his/her left hand between the first and second fingers that were discolored. Observation at the time of interview revealed a green blanket with twenty two burn holes in it. Another blanket which was blue and laying across the foot of the Resident A's bed was observed to have twenty four burn holes in it.</p> <p>An interview with Certified Nurse Aide (CNA) #3, on 10/04/12 at 9:40 AM, revealed she was familiar with Resident A and provided supervision to smoking residents when assigned. CNA #3 stated she was familiar with Resident A who had utilized a safety smoking apron in the past. CNA #3 stated she had on occasion seen Resident A flick ashes on his/her lap when not paying attention. She confirmed she was unaware that Resident A was supposed to have a safety apron applied when smoking.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 10/03/12 at 2:30 PM, revealed different staff was assigned to go outside with the residents at scheduled smoking times. LPN #2 did not know of any residents that were care planned to wear a protective smoking apron and did not know how all the staff that was assigned to supervise residents during smoking time knew which resident was required to utilize a safety smoking apron.</p> <p>An interview with the Director of Nursing (DON), on 10/04/12 at 9:30 AM, revealed supervision for residents during smoking times was assigned.</p>	F 323			

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PRINTED: 10/19/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/05/2012
NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEBY ST. FRANKLIN, KY 42135		
(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 323	<p>Continued From page 9</p> <p>The nursing staff, receptionist and dietary staff all took alternating turns to supervise residents during the smoking break. The DON did not explain how staff would know which residents might need a safety smoking apron.</p> <p>An interview with the Administrator, on 10/05/12 at 3:00 PM, revealed he had just been made aware safety smoking aprons not being utilized. He stated those providing supervision during resident smoking times should have been aware to utilize safety smoking aprons for residents that had been assessed as needing them.</p> <p>2. Review of the Material Safety Data Sheet (MSDS) - "Liquid Oxygen" revealed 2. HAZARDS IDENTIFICATION: "EMERGENCY OVERVIEW: WARNING! Extremely cold oxidizing liquid and gas under pressure, Vigorously accelerates combustion, Combustibles in contact with liquid oxygen may expose on ignition or impact, Can cause severe frostbite. Potential Health Effects Information: Routes of Exposure: ...EYE CONTACT: Tissue freezing and severe cryogenic burns of eyes, SKIN CONTACT: Tissue freezing and severy cryogenic burns of skin..."</p> <p>The facility was unable to provide a facility policy and procedure or Liquid Oxygen Safety Guideline which addressed safe handling of liquid oxygen.</p> <p>Observation, on 10/03/12 between 10:00 AM and 3:00 PM with the Maintenance Supervisor, revealed the two (2) rooms where oxygen was being transfilled had doors being propped open by staff while trans-filling. Interview, on 10/03/12 at 1:50 PM with Licensed Practical Nurse (LPN) #1, revealed the room is normally full of oxygen</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>tanks so it is more habit than anything to stand in the corridor and quickly trans-fill the oxygen instead of closing the door. Interview, on 10/03/12 at 1:50 PM with Licensed Practical Nurse (LPN) #2, revealed she sometimes does not have room to close the door while she is trans-filling.</p> <p>Additionally, on 10/03/12 at 1:30 PM, an observation revealed the Housekeeping Supervisor standing by a liquid oxygen tank on the outside of the facility by the glass doors on the 100 Hall and a basket ball sized circumference of a white liquid like substance was observed spewing from the tank.</p> <p>Interview conducted with the Assistant Director of Nursing (ADON), on 10/03/12 at 2:35 PM, revealed maintenance staff had found the liquid oxygen tank leaking in the oxygen storage room on 10/03/12 sometime prior to 1:50 PM, when he was checking the door. The ADON thought he had notified the Administrator but had not. The ADON had no idea how long the liquid oxygen tank had been leaking and said the Maintenance Supervisor transported the leaking liquid oxygen tank through the facility and outside the door. The Housekeeping Supervisor then transported the tank to the far side of the facility property.</p> <p>Interview with the Housekeeping Supervisor, on 10/03/12 at 3:45 PM, revealed the facility had not provided him any training for the management of liquid oxygen trans-filling or management of leaking liquid oxygen.</p> <p>Review of the facility's training records revealed</p>	F 323			

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F 323	Continued From page 11 documentation regarding filling the oxygen tank; however, it did not detail to ensure the door is closed to the oxygen storage room while transfilling. Further review revealed no detail with regard to training related to safety procedures when a liquid oxygen tank is leaking without manual manipulation of the valve. Additionally, there was no safety procedure detailing when the tank would be considered safe to transport throughout the facility. The document revealed to refer to Liquid Oxygen Safety Guidelines; however, the facility was unable to provide documented evidence of this document to review.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observations revealed a Santi-Bucket used for cleaning surface areas did not contain any sanitizer solution and the stove drip pans had a thick build up of food drippings which were covered with foil.	F 371	F371  1. An observation by the Dietary Service Manager on 10/25/2012 noted that the sanitizer solution tested at 200 parts per milliliter of sanitizer to water and that the drip pans in the stove were free of buildup. The Administrator observed on 10/26/2012 that all dietary staff including the Dietary Services Manager were properly wearing a hair net that covered all hair.  2. An observation by the Dietary Service manager on 10/26/2012 noted that the sanitizer solution tested at 200 parts per milliliter of sanitizer to water and that the drip pans in the stove were free of buildup. The Administrator observed on 10/29/2012 that all dietary staff including the Dietary Services Manager were properly wearing a hair net that covered all hair.  3. The Administrator will re-educate the Dietary Services Manager on covering all hair in the food service area. The Dietary Manager will re-educate all Dietary staff on the use of hair nets, the proper dilution levels and use of cleaners in the kitchen, and the cleaning schedule, including the stove drip pans. This re-education will be completed by 11/18/2012. The drip pans were added to the cleaning schedule on 10/05/2012.  4. The Dietary Services Manager will complete weekly kitchen sanitation audits for twelve (12) weeks to include proper use of sanitizing solution and following the cleaning schedule. The Administrator will observe meal preparation three (3) times per week for four (4) weeks followed by weekly for eight (8) weeks to assure all dietary staff are using hair nets to cover all hair. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months and when the Quality Assurance Committee feels that the deficiency is corrected. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12

