

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

PRINTED: 06/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/05/2011
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NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY	STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050
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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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F 000	INITIAL COMMENTS Amended A standard health survey was conducted 05/03/11 through 05/05/11 and a Life Safety code survey was conducted on 05/03/11. The facility was found to not meet minimum requirements for recertification and deficiencies were cited with the highest scope and severity at an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	Submission of this plan of correction does not constitute admission of agreement with conclusions set forth in the statement of deficiencies. However, in an effort to enhance the care furnished to our residents, we have augmented some of our existing policies and protocols. We acknowledge that federal and state regulations require a plan of correction, and we are therefore submitting this plan.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide maintenance and housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior in bathrooms and in hallways of the facility. Two (2) commode seats on the North Wing were stained. The East Wing shower stall wall had tile missing. Wheelchairs and geri-chairs had cracked armrests. Floor tiles on the North and South Wing bathrooms were stained. The findings include:	F 253	1. On 5/20/2011, an inspection of the bathroom's raised toilet seats in rooms 114 and 117 showed no dried brown substances on the side of the seats, however there was a permanent discoloration of the seat. Two new raised toilet seats were ordered to replace the discolored seats and will be installed upon delivery. On 5/5/2011, residents in rooms 113-1, 114-2, 117, 118-1 and 128-1 with cracked wheelchair armrests and room 116-2 with a cracked geri-chair armrest were replaced with new armrests. On 5/10/2011, the Housekeeping Supervisor applied fresh caulk around the base of the toilet commodes in rooms 113, 115, 116 and 119, eliminating the stains. On 5/20/2011, an inspection of the east wing shower room revealed missing cove base tile at floor level to the left of the shower stall opening with glue residue. All residents who used this shower are in shower chairs with legs facing out of the shower stall prohibiting any leg movement in the direction of the missing tile residue. Effective 5/19/2011 this shower room has been taken out of service for renovation which will include repair of all vertical tiles.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
X Greene Gales RN

TITLE
X Director of Nsg

(X6) DATE
X 6/16/2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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.

