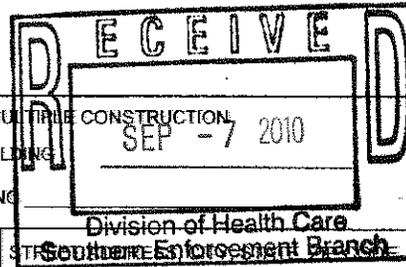


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 08/31/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185125</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/19/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HILLCREST NURSING HOME</b>	Division of Health Care <del>Southern Enforcement Branch</del> 1245 AMERICAN GREETINGS RD, P O BOX 556 CORBIN, KY 40702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<b>INITIAL COMMENTS</b>	F 000		
F 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,</p>	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David M. Myers, Administrator TITLE: \_\_\_\_\_ (X6) DATE: 9/2/10

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

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F 156	<p>Continued From page 1</p> <p>including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and</p>	F 156		

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F 156	<p>Continued From page 2</p> <p>provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to include the date of non-coverage in the Notice of Medicare Provider Non-Coverage denial notice for five (5) of five (5) resident (residents #26, #27, #28, #29, and #30) records reviewed that had received a denial notice.</p> <p>The findings include:</p> <p>A review of the denial notices for Non-Medicare coverage for residents #26, #27, #28, #29, and #30 revealed the notices sent to the resident/responsible party failed to include the date non-coverage would begin.</p>	F 156		

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F 156	Continued From page 3 An interview with the facility Bookkeeper conducted on August 19, 2010, at 8:15 a.m., revealed the Bookkeeper was responsible for issuing the denial notices to residents/responsible parties. The Bookkeeper stated she was unaware of the requirement to include the date non-coverage would begin.	F 156		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide food that was palatable, attractive, and at the proper temperature. Observation of the evening meal on August 17, 2010, revealed milk was served at an above the recommended point of service temperature.  The findings include:  Observation on August 17, 2010, of the evening meal on the East Wing revealed the second meal cart was delivered to the wing at 5:32 p.m. The last tray to be delivered from the cart was delivered at 5:58 p.m. The surveyor requested a test tray. The facility's Registered Dietitian (RD) used the facility's thermometer to test the food temperatures. The temperature of the milk on the test tray read 50 degrees Fahrenheit. The temperature was verified with the RD and another	F 364		

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F 364	Continued From page 4 surveyor who was present.  A review of the facility's policy, which contained no date, revealed resident food trays are to be passed in a period of less than 20 minutes. The policy also revealed cold food would be served at a temperature of 41 degrees or less.  An interview with the RD on August 17, 2010, at 6:05 p.m., revealed the point of service temperature for milk was to be 41 degrees or less. The RD further stated the milk had been placed on ice prior to delivery, and the RD had been unaware of the length of time the trays had sat on the unit prior to being delivered to the residents.  An interview was conducted on August 17, 2010, at 6:15 p.m., with Certified Nursing Assistants (CNAs) #1, #2, #3, #4, and #5. The CNAs stated the trays on the East Wing usually took until 6:30 p.m. every evening to be served to residents. The CNAs were unaware of any timeframe required for the trays to be delivered to the residents. The CNAs further revealed they were unaware of the facility's policy regarding the maximum length of time allowed to deliver a tray to a resident before the tray should be replaced.  An interview with a resident who lived on the East Wing of the facility on August 17, 2010, at 6:20 p.m., and whose tray was delivered last, reported that often the food trays sat on the delivery racks for an hour, before being delivered to the residents. The resident stated the food was frequently cold at the evening meals.	F 364		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	<p>Continued From page 5</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to label all drugs and biologicals used in the facility in accordance with currently accepted</p>	F 431		

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F 431	<p>Continued From page 6</p> <p>professional principles including the expiration date when applicable. The facility had one (1) vial of open (in use) insulin that did not have the date when first opened written on the bottle. In addition, a bottle of Xalatan ophthalmic solution displayed a pharmacy label, "Store in Refrigerator" but was in the medication cart unrefrigerated.</p> <p>The findings include:</p> <p>Observation of the West Wing medication room on August 19, 2010, at 10:30 a.m., revealed that one open and in use vial of insulin was stored in the refrigerator and did not have the date when first opened written on the bottle. The expiration date could not be determined for the bottle of insulin. A bottle of Xalatan ophthalmic solution was labeled by the pharmacy to "Store in Refrigerator," however, the solution was stored in the medication cart rather than the refrigerator.</p> <p>An interview was conducted with the West Wing Unit Manager (UM) on August 19, 2010, at 10:30 a.m. The UM stated the nurse who opened the bottle was responsible for labeling the bottle with the date opened. The UM stated the bottle was not labeled correctly. The UM further stated she did not know why the Xalatan ophthalmic solution was not stored in the refrigerator as directed on the label.</p>	F 431			
F 465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p>	F 465			