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F 371	<p>Continued From page 12</p> <p>Findings Include:</p> <p>There was no facility policy and procedure for cleaning of the kitchen area provided:</p> <p>Review of a cleaning schedule, no date, revealed the back half of the stove top and top shelf was to be cleaned but the drip pans of the stove were not listed to be cleaned.</p> <p>An observation of the facility kitchen on 10/02/12 at 10:10 AM revealed the Santi-Bucket which was being used for wiping and cleaning kitchen surfaces contained water that was grey in color. The Dietary Manager tested the water with a solution test strip to determine the concentration of sanitizer solution. The strip indicated there was zero sanitizer in the water. The Dietary Manager stated at the time that the water should have shown 200 parts per milliliter of sanitizer to water. She stated the staff would dribble solution into the Santi-Bucket water and then use a test strip to determine if there was adequate sanitizer solution. She had no explanation why the test strip indicated there was zero sanitizer in the santi-bucket.</p> <p>Additional observation of the drip pans on the stove revealed a thick build up of crusted food debris which was covered over with foil. The Dietary Manager stated the drip pans were cleaned one time a week but they could not get it all clean because there was not a place that was big enough in the kitchen to clean them.</p> <p>An observation on 10/02/12 at 5:15 PM revealed the kitchen staff that was plating resident's food was observed with a hair restraint that did not</p>	F 371			

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F 371	Continued From page 13 cover her hair completely. The hair restraint only covered the crown of her head and pony tail and the top, sides and back of the hair was not covered. Additionally, the Dietary Manager had on a hair restraint that did not cover the hair completely.  An interview with the Dietary Manager on 10/02/12 at 5:25 PM revealed kitchen staff should always ensure hair was completely covered by a hair restraint, no exceptions.	F 371		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to be administered in a manner that enabled it to use resources effectively and efficiently to maintain the highest practicable physical, mental and psychosocial well-being of each resident. The Administrator failed to ensure facility staff had the appropriate training to utilize and manage liquid oxygen related to trans-filling and handling of accidental leaks  Additionally, the Administrator failed to ensure Maintenance staff was trained and knowledgeable to Life Safety Code Requirements to ensure facility compliance and the protection of	F 490	F490  1. The Administrator will ensure that by 11/18/2012 all appropriate staffs have been trained on appropriate and safe transfilling of liquid oxygen tanks and steps to take with accidental leaks. The Administrator will ensure by 11/18/2012 that the Maintenance Director is educated on Life Safety Code Requirements.  2. The Administrator will ensure that by 11/18/2012 all appropriate staff have been trained on appropriate and safe transfilling of liquid oxygen tanks and steps to take with accidental leaks. The Administrator will ensure by 11/18/2012 that the Maintenance Director is educated on Life Safety Code Requirements.  3. The Regional Director of Operations will re-educate the Administrator by 11/18/2012 on his responsibility to administer the facility in a manner to ensure all training occurs as directed by the Federal Regulations and Life Safety Codes.  4. The Regional Director of Operations will review training records on a monthly basis for three (3) months to assure that training is occurring as scheduled. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for at least three (3) months and when the Quality Assurance Committee feels that the deficiency is corrected. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing, and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly  Completion Date: November 19, 2012	

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F 490	Continued From page 14 residents. (Refer to the Life Safety Code CMS2567.)  Findings include:  A review of the Administrator's Job Description, dated 07/01/12, revealed the position purpose was to direct day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern nursing facilities to assure that the highest degree of quality care can be provided residents at all times.  (Refer to F323) The facility failed to ensure staff was trained and knowledgeable regarding the safe use, transport of a liquid oxygen tank and handling of accidental leaks. On 10/03/12, staff was observed propping the oxygen storage room door open while completing the transfill process. Additionally, on 10/03/12 staff observed the Maintenance Supervisor moving a leaking liquid oxygen tank through the facility to the outside of the facility and the Housekeeping Supervisor was then observed, by the survey team to transport the same leaking tank outside to the far side of the property. Review of the facility's training records revealed documentation regarding filling the oxygen tank; however, it did not detail to ensure the door is closed to the oxygen storage room while transfilling. Further review revealed no detail with regard to training related to safety procedures when a liquid oxygen tank is leaking without manual manipulation of the valve. Additionally, there was no safety procedure detailing when the tank would be considered safe to transport throughout the facility. The document revealed to refer to Liquid Oxygen Safety	F 490			