OFFICE OF INSPECTION
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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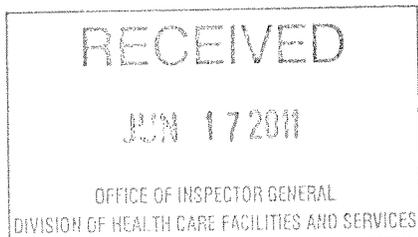
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F 253	<p>Continued From page 1</p> <p>Observation during initial tour on 05/03/11 at 9:15am revealed bathrooms 114 and 117 with a dried brown substance on the side of a raised toilet seat. Further observation revealed residents in room 113-1, 114-2, 117, 118-1, and 128-1 with cracked wheelchair armrests and room 116-2 with a cracked geri- chair armrest. Observation on 05/04/11 at 9:00am revealed the East Wing shower room stall wall had three-fourth (3/4) of the tile missing from the base. Further observation revealed a rough brown surface area where the tile base was missing.</p> <p>Interview on 05/04/11 at 2:30pm with Housekeeper #2 revealed cleaning rooms included daily mopping, dusting and cleaning of bathrooms. Housekeeper #2 stated the quality of care could be affected if the resident's environment is not kept clean. She further revealed if any repairs are noted during cleaning a maintenance log was filled out</p> <p>Observation on 05/05/11 at 11:20am of the South Wing and North Wing bathroom, rooms 113, 115, 116, 119 revealed the commode bases were stained with a black substance. Observation on 06/06/11 at 11:25am revealed bathrooms 114 and 117 continued to have a dried brown substances on the raised toilet seats.</p> <p>Interview on 05/05/11 at 11:30am with the Director of Housekeeping during the facility's walk thru revealed that housekeeping was responsible for maintaining the cleanliness of the resident's environment. He further stated the dry brown substance on the raised commode toilet seat was not clean, sanitary or homelike.</p>	F 253	<p>Once the renovation is complete with all repairs, then the shower will be reopened.</p> <p>2. An inspection of the building by the Maintenance Director and Housekeeping Supervisor on 5/20/2011 revealed no other areas as identified in this deficiency.</p> <p>3. The facility currently has an education, reporting and work completion policy and system in place. All housekeeping, maintenance and nursing staff will be reeducated by the Staff Development Coordinator no later than 6/10/2011 on identifying, reporting, proper sanitation and repairs related to toilet seats, armrests, commode bases and shower room tiles as cited in the F253 deficiency.</p> <p>4. The Director of Housekeeping will develop an audit sheet encompassing all toilet seats, armrests, commode bases and shower room tiles as cited in F253 to ensure compliance and will audit the building weekly for those areas cited in this deficiency. These audits will be conducted for 3 months and will be reported to the monthly quality assurance committee. The committee will then determine the need for continuation.</p> <p>5. The Administrator is responsible for compliance.</p>	6/10/2011
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F 253	Continued From page 2 Interview on 05/05/11 at 11:40am with the Director of Maintenance during the facility walk thru revealed staff were to log in any maintenance concerns on the maintenance sheet. He stated by not repairing cracked wheelchair/geri-chair armrests immediately could cause skin tears to occur to resident arms. In addition, the floor stains were difficult to repair because the floor tile could not be replaced. The existing floor tile contained asbestos material and the facility had an ongoing Operations and Maintenance program in accordance with the environmental Protection Agency, (EPA) regulations. Further interview revealed the black substance around the commode base should be caulked for homelike appearance. The Director of Maintenance stated the East Hall shower stall's missing tile bases had been placed on hold due to the Maintenance Director's recent hand injury. He stated the resident's skin could be injured by the rough surface of the missing tile base. Review of the March-May maintenance defects log revealed no wheelchairs or geri-chairs were in need of maintenance. Further review of the Person Centered Care Meeting dated 12/28/10 revealed the East Hall shower room had been in need of renovation since 12/28/10.	F 253			

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JUN 17 2011

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 5/03/2011. The facility was found to be in compliance with 42 CFR 482.41(b) Code of Federal Regulations, relating to NFPA 101 Life Safety Code 2000 Edition. The highest scope and severity deficiency identified was an "F".	K 000		
K 018 SS=E	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 1 1/4 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,	K 018	1. On 5/23/2011, the 12" tall x 11" wide x 7" deep plastic trashcans that were placed in front of residents' room doors 106, 109, 116, 121 and 127 were removed. 2. An inspection by the housekeeping supervisor on 5/23/2011 noted that there were no other rooms that had trashcans in front of the resident doors. 3. The maintenance director will assess and attempt to correct the problem starting 5/23/2011 through the purchase of friction door holders or other acceptable devices to eliminate self closing of doors. If additional assistance is needed the maintenance director will contact contractors to request consultation on repair of the doors. The social service director will notify residents; and nursing and housekeeping staff will receive documented inservices by the staff development coordinator no later than 6/10/2011 as to the need to not obstruct the door with trashcans. 4. The housekeeping supervisor has developed an audit form and will inspect these rooms 5 days per week for 1 month then weekly for 2 months and will report to the quality assurance committee monthly.	