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F 465	Continued From page 7  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Splintered, chipped doors, doorframes, and walls were observed in (8) eight resident rooms. A phone jack was observed hanging from the ceiling in resident room 112. An unknown dried green substance was observed on the tile in resident room 111. Resident room 114 was observed to have a hole in the wall. The baseboards in resident room 118 and the West Wing dining room were observed to be soiled and/or in need of paint. Two toilets were observed to be soiled/rusted. An electric cord was observed lying over the foot of a resident's bed. The West Wing medication cabinets were dusty inside and out and the medication cart drawers were soiled. One geri-chair was observed to be torn and ragged.  The findings include:  Observations of the facility from August 17-19, 2010, revealed the following areas were in need of maintenance/housekeeping services:  1. The Medication room on the West Wing was observed to have dust inside and outside the cabinets.  2. The medication carts in the West Wing Medication room were observed to be soiled and had dust built up inside the drawers.  3. The baseboards in resident room 118 and in	F 465			

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F 465	<p>Continued From page 8</p> <p>the West Wing dining room were observed to be soiled and/or in need of paint.</p> <p>4. Resident rooms 112, 108, 106, 104, 101, 121, 110, and 217 were observed to have paint missing from doorframes and walls.</p> <p>5. Resident rooms 106 and 121 were observed to have splintered edges on the doors.</p> <p>6. Resident room 111 was observed to have a dried greenish substance on the tile under the lavatory.</p> <p>7. Resident room 114 was observed to have a hole in the wall approximately twelve inches in length where the plaster was missing, behind the resident's chair.</p> <p>8. Resident room 112 had a wire hanging loose from the ceiling with a phone jack on the end of it.</p> <p>9. Resident room 213 was observed to have an electric cord lying across the foot of the resident's bed.</p> <p>10. The toilet in resident room 108 was observed to be soiled and the toilet in resident room 219 was observed to be rusted.</p> <p>11. A geri-chair in resident room 124 was observed to have multiple torn areas on the arms of the chair.</p> <p>An interview was conducted with the Maintenance Supervisor (MS) and Housekeeping Supervisor (HS) on August 18, 2010, at 4:00 p.m. The MS stated he did not make maintenance rounds on a regular basis, but that staff would complete a</p>	F 465		

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F 465	Continued From page 9 maintenance request for items that needed maintenance work. The HS stated she made random checks of resident rooms daily; however, she did not check every room.	F 465			

F156

In order to ensure our continuing compliance with licensure criteria, please accept the following plan of correction:

1) The bookkeeper notified resident #26, #27, #28, #29, and #30 and/or their responsible parties of the date of non-coverage in their notice that had been sent.

2) The responsible parties for all residents whose payer source is Medicare, will now be receiving an updated Medicare non-coverage form which will include all information. All letters mailed in the month of September have been updated to include the date that non-coverage begins.

3) The bookkeeper was inserviced on 8/19/10 on the correct completion of the Medicare non-coverage form. The Medicare non-coverage form has been updated to include a space for the date that non-coverage begins. The bookkeeper will also call the family to alert them of the change of payer source, and mail the letter a second time certified if it is not signed and returned promptly by the family.

4) The bookkeeper will keep a clipboard with a copy of the mailed denial of coverage forms until returned signed. As the Medicare forms are returned signed, it will be placed in their financial file and removed from the clipboard. Any discrepancies will be corrected immediately and reported to the QA Committee for review.

5) Completion Date: 8/27/10.

F364

In order to ensure our continuing compliance with licensure criteria, please accept the following plan of correction:

1) A new tray was prepared to replace the test tray for which the temperature was tested on 8/17/10. The resident received a tray and milk with good point of service temperatures.

2) The meal service was monitored on 8/17/10 by the Dietary Manager and Registered Dietitian, who then re-worked the trolley arrangement to ensure that all residents received food and drink which was at the recommended point of service temperatures.