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F 490	<p>Continued From page 15</p> <p>Guidelines; however, the facility was unable to provide documented evidence of this document to review.</p> <p>(Refer to the Life Safety Code (LSC) CMS 2567L 10/03/12) The facility failed to ensure compliance with thirteen LSC requirements. K72,143, and 147 were repeat deficiencies from the previous recertification survey 06/14/11 which were identified out of compliance during this survey. Interviews with the newly hired Maintenance Supervisor, on 10/03/12 between 10:00 AM and 3:00 PM, revealed he was unaware of most of the LSC requirements.</p> <p>An interview with the Administrator, on 10/05/12 at 3:00 PM, revealed prior to 10/03/12 there had been no inservicing provided to the Housekeeping Supervisor that transported a leaking liquid oxygen tank through the facility and to the outside of the facility. Additionally, the Administrator was unable to provide a facility policy that addressed the management of potential leaking liquid oxygen or ensuring the door was closed when trans-filling liquid oxygen. Furthermore, interview on 10/03/12 at 4:45 PM, revealed that for more of the technical aspects of the LSC requirements he relies on the surveyors for guidance.</p>	F 490		
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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: 1992.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1992, with 33 smoke detectors and 6 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1992.</p> <p>GENERATOR: Type II generator installed in 2010. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was conducted on 10/02/12 and 10/03/12. Franklin-Simpson Nursing &amp; Rehab was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Ninety-Eight (98) beds with a census of eighty seven (87) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare requirements.</p>	11/19/12

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.

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	K018	
K 018 SS=F	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke	K 018	1. The Maintenance Director will adjust the privacy curtain track in Room 223 so that the door will close without impediment to resist the passage of smoke, in accordance with NFPA standards before 11/18/2012. The Administrator observed Room 226 without a walker blocking the door on 10/22/2012. The Maintenance Director will adjust the privacy curtain track in Room 222 so that the door will close without impediment to resist the passage of smoke, in accordance with NFPA standards before 11/18/2012. The Maintenance Director and/or Housekeeping and Laundry Supervisor adjusted the alignment of the resident's bed on 10/23/2012 in Room 215 to insure proper closure of the door. The Maintenance Director will adjust the privacy curtain track in Room 133 so that the door will close without impediment to resist the passage of smoke, in accordance with NFPA standards by 11/18/2012.  2. The Maintenance Director has completed an audit of all other facility doors on 10/25/2012 to insure they resist the passage of smoke and have no impediments to closure. The identified concerns from this audit by the Maintenance Director will be corrected by 11/18/2012.  3. The Administrator will re-educate the Maintenance Director related to assuring facility doors meet the standards to resist the passage of smoke and have no impediments to closure. This education by the Administrator will be provided on 11/01/2012.  4. The Maintenance Director will audit all facility doors monthly for three (3) months to assure all doors meet the standards to resist the passage of smoke and have no impediments to closure. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12

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K 018	<p>Continued From page 2</p> <p>compartments, sixty-eight (68) residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure six (6) resident doors could be closed with a single motion.</p> <p>The findings include:</p> <p>Observations, on 10/03/12 between 9:00 AM and 3:00 PM with the Maintenance Supervisor, revealed the corridor doors to the resident rooms were blocked from closing. The rooms affected by this were rooms# 223 privacy curtain blocking door, 226 walker blocking door, 222 privacy curtain blocking door, 220 privacy curtain blocking door, 215 resident bed blocking door, and 133 privacy curtain blocking door.</p> <p>Interviews, on 10/03/12 between 9:00 AM and 3:00 PM with the Maintenance Supervisor, revealed he was unaware the items were blocking the doors from closing.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety non-compliance.</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</p>	K 018			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  10/03/2012
NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBEY ST. FRANKLIN, KY 42135		
(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 018	Continued From page 3 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. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or 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  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or	K 018			

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K 018	Continued From page 4 plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018			
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke doors that would self-close and resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure all doors in the smoke barriers would self-close and cross-corridor doors were functioning properly.  The findings include:	K 027	K027  1. The smoke barriers located on C Hall at the dining room and across from the DON office will have a coordinating device installed to meet the requirement of self-closing to resist the passage of smoke. The Maintenance Director has received a quote on the installation of the device. The vendor, Western Kentucky Door & Specialties, has indicated that it will install the coordinating device before 11/18/2012.  2. The Maintenance Director and the vendor have audited all smoke barrier doors to ensure the doors meet the requirement of self-closing to resist the passage of smoke. The identified concerns will be corrected by 11/18/2012.  3. The Administrator will re-educate the Maintenance Director on the requirement that all smoke barrier doors close appropriately to resist the passage of smoke. This education will be completed by 11/01/2012.  4. The Maintenance Director will check the smoke barrier doors monthly for three (3) months to ensure that they are operating properly to self-close and resist the passage of smoke. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012		

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K 027	<p>Continued From page 5</p> <p>Observation, on 10/02/12 between 3:15 PM and 3:40 PM with the Maintenance Supervisor, revealed that the doors in the smoke barriers would not close and latch with the current hardware installed. The doors were equipped with closing hardware but the doors would not close and latch. Preventing the doors from meeting the requirement of self-closing in order to resist the passage of smoke.</p> <p>Interview, on 10/02/12 between 3:15 PM and 3:40 PM with the Maintenance Supervisor, revealed that he was not aware the doors were not properly closing.</p> <p>Observation, on 10/03/12 between 11:00 AM and 2:00 PM with the Maintenance Supervisor, revealed the cross-corridor doors located on C Hall at the dining room and next to the Director of Nursing' office would not close completely when tested. Observation revealed the doors did not have a coordinating device installed on the doors, which prevented them from closing properly.</p> <p>Interview, on 10/03/12 between 11:00 AM and 2:00 PM with the Maintenance Supervisor, revealed he was unaware the doors needed a coordinating device to ensure the door without the astragal would always close first.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they installed the smoke barrier doors after the last survey but he was unaware the doors were not performing correctly.</p>	K 027		