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

Ronald J. Stelzer

TITLE

Administrator x 5/26/11

(X6) DATE

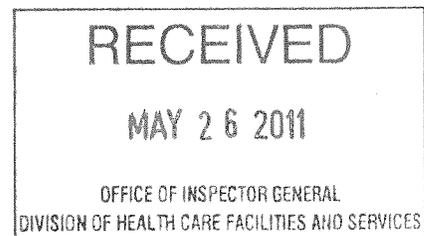
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If continuation sheet Page 1 of 12
MAY 26 2011
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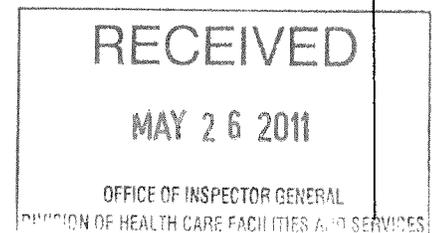
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K 018	Continued From page 1 according to NFPA standards. The deficiency had the potential to affect all residents, staff and visitors within three (3) smoke compartments. The facility is licensed for sixty (60) beds, with a census of fifty four (54) the day of the survey. The findings include: Observations on 05/03/11 revealed; trash cans holding resident room doors open. The resident rooms that were affected by this were; 106,109,116,121 and 127. Interview with the Maintenance Director revealed that he was unaware that the trash cans were being used to hold open the resident doors. Reference: NFPA 101 (2000 Edition) 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 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	The quality assurance committee will determine the need for continuation. 5. The Director of Maintenance is responsible for compliance.	6/10/2011
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	K 025	1. On 5/4/2011, the interior of the identified data line sleeve was sealed with rated material by the maintenance director. 2. An inspection of the South Wing attic for any other open areas was conducted by the maintenance	



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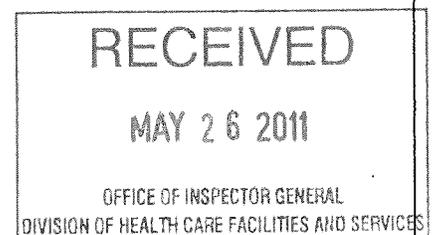
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K 025	Continued From page 2 panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The facility has the capacity for sixty (60) beds and the census was fifty four (54) on the day of the survey. The deficiency has the potential to affect two (2) smoke compartments. The findings include: A tour of the facility conducted on 05/03/11, revealed that all the smoke partitions extended above the ceiling, into the attic, located in the South Wing, were penetrated by data line sleeves, and data lines. The space around the data line sleeves were filled with a material rated equal to the rated partition but the interior of the sleeves were not filled with material rated to resist the passage of smoke. An interview with the Maintenance Director 05/03/11 revealed he was not aware of the penetrations. The Maintenance Director also stated that he would take care of the penetrations immediately.	K 025	director on 5/4/2011 and no other penetrations were found. 3. A review of facility practices indicated that any time a contractor accesses the attic the maintenance director is to supervise or inspect the attic for penetrations to the smoke barriers. The maintenance director received documented reeducation by the administrator on 5/23/2011 to post check for penetrations whenever vendors access the attic. 4. The maintenance director has developed a vendor log and penetration audit to be completed whenever a vendor accesses the attic noting the name of vendor, reason for access, date, time and maintenance director post check for penetration, date, time and initials. This log will be maintained by the maintenance director and will be reported to the quality assurance committee for 3 months. The quality assurance committee will determine the need for continuation. 5. The Administrator is responsible for compliance.	6/10/2011
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		



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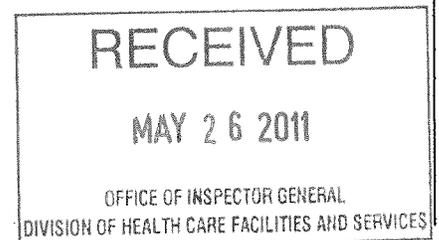
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K 052 SS=F	Continued From page 3 A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide for a properly maintained and tested fire alarm system with approved functioning components. The deficient practice affected all smoke compartments, visitors, staff and 54 residents. The facility has the capacity for 60 beds and at the time of the survey, the census was 54. Findings include: Observation of the facility fire alarm system with the Maintenance Director on 05/03/11 at 10:07 AM, revealed the fire alarm annunciator panel located at the nurses' station, next to the main entrance, showed the system to be in silent mode. The Maintenance Director stated they had a fire drill on 04/29/11 at 11:05 AM. Fire drill	K 052	1. On 5/3/2011, the maintenance director reset the nurse's station fire alarm annunciator panel whose LCD display read "alarm silence?". 2. A review and test of the fire alarm system on 5/3/2011 by the maintenance director and surveyor revealed that the fire alarm system was fully functional prior to and after the resetting of the annunciator panel. 3. A review of the fire alarm protocols to ensure proper alarm resetting will be conducted by the maintenance director and administrator for any needed modifications to be completed no later than 5/27/2011. The staff development coordinator will conduct and document a mandatory inservice for all supervisory and nursing staff on proper fire alarm procedures and alarm resets to be completed no later than 6/10/2011. 4. The maintenance director will establish an audit form that will be used after any fire alarm activation that will ensure that the proper following of alarm reset procedures. The maintenance director will review this audit form after each activation of the fire alarm and this will be reported to the quality assurance committee monthly for 3 months. The quality assurance committee will determine the need for continuation. 5. The Maintenance Director is responsible for compliance.	6/10/2011