3) The trolleys were re-arranged and meal pass observed from 8/23-8/27/10 to ensure that all residents were receiving food and drink at the recommended point of service temperatures. Nursing staff were in-serviced by the Dietary Manager on 8/27/10 on correct meal pass protocol and required point of service temperatures.

4) The Dietary Manager will continue to conduct random meal pass audits weekly x 1 month, and then monthly thereafter to ensure that all residents are receiving food and drink at the recommended point of service temperatures. She will work closely with the Registered Dietitian and re-arrange the trolleys as necessary to ensure that no problems occur. Any discrepancies will be corrected immediately and reported to the QA Committee for follow up.

5) 8/27/10.

F431

In order to ensure our continuing compliance with licensure criteria, please accept the following plan of correction:

- 1) The unlabeled insulin vial that was opened by the nurse the night before was immediately labeled. Storage information was obtained from the pharmacy on the Xalatan ophthalmic solution. It was noted that this solution only had to be refrigerated "prior to opening," and then could be stored at room temperature. This was corrected and the bottle labeled appropriately.
- 2) All other medications were checked and found to be labeled and stored appropriately.
- 3) All nurses have been inserviced by the Director of Nursing on correct labeling and storage of medications.
- 4) The med-carts/rooms will be checked weekly x 1 month and then monthly thereafter by the Unit Supervisor to ensure compliance with professional standards regarding labeling and storage of medications. Any discrepancies will be corrected immediately and reported to the QA Committee for review.
- 5) 8/20/10

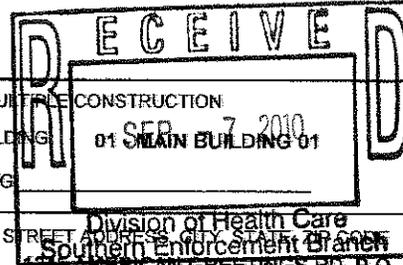
F465

In order to ensure our continuing compliance with licensure criteria, please accept the following plan of correction:

- 1) The West Wing Medication Room cabinets and med carts have been thoroughly cleaned and all dust and build up removed; The baseboards in room 118 and the West Wing dining room/day room were cleaned and re-painted; The doors and walls in rooms 112, 108, 106, 104, 101, 121, 110, and 217 were touched up where pain was missing; The doors in resident rooms 106 and 121 are being replaced, with new ones already ordered; The stained tile in room 111 has been replaced; The hole in the wall of room 114 has been dry-walled and painted; The phone jack wire has been ran appropriately in room 112; The electric cord was removed from the foot of the bed in room 213; The toilet in room 108 was thoroughly cleaned and the raised toilet seat in room 219 was replaced; The geri-chair was removed from service from room 124 and the arms replaced.
- 2) The housekeeping and maintenance supervisors made a joint inspection of every room of the facility for any needed repairs to ensure that the facility is providing a safe, functional, sanitary and comfortable environment for residents, staff and the public. Any problems were corrected immediately.
- 3) The housekeeping and maintenance supervisor have been inserviced by the Administrator on the importance of keeping the facility well maintained at all times, as well as the need to check for work orders throughout the day. This includes the completion of a weekly walking round of every room of the facility to ensure that all areas are safe, functional, sanitary and comfortable. All staff has been inserviced to complete a work order for any needed repairs or if anything needs to be replaced.
- 4) The housekeeping and maintenance supervisor have completed a thorough inspection of all areas of the facility. They will make walking rounds, checking all rooms of the facility weekly to ensure that all areas are in compliance. Any discrepancies will be corrected immediately and reported to the QA committee for review.
- 5) Completion Date: 9/7/10.

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NAME OF PROVIDER OR SUPPLIER  HILLCREST NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Care Southern Enforcement Branch 1215 AMERICAN GREETINGS RD, P O BOX 556 CORBIN, KY 40702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS  A life safety code survey was initiated and concluded on August 17, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.  Deficiencies were cited with the highest deficiency identified at "E" level.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. The facility failed to ensure that penetrations above fire/smoke barrier doors were properly sealed. This deficient practice affected four (4) of nine (9) smoke compartments, staff, and approximately forty-five (45) residents. The facility has the capacity for 120 beds with a census of 117 on the day of the survey.	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>David M. Hayes, Administrator</i>	TITLE	(X6) DATE 9/2/10
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER  HILLCREST NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1245 AMERICAN GREETINGS RD, P O BOX 556 CORBIN, KY 40702		
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K 025	<p>Continued From page 1</p> <p>The findings include:</p> <p>During the Life Safety Code survey on August 17, 2010, at 10:10 a.m., with the Director of Maintenance, unsealed penetrations around electrical conduit were observed in the fire/smoke barrier wall above the cross-corridor doors next to room 222. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility. An interview on August 17, 2010, at 10:10 p.m., revealed electrical contractors had recently been working at the facility and did not properly seal the fire/smoke barrier walls when the work was completed. During the survey a fire/smoke barrier near room 121 was also observed to have electrical conduit penetrating the fire/smoke barrier wall.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> </ol>	K 025		