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K 027	Continued From page 6 Reference: NFPA 101, 19.3.7.6*. (2000 Edition) Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027	K029  1. The doors listed under the K029 tag, unit managers office on A Hall, housekeeping supply closet on C hall, business office, both of them, therapy gym, both doors, LED office, dry storage in kitchen, sprinkler valve room, dietary managers office, Social Services/Admissions office, DON office, classroom, beauty shop, medical records, housekeeping supervisor's office, will have a door closer installed to provide the doors with the proper closing to insure its providing a smoke barrier per NFPA guidelines. The vendor, Western Kentucky Door & Specialties, has indicated that it will be completed by 11/18/2012.  2. The remaining doors throughout the facility were audited on 10/24/2012 by the vendor, Western Kentucky Door & Specialties, to determine if a door closer is needed. If the audit identifies any doors needing a closer, they will be installed by the vendor, Western Kentucky Door & Specialties before 11/18/2012.  3. The Administrator will re-train the Maintenance Director on 11/01/2012 of the requirements for doors of having a closing device and resisting the passage of smoke when the room is larger than 50 square feet with substantial combustible material.  4. The Maintenance Director will audit the facility's doors on a weekly basis for three (3) months to ensure the doors are self-closing and resisting the passage of smoke. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012		
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	K 029			

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K 029	Continued From page 7 accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure sixteen (16) rooms with hazardous storage had the proper door closer for separation.  The findings include:  Observation, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed: 1) The unit managers' office on A Hall did not have a door closer installed. 2) The housekeeping supply closet on C Hall did not have a door closer installed. 3) Both business offices on C Hall did not have a door closer installed. 4) Both doors for the Therapy area did not have a door closer installed. 5) The life enrichment office did not have a door closer installed. 6) The dry storage room in the kitchen did not have a door closer installed. 7) The sprinkler valve room did not have a door closer installed. 8) The dietary manager office did not have a door closer installed. 9) The social services/admissions office did not have a door closer installed. 10) The Director of Nursing office did not have a door closer installed. 11) The Nursing Services office did not have a door closer installed.	K 029		

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K 029	<p>Continued From page 8</p> <p>12) The Beauty Salon did not have a door closer installed.</p> <p>13) The medical records office did not have a door closer installed.</p> <p>14) The housekeeping supervisor office did not have a door closer installed.</p> <p>Any room larger than 50 square feet with substantial combustible material must have a door that resists the passage of smoke and a closing device.</p> <p>Interview, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety noncompliance. He was unaware the storage in the listed areas made them hazardous storage.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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</p>	K 029			

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K 029	Continued From page 9 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 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), 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.	K 029		
K 045 SS=F	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 darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	K045  1. The Maintenance Director has replaced the outside emergency lighting with 2 bulb lights at the following locations: B wing front door was completed on 10/22/2012, B wing back door was completed on 10/18/2012, kitchen exit by dry storage was completed on 10/19/2012, and A wing front door was completed on 10/19/2012.  2. The Maintenance Director audited on 10/22/2012 all external exits to insure that appropriate lighting is present and that it will not leave the area in darkness if one bulb fails.  3. The Administrator will re-educate the Maintenance Director regarding the requirements of illumination on means of egress, including exit discharge so that failure of any single lighting fixture will not leave the area in darkness. This education will be provided by the Administrator on 11/01/2012.  4. The Maintenance Director will audit the outside emergency lights monthly for three (3) months to ensure compliance. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12

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K 045	<p>Continued From page 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at four (4) exits.</p> <p>The findings include:</p> <p>Observation, on 10/03/12 between 8:50 AM and 3:30 PM with the Maintenance Supervisor, revealed the exterior exits at the b-wing front door, the b-wing back door, kitchen exit by the dry storage room, and the front door of a-wing only had a single light for illumination of the outside of the exit.</p> <p>Interview, on 10/03/12 between 8:50 AM and 3:30 PM with the Maintenance Supervisor, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Further interview revealed he just placed new light fixtures on the front of the building with a single bulb.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety noncompliance.</p>	K 045			

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K 045	Continued From page 11 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			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times.  The findings include:	K 050	K050  1. The Maintenance Director will conduct fire drills at unexpected times throughout the shifts, so that there will not be any expected times for a drill. The Maintenance Director has been retrained on 10/24/2012 by the Administrator in Training on the completion of the fire drills. The Maintenance Director will vary the times of the drills each month.  2. The Maintenance Director will be re-educated by the Administrator on 11/01/2012 on the requirement of performing fire drills at random times, so that staff will not be expecting the drills.  3. The Maintenance Director will be re-educated by the Administrator on 11/01/2012 on the requirement of performing fire drills at random times, so that staff will not be expecting the drills.  4. The Maintenance Director will audit fire drills to assure all have been completed randomly. The results of the audits will be reviewed with the Quality Assurance Committee quarterly for one year. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12	