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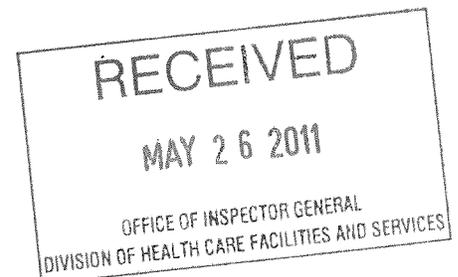
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K 052	Continued From page 4 record review confirmed the fire drill. The Maintenance Director also stated it was a two step reset process to reset the alarm, and only one step had been reset. The two steps in the reset process are: reset the detectors; then reset the annunciator. Only the detectors had been reset. A call to the alarm company on 05/03/11 by the Maintenance Director confirmed they showed the system to have been in the reset mode since 04/29/11. Observation revealed, in the silent mode, the magnetic hold open devices on the corridor doors were energized. Interview with the Maintenance Director revealed during a fire drill, the charge nurse would silence the alarm, and give a coded announcement. This statement was confirmed by fire drill policy review. The Maintenance Director also stated the charge nurse was responsible for resetting the alarm, but on 04/29/11 he was the person that reset the alarm. Interview with the Director of Nursing revealed the Charge nurse at the time of the fire drill is responsible for silencing the alarm and giving the coded announcement, but it was the Maintenance Directors responsibility to reset the alarm, because nursing staff did not know how to reset the alarm. Review of the fire drill policy revealed no one was listed as the responsible person to ensure the fire alarm control panel was reset after the fire drill. A test of the fire alarm system at 3:30 PM revealed the fire alarm did annunciate from the silent mode and de-energized the magnetic hold open devices. The system would reset to normal, if the two step reset process was executed properly. A letter from Able Alarm & Electronic	K 052		



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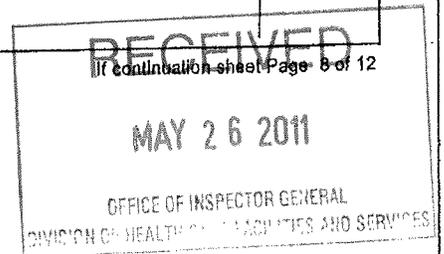
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K 056	Continued From page 6 building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency has the potential to affect all fifty four (54) residents, staff and visitors. The facility is licensed for sixty (60) beds and the census on the day of the survey was fifty four (54) residents. The findings include: Observation on 05/03/2011 at 9:45 AM with the Maintenance Director, revealed three (3) overhangs with no sprinklers. The overhangs are located at the exits in the North and South Wing, and the Front Entrance. All three (3) overhangs are over four (4) foot in width. Interview with the Maintenance director on 05/03/2011 at 9:45 AM, indicated he was not aware the overhangs needed to be sprinkled. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs	K 056	2. An inspection of the exterior of the building by the maintenance director on 5/20/2011 revealed no other areas as identified in the statement of deficiencies K056. 3. On 5/20/2011, the administrator contacted an independent contractor and the facility's sprinkler contractor to inspect the identified areas and to provide the necessary work to ensure facility compliance with K056. An expedited time frame will then be established, based on the contractor's recommendations and ability to correct the cited deficiency. This work will be expected to be started no later than 6/10/2011, however if the contractor is unable to schedule or complete this work within this time frame then OIG will be contacted to apprise them of the anticipated completion schedule. 4. An audit form will be developed by the maintenance director no later than 5/27/2011, to conduct checks 5 times per week to ensure that no combustible material is stored under the overhangs. This audit will be performed until the outside contractor completes any necessary work to resolve this deficiency. The maintenance director will report monthly to the quality assurance committee the results of the audit. The quality assurance committee will determine the need for continuation. 5. The Maintenance Director is responsible for compliance.	6/10/2011