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K 025	Continued From page 2 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 046 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on interview, the facility failed to ensure that exterior exits contained emergency lighting serviced by the emergency generator as required. This deficient practice affected four (4) of nine (9) smoke compartments, staff, and approximately sixty-five (65) residents. The facility has the capacity for 120 beds with a census of 117 on the day of the survey.  The findings include:  During the Life Safety Code survey on August 17, 2010, at 9:40, a.m., an interview with the Director of Maintenance revealed exterior exit lights were not connected to the emergency generator as required. The facility must provide sufficient lighting to the public way. The Director of Maintenance stated this emergency lighting issue had never come up before.  Reference: NFPA 101 (2000 Edition).  7.9.1.1* Emergency lighting facilities for means of egress	K 046		

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K 046	Continued From page 3 shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply  For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.	K 046		
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain gas clothes dryers. This deficient practice affected one (1) of nine (9) smoke compartments and staff. The facility has the capacity for 120 beds with a census of 117 on the day of the survey.  The findings include:	K 130		

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K 130	Continued From page 4  During the Life Safety Code tour conducted on August 17, 2010, at 9:50 a.m., with the Director of Maintenance, a temperature probe for the dryer's burner tube box was observed to be disconnected and lying on the bottom of the cabinet. This temperature probe ensures the dryer operates safely as intended. An interview with the Director of Maintenance on August 17, 2010, revealed the maintenance contractor should have repaired this item when servicing the dryer. Another dryer was observed to have this same type of probe halfway disconnected from the burner tube box.	K 130		

Life Safety Code:

K025

- 1) The 4/9 areas found to need sealing around electrical conduit in the fire/smoke barrier walls have been repaired.
- 2) All areas in the fire/smoke barrier walls are now sealed properly to prevent fire and smoke from spreading to other areas of the facility.
- 3) Maintenance staff has been inserviced by the Administrator on the need to inspect areas where contractors have been working to ensure that fire/smoke barriers have been repaired with fire caulking to prevent smoke and fire from spreading to other areas of the facility.
- 4) Maintenance staff will complete monthly inspections of all Fire/Smoke Barrier walls to ensure that they remain sealed, with no defects which would allow smoke and fire to spread to other areas of the facility. Any discrepancies will be corrected immediately and reported to the QA Committee for review.
- 5) Completion Date: 8/17/10.

K046

- 1) All exterior exit lights have been connected to the emergency generator.
- 2) Additional exterior lights have been added to ensure that sufficient lighting is provided to light the public way.
- 3) Maintenance staff has been inserviced by the Administrator on the importance of ensuring that all emergency exits are well lit at all times, and that these must be connected to the emergency generator.
- 4) Maintenance will perform weekly rounds to ensure that all exit lights are well maintained and working off of the generator, and lighting is appropriate to illuminate all public ways sufficiently. Any discrepancies will be corrected immediately and reported to the QA committee for follow up.
- 5) Completion Date: 8/30/10.

K130

- 1) The temperature probes on both dryers have been connected appropriately to ensure that the dryer operates safely at all times.
- 2) Both dryers were thoroughly checked to ensure that they are operating appropriately. No further problems were found.
- 3) Laundry and Maintenance staff were in-serviced by the Administrator on the importance of making sure that the dryer probes are always appropriately placed to ensure safe operation of this equipment. Any discrepancies are to be immediately reported and corrected.
- 4) The maintenance and housekeeping supervisors will perform weekly rounds, checking all dryers to make sure that they are maintained appropriately and temperature probes are properly placed and in good working order. Any discrepancies will be corrected immediately and reported to QA for follow up.
- 5) Completion Date: 8/17/10.