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K 050	Continued From page 12  Fire Drill review, on 10/02/12 at 4:15 PM with the Maintenance Supervisor, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on first shift were conducted routinely at 7:30 AM, second shift routinely around 3:00 PM or around 7:30 PM, and third shift routinely at 5:30 AM and 10:20 AM.  Interview, on 10/02/12 at 4:15 PM with the Maintenance Supervisor, revealed he was unaware the fire drills were not being conducted as required. The Maintenance Supervisor was unaware of the time separation on each shift to consider the times unexpected. Further interview revealed he always has to check with the Administrator to make sure it is a good time to have a fire drill.  Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety incompliance. Further interview revealed he was unaware of the need for unexpected times regarding the fire drills.  Reference: NFPA 101 (2000 edition)  19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	K054  1. The Regional Plant Operations Director asked the Maintenance Director to remove all the battery operated smoke detectors in the building because these detectors are not tied into the fire panel. The battery operated smoke detectors were removed on 10/26/2012. The facility's current system is established to handle the fire protection needs of the building without the use of the battery operated smoke detectors.  2. The facility will re-educate our staff by 11/18/2012 on the importance of always monitoring resident care areas, including patient rooms, for any signs of potential fire hazards and reporting those hazards immediately to the maintenance director or administrator.  3. The Maintenance Director will be re-educated by the Administrator on the use of the existing smoke detectors and the requirements of the fire prevention system in the building. The re-education by the Administrator will be completed on 11/01/2012.  4. The Maintenance director will audit the facility's fire prevention system each week and document any re-education or training which needs to be provided on the fire prevention system. The audit and any identified issues will be addressed immediately, and the results will be reported to the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  All required smoke detectors, including those	K 054		11/19/12

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PRINTED: 10/19/2012  
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135	
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K 054	<p>Continued From page 13</p> <p>activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure that the battery powered smoke detectors in each resident room were being properly tested and cleaned.</p> <p>The findings include:</p> <p>Record review, on 10/02/12 at 4:25 PM with the Maintenance Supervisor, revealed there was no documentation of Smoke Detector weekly testing or monthly cleaning of the smoke detectors since June 30, 2012. Smoke detectors must be tested according to the manufacturer's specifications to ensure their reliability. Review of the manufacturer's specifications of the battery powered smoke detectors in the resident rooms recommended a weekly check of the smoke detectors and a monthly cleaning of the detector.</p> <p>Interview, on 10/02/12 at 4:25 PM with the Maintenance Supervisor, revealed he was unaware the facility did not have current checks of the smoke detectors. The company changed</p>	K 054		

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K 054	Continued From page 14 owners after June the 30th and the new companies' version of the Tels program, which is a computer program that documents all the maintenance done in the facility, did not contain the smoke detector checks like the previous version. Further interview revealed he was unaware the detectors were supposed to be cleaned monthly.  Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety noncompliance.  Reference: NFPA 72 (1999 ed.) 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer ' s instructions. The frequency of maintenance shall depend on the type of equipment and the local ambient conditions.	K 054	1. The Maintenance Director has contacted our sprinkler company, Tri-State Fire Protection, Inc. about moving the sprinkler heads in the following areas: therapy office, lobby hallway, housekeeping supervisor's office, women's bathroom on c hall, a wing med room, a wing shower room, resident bathroom #201, resident bathroom, #112, resident bathroom #109. The facility will move the sprinkler heads that are within 4 inches of the wall in the following areas: closet in room #221, closet in room #213, closet in room #215, closet in room #112, closet in room #127, closet in room #126, closet in room #132, closet in room #139, closet in room #135, closet in room #133, unit managers office in a wing, unit managers office in b wing, dry storage in the kitchen, soiled utility room on c hall. The sprinkler company, Tri-State Fire Protection, Inc. has submitted a proposal and has scheduled the work to be completed before 11/18/2012.  2. The sprinkler company, Tri-State Fire Protection, Inc. has audited the facility to insure that all sprinkler heads are visually inspected. After being inspected, those sprinkler heads identified as needing to be moved; related to the distance from the light fixture or the distance from the wall, will be moved. The Maintenance Director will insure that the sprinkler company performs the work and completes the tasks required to bring us in compliance before 11/18/2012.  3. The Maintenance director will be re-educated by the Administrator on 11/01/2012 on the requirements for fire sprinkler heads and the importance of having the proper inspections completed by the fire sprinkler company.  4. The Administrator, Maintenance Director, Director of Nursing or the Assistant Director of Nursing will audit the sprinkler heads monthly and the audit will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056		11/19/12	

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K 056	<p>Continued From page 15</p> <p>switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures in nine (9) areas and located at least 4 inches from a wall in ten (10) areas.</p> <p>The findings include:</p> <p>Observations, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in the Therapy office, Lobby Hall, Housekeeping Supervisor Office, women's bathroom on C-hall, A-wing Med Room, and A-wing shower room were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in the resident bathrooms of rooms#201, 112, and 109.</p> <p>Interview, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head.</p>	K 056			

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K 056	Continued From page 16  Observation, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed sprinkler heads in the in resident closets of rooms#221, 213, 215, 112, 127, 126, 132, 139, 135, and 133 that were located within 4 inches of the wall. Further observation revealed the unit manager's office on A and B wing, Dry Storage room in Kitchen, and the soiled utility room on C hall also had sprinkler heads located within 4 inches of the wall.  Interview, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware of the requirement that a sprinkler head must be installed at a minimum of 4 inches from any wall.  Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety noncompliance.  Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)	K 056			