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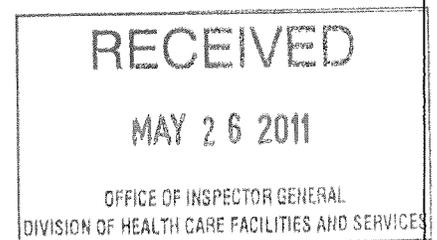
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HOMESTEAD NURSING C B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2011
NAME OF PROVIDER OR SUPPLIER HOMESTEAD NURSING CENTER, NEW CASTLE, KENTUCKY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050	
(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 056	Continued From page 7 or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The Findings Include: Observation on 05/03/11 at 10:45 AM revealed storage within 18" of a sprinkler head. The deficient practice affected one (1) of four (4) smoke compartments. The facility is licensed for sixty (60) beds, with a census of fifty four (54) the day of the survey. Interview with the Maintenance Director on 05/03/11 at 10:45 AM confirmed the observation, and would have the storage removed.	K 062	1. On 5/3/2011, the storage within 18" of the sprinkler head in the identified nursing supply room was removed. 2. On 5/3/2011, an inspection by the maintenance director of all other storage areas revealed no other storage within 18" of a sprinkler head. 3. On 5/23/2011, a policy review was conducted and was found to include restrictions of storage within 18" of a sprinkler head. The staff development coordinator will conduct a documented mandatory in-service for all staff, no later than 6/10/2011, on proper storage not to be within 18" of a sprinkler head. 4. A weekly audit form will be developed by the Director of Nursing no later than 5/27/2011, to ensure that storage is not within 18" of a sprinkler head in all nursing storage areas. The audit will be performed by the 7-3 Team Leader or alternate for 3 months and will be reported to the quality assurance committee monthly. The quality assurance committee will determine the need for continuation. 5. The Director of Nursing is responsible for compliance.	6/10/2011



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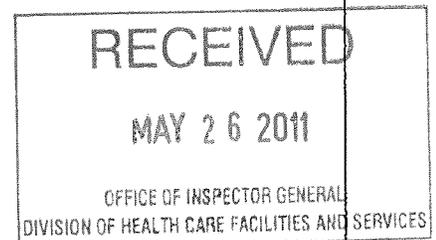
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K 062	Continued From page 8 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062		
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the installed fire extinguishers. The deficient practice affected four of four smoke compartments, staff and all residents. The facility has the capacity for 60 beds with a census of 54 the day of survey. Findings include: Observation on 05/03/11 at 9:47 AM revealed the portable fire extinguishers throughout the facility were not being inspected monthly. The last monthly inspection was performed on 02/20/11. Interview with the Maintenance Director revealed he was aware of the requirement.	K 064	1. On 5/19/2011, the maintenance director checked all fire extinguishers and ensured they were all properly checked and documents per the requirements of K064. 2. On 5/20/2011, the administrator checked all facility fire extinguishers and verified they were properly checked and documented. 3. On 5/23/2011, a policy review determined that there was a policy of monthly fire extinguisher checks by the maintenance director. The maintenance director received documented reeducation by the administrator on 5/23/2011 to document all monthly fire extinguisher checks. 4. The maintenance director has revised a log to include monthly checks for each fire extinguisher including date, location and person checking and will be presented by the maintenance director on a monthly bases for 3 months. The quality assurance committee will determine the need for continuation. 5. The Administrator is responsible for compliance.	6/10/2011



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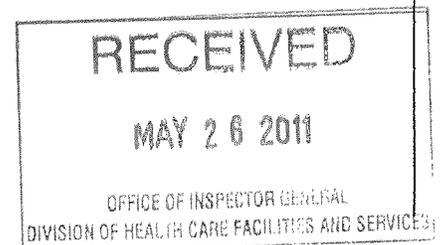
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K 064	Continued From page 9 Reference: NFPA 10 6.2.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require. 6.2.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Operating instructions on nameplate legible and facing outward (4)* Safety seals and tamper indicators not broken or missing (5) Fullness determined by weighing or " hefting " (6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle (7) Pressure gauge reading or indicator in the operable range or position (8) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units) (9) HMIS label in place	K 064		
K 147 SS=F	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 according to NFPA	K 147	1. On 5/3/2011, the maintenance director locked the electrical panel on north wing. On 5/20/2011, the refrigerator in the director of nurses office and housekeeping offices were unplugged and the dietary refrigerator was moved to an area where it was plugged into an electrical wall outlet. On 5/25/2011, a cover was placed on the water softener room heater fan. On 5/3/2011, the resident's bed in room 129 was plugged into an electrical wall receptacle. On 5/13/2011, the portable floor mixer was removed from under the	



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K 147	<p>Continued From page 10</p> <p>standards. This deficient practice affected all smoke compartments, including residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty four (54) the day of the survey.</p> <p>The findings include:</p> <p>Observations on 05/03/11, with the Maintenance Director revealed:</p> <p>(1) The Electrical panel located in the resident corridor of the North Wing next to room #117 were unlocked. Interview with the Maintenance Director revealed that he was unaware that electrical panels located in public areas had to be locked.</p> <p>2) A refrigerator located in the Director of Nursing office was plugged into a power strip, a second refrigerator was observed in the Housekeeping storage room, plugged into an extension cord, and a third refrigerator was observed in the Klitchen storage area plugged into an extension cord. The observations were confirmed with the Maintenance Director.</p> <p>3) A heater fan located in the ceiling of the water softener closet was missing the cover. This observation was confirmed with the Maintenance Director.</p> <p>4) A resident bed was plugged into a power strip, located in room #129. Interview with the Maintenance Director revealed he was aware medical equipment could not be plugged into power strips, but was unaware that the power strip was being used on this bed.</p>	K 147	<p>dietary storage room electrical panel and the dietary microwave was plugged into an electrical wall receptable.</p> <p>2. On 5/3/2011, the maintenance director conducted and inspection of the facility and found no other areas as cited in K147.</p> <p>3. Monthly safety audits will be revised to ensure compliance with electrical standards as identified in K147 including refrigerators and equipment plugged into electrical outlets, ceiling heater fan covers, and electricl panels locked and clear. The staff development coordinator will conduct a documented mandatory inservice for all staff, no later than 6/10/2011, on safety compliance, practices and reporting as related to the above areas cited in K147.</p> <p>4. Monthly revised electrical safety audits will be reported by the designated safety person to the monthly safety committee. The maintenance director will report the safety committee audit findings for 3 months to the quality assurance committee. The quality assurance committee will determine the need for continuation.</p> <p>5. The Maintenance Director will be responsible for compliance.</p>	6/10/2011



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K 147	Continued From page 11 5) A floor mixer was being stored in front of an electrical panel in the Kitchen Storage area. This observation was confirmed with the Maintenance Director. 6) A microwave oven was plugged into a power strip located in the Kitchen. This observation was confirmed with the Maintenance Director. 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. Reference: NFPA 70 (1999 edition) 110-26. 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 qualified persons.	K 147			