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K 056	<p>Continued From page 17</p> <p style="text-align: center;">Maximum Allowable Distance</p> <table border="0"> <tr> <td>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td>of Deflector Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures and located at least 4 in from a wall.</p> <p>The findings include:</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)																											
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K 056	<p>Continued From page 18</p> <p>Observations, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed the sprinkler heads located in the Therapy office, Lobby Hall, Housekeeping Supervisor Office, women ' s bathroom on C-hall, A-wing Med Room, and A-wing shower room were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in the resident bathrooms of rooms# 201, 112, and 109.</p> <p>Interview, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head.</p> <p>Observation, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed sprinkler heads in the in resident closets of rooms# 221, 213, 215, 112, 127, 126, 132, 139, 135, and 133 that were located within 4 inches of the wall. Further observation revealed the unit manager ' s office on A and B wing, Dry Storage room in Kitchen, and the soiled utility room on C hall also had sprinkler heads located within 4 inches of the wall.</p> <p>Interview, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware of the requirement that a sprinkler head must be installed at a minimum of 4 inches from any wall.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the</p>	K 056			

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K 056	Continued From page 19 surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety Incompliance.  Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP).  Maximum Allowable Distance Distance from Sprinklers to of Deflector above Bottom of Side of Obstruction (A) Obstruction (in.) (B) Less than 1 ft 0 1 ft to less than 1 ft 6 in. 21/2 1 ft 6 in. to less than 2 ft 31/2 2 ft to less than 2 ft 6 in. 51/2 2 ft 6 in. to less than 3 ft 71/2 3 ft to less than 3 ft 6 in. 91/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 16 1/2 5 ft and greater 18  For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers	K 056		

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K 056	Continued From page 20 shall be located a minimum of 4 in. (102 mm) from a wall.	K 056			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, record review, and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the interior of the pipe in the sprinkler system was inspected within the past five (5) years, and items were stored 18 " from any sprinkler heads in five (5) rooms.  The findings include:  Observation and record review, on 10/02/12 at 4:15 PM with the Maintenance Supervisor, revealed the facility failed to provide documentation that the interior of the sprinkler piping had been inspected within the last 5 years. Further observation revealed the last interior pipe inspection was performed in November of 2000.  Interview, on 10/02/12 at 4:15 PM with the	K 062	K062  1. The sprinkler company will complete an interior pipe inspection as per NFPA standards, to insure there are no obstructions in the lines. The items in the closets will be rearranged to insure proper clearance of 18 inches from the sprinkler heads, the resident closet in room #226, the resident closet in room #108, the resident closet in room #205, the resident closet in room #204, and the life enrichment closet. The inspection and clearance will be completed prior to 11/18/2012.  2. The sprinkler company will complete the required inspection before 11/18/2012 and the Maintenance Director will audit the remaining closets throughout the building to insure that there is 18 inch clearance.  3. The Maintenance Director will be re-educated by the Administrator on 11/01/2012 on the requirements of the interior pipe inspection and also on the 18 inch clearance under the sprinkler heads.  4. The Maintenance director will audit the facility weekly for compliance with the 18 inch clearance throughout the building. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12	

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K 062	<p>Continued From page 21</p> <p>Maintenance Supervisor, revealed he was not aware the interior piping of the sprinkler system had to be inspected once every five years. Further interview revealed he relied on the sprinkler company to do the proper maintenance to the system.</p> <p>Observations, on 10/03/12 between 9:00 AM and 2:00 PM with the Maintenance Supervisor, revealed there were items being stored within 18 inches of the sprinkler head in the closet of rooms #226, 204, 108, 205 and the activities closet.</p> <p>Interview, on 10/03/12 between 9:00 AM and 2:00 PM with the Maintenance Supervisor, revealed he was unaware of the storage in the closets being within 18 inches of the sprinkler head.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety noncompliance.</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected,</p>	K 062			

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K 062	Continued From page 22 tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather)  2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-hlgh temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter  2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter	K 062			

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OMB NO. 0938-0391

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K 062	<p>Continued From page 23</p> <p>2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated In Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary</p>	K 062			

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K 062	Continued From page 24 temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.  Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a class-k fire extinguisher for the kitchen was readily available, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, no residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the class-k fire extinguisher had the proper signage in the kitchen.  The findings include:  Observation, on 10/03/12 at 10:30 AM with the Maintenance Supervisor, revealed there was no signage stating that the hood suppression system	K 069	K069  1. A sign was placed in the kitchen on 10/19/2012 to insure that the staff know to use the fire suppression hood system first, and then use the class K fire extinguisher.  2. The Maintenance Director will insure that all fire extinguishers in the building have the proper signage by 11/18/2012.  3. The Administrator will re-educate the Maintenance Director on 11/01/2012 about the requirements for fire extinguishers.  4. The Maintenance Director will audit extinguishers monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12

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K 069	Continued From page 25 must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.  Interview, on 10/03/12 at 10:30 AM with the Maintenance Supervisor, revealed he was unaware of the signage requirement.  Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety noncompliance.  Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher	K 069		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect one (1) of	K 072	K072  1. The electric wheelchair on A wing will not be charged in the hallway, and staff will be re-educated on the need to provide clearance in the hallways and remove any obstructions by 11/18/2012. The chairs in the corridor on a wing will be moved, and the residents will be allowed to use the sitting area on a wing instead of the hallway. We will discuss this change in our resident council meeting next month, and address any issues which are brought up by the residents related to this change. The resident council meeting will be scheduled before 11/18/2012 or a special meeting will be called to discuss this item.  2. The Maintenance Director will audit the compliance for clearance of the hallway during his daily rounds, and address any issues identified immediately. The Maintenance Director and staff of the facility will be re-educated on the clearance in the hallways and obstructions before 11/18/2012.  3. The Administrator will re-educate the Maintenance Director on monitoring for clear hallways, without obstruction on 11/01/2012. All facility staff will be re-educated on the hallways being free of obstructions and impediments by the Education and Training Director, Director of Nursing, Administrator or Assistant Director of Nursing by 11/18/2012.  4. The Maintenance Director will conduct weekly rounds in the facility for twelve (12) weeks to ensure that hallways are free of obstructions and impediments. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12

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K 072	<p>Continued From page 26</p> <p>five (5) smoke compartments, forty (40) residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure wheelchairs and chairs were properly stored out of the corridor when not in use. This deficiency was cited on the survey last year on 06/14/11.</p> <p>The findings include:</p> <p>Observation, on 10/03/12 between 3:30 PM and 4:20 PM with the Maintenance Supervisor, revealed an electric wheelchair was stored and plugged into the wall in the A-wing corridor from 3:30 PM to 4:20 PM. Further observation revealed several chairs stored in the corridor from 3:30 PM to 4:20 PM of the A-wing.</p> <p>Interview, on 10/03/12 between 3:30 PM and 4:20 PM with the Maintenance Supervisor, revealed the facility routinely stored the chairs in the corridor so that the residents could sit in them if they wished.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety noncompliance. Further interview revealed the facility was keeping the chairs in the carpeted area out of the corridor but the chairs had moved back to the outside of the resident rooms so they could sit and watch other residents.</p> <p>This is a repeat deficiency.</p>	K 072			

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K 072	Continued From page 27	K 072		
K 073 SS=F	<p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 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.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated.</p> <p>The findings include:</p> <p>Observation, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed several stuffed animals, wreaths, and artificial floral arrangements throughout the facility had no flame retardant applied.</p> <p>Interview, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware decorations were required to be</p>	K 073	<p>K073</p> <ol style="list-style-type: none"> <li>1. The Maintenance Director will spray the decorations, stuffed animals, wreaths, and artificial floral arrangements throughout the building with fire retardant spray. The spraying will be completed by November 19, 2012.</li> <li>2. The Maintenance Director will audit the facility for items which need to be sprayed and will develop a system to document his efforts of spraying with fire retardant. Any identified items will be sprayed by November 19, 2012</li> <li>3. The Administrator will re-educate the Maintenance Director on November 1, 2012 about the NFPA guidelines related to decorations and furnishings in the health care facility.</li> <li>4. The Maintenance Director will audit weekly for 8 weeks, the completion of the spraying for decorations and furnishings. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.</li> </ol> <p>Completion Date: November 19, 2012</p>	11/19/12

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K 073	Continued From page 28 treated with a fire retardant spray.  Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety noncompliance.  Reference: NFPA 101 (2000 Edition)  19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073			
K 143 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Transferring of oxygen is:  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;  (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143	K143  1. The liquid oxygen transfer rooms were vented to the outside on 10/29/2012 by Rollin Mechanical. The liquid oxygen transfer rooms will have a 1 hour fire rated door installed by Western Kentucky Door & Specialties by 11/18/2012.  2. All staff who transfill liquid oxygen (licensed staff) will be re-educated on how to fill a portable liquid oxygen tank to include keeping the door closed as well as procedure to follow if a valve sticks during filling. This education will be provided by the Director of Education, Director of Nursing, Assistant Director of Nursing, or Unit Managers by 11/18/2012. The Maintenance Director will be re-educated on the requirements of the liquid oxygen rooms on 11/01/2012.  3. All staff who transfill liquid oxygen (licensed staff) will be re-educated on how to fill a portable liquid oxygen tank to include keeping the door closed as well as procedure to follow if a valve sticks during filling. This education will be provided by the Director of Education, Director of Nursing, Assistant Director of Nursing, or Unit Managers by 11/18/2012. The Maintenance Director will be re-educated by the Administrator on 11/01/2012 in regards to the liquid oxygen requirements for the facility.  4. The Maintenance Director will conduct weekly audit of the liquid oxygen rooms. The results of the audits will be reviewed with the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12	

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K 143	<p>Continued From page 29</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire rated door and the door was being closed at the time of oxygen trans-filling.</p> <p>The findings include:</p> <p>Observation, on 10/03/12 between 10:00 AM and 3:00 PM with the Maintenance Supervisor, revealed the two (2) rooms in which oxygen was being transferred did not have proper ventilation. The rooms were mechanically ventilated to the attic and did not vent to the outside of the facility. Further observation revealed the oxygen trans-filling rooms did not have a fire rated door on them. Another observation revealed the door was being propped open by staff while trans-filling.</p> <p>Interview, on 10/03/12 at 1:50 PM with Licensed Practical Nurse (LPN) #1, revealed the room is normally full of oxygen tanks so it is more habit than anything to stand in the corridor and quickly trans-fill the oxygen instead of closing the door. Interview revealed she was aware the door was suppose to be closed and latch before transfilling could occur.</p>	K 143			

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K 143	<p>Continued From page 30</p> <p>Interview, on 10/03/12 at 1:50 PM with Licensed Practical Nurse (LPN) #2, revealed she sometimes does not have room to close the door while she is trans-filling. Interview revealed she was aware the door was suppose to be closed and latch before transfilling could occur.</p> <p>Interview, on 10/03/12 between 10:00 AM and 3:00 PM with the Maintenance Supervisor, revealed he was unaware the doors on the oxygen trans-filling rooms must be fire rated, and the room must mechanically vent to the outside.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed the facility thought they were in compliance because they mechanically vented the oxygen rooms to the attic and the plan of correction was accepted on the last visit; however, review of the facility's Plan of Correction revealed the facility did not detail where the vent the facility installed actually vented to.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <ul style="list-style-type: none"> <li>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</li> <li>b. The area is mechanically ventilated, is</li> </ul>	K 143			

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K 143	Continued From page 31 sprinklered, and has ceramic or concrete flooring; and c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted. Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfiling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143			
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, fifty-eight (58) residents, staff and visitors. The facility is certified for ninety-eight (98) beds with a census of eighty-seven (87) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them and power strips were being used properly. Bwing clean linen room had linens	K 147	K147  1. The Maintenance Director on 10/22/2012 has placed a red tape around the electrical panels to identify a 3 foot clearance, and to help provide a visual reminder to staff of the area which needs to be clear. The refrigerators will be plugged directly into a wall outlet and not plugged into a power strip. The Maintenance Director and an electrician will be adding additional plugs in the rooms to provide an adequate number for the usage. The power strips with the extension cords will be removed and the staff will be re-educated on the requirements related to the use of extension cords in the building.  2. The Maintenance Director will check to make sure that extension cords are not being used in the facility. The Maintenance Director will audit the facility for inappropriate usage of both multi plug outlets and extension cords.  3. The Maintenance Director will check the facility on a weekly basis to insure that extension cords are removed. Staff will be re-educated by 11/18/2012 about the use of extension cords and to report to the maintenance director.  4. The Maintenance Director will report his audit results to the Quality Assurance Committee on a monthly basis for three (3) months. If at any time a concern is identified, a Quality Assurance Committee meeting will be held to review concerns for further recommendations as needed. The members of the Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Assistant Director of Nursing and the Facility Rehabilitation Coordinator. The Medical Director will attend at least quarterly.  Completion Date: November 19, 2012	11/19/12	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185331	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  10/03/2012
NAME OF PROVIDER OR SUPPLIER  FRANKLIN-SIMPSON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 414 ROBESY ST. FRANKLIN, KY 42135		
(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 147	<p>Continued From page 32</p> <p>stored six (6) Inches from the electrical panel. Seven resident rooms and two offices utilized power strips violating the requirements. Furthermore the facility was cited this deficiency previously on 06/14/11 regarding power strips, the facility had recently conducted an audit which failed to identify these issues.</p> <p>The findings include:</p> <p>Observations, on 10/03/12 at 10:00 AM with the Maintenance Supervisor, revealed the electrical panels in the B-wing clean linen room had storage of a linen rack full of clean linen within six (6) inches of the electrical panels.</p> <p>Interview, on 10/03/12 at 10:00 AM with the Maintenance Supervisor, revealed he was awara there could not be storage within three (3) feet of an electrical panel. He stated the rack was not in that position the day before but had been moved on the day of the survey.</p> <p>Observations, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed;</p> <ol style="list-style-type: none"> <li>1) A refrigerator was plugged into a power strip located in room# 221.</li> <li>2) A refrigerator was plugged into a power strip located in room# 222.</li> <li>3) An oxygen concentrator was plugged into a power strip located in room# 220.</li> <li>4) A bed was plugged into a power strip located in room# 214.</li> <li>5) A bed, oxygen concentrator, and a refrigerator were plugged into a power strip located in room# 212.</li> </ol>	K 147			

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K 147	<p>Continued From page 33</p> <p>6) An electric chair and a refrigerator were plugged into a power strip located in room# 202.</p> <p>7) A power strip was plugged into a power strip located in the life enrichment office.</p> <p>8) An oxygen concentrator was plugged in a power strip located in room# 207.</p> <p>9) An extension cord was plugged into a power strip going to a refrigerator located in the Housekeeping supervisor office.</p> <p>Interview, on 10/03/12 between 9:00 AM and 4:00 PM with the Maintenance Supervisor, revealed he was unaware of what could be plugged into a power strip.</p> <p>Interview, on 10/03/12 at 4:45 PM with the Administrator, revealed that for more of the technical aspects of Life Safety he relies on the surveyors for guidance. He revealed they do make rounds throughout the facility looking for any life safety Incompliance. Further interview revealed he was disappointed since they had just performed a round by the maintenance personnel looking for oxygen concentrator's plugged into power strips.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 99 (1999 edition) 110-26. Spaces 10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to</p>	K 147		

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K 147	<p>Continued From page 34</p> <p>qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft)</td> </tr> <tr> <td></td> <td></td> <td colspan="2">1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)				1.2 m (4 ft)		K 147		
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K 147	Continued From page 35  (a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the	K 147			

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K 147	Continued From page 36 electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance	K 147		

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K 147	Continued From page 37 specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.  Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147			