

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

PRINTED: 02/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/20/2012
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 164 SS=D	<p>A standared health survey was initiated on 01/18/12 and concluded on 01/20/12. A Life Safety Code survey was conducted on 01/19/12 with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be imposed.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>F164</p> <ol style="list-style-type: none"> 1. Resident #14 was interviewed by the Director of Nursing on 1-19-2012. The Resident states they do not feel their privacy was violated when the skin assessment and wound care was completed. Resident states she has no adverse effects from the isolated incident that occurred on 1-19-2012 at 2:50 pm by the licensed nurse; the comprehensive care plan and nurse aide care plan were updated accordingly. 2. On 1/19/2012 the clinical nursing team, supervised by the Director of Nursing audited medical treatment, personal privacy including 	<p>3/1/12</p> <p>3-15-12</p> <p>per Adm.</p> <p>by PB</p> <p>3-1-12</p>	

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

TITLE

(X6) DATE

X. J. Harris

X. Administrator

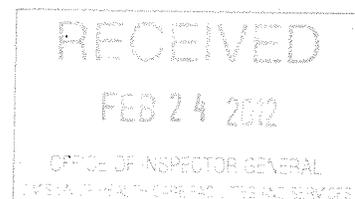
2/29/12

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

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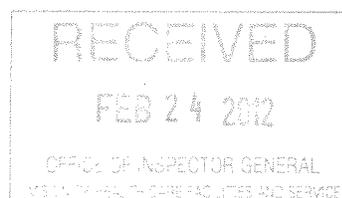
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F 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the Resident's Rights Handbook, it was determined the facility failed to provide privacy during wound care and a skin assessment for one (1) of twenty-four (24) sampled residents, Resident #14. The facility provided wound care and a skin assessment for Resident #14 while exposed to an open window blind.</p> <p>The findings include:</p> <p>Review of the facility's Resident Rights Handbook, revision date KY 09/11; page 25; section 5 revealed the resident shall have the right to personal privacy and confidentiality of his personal and clinical records and #5. (a.) Personal privacy included accommodations, medical treatment, written and telephone communications, personal care, and visits...</p> <p>Observation of wound care and a skin assessment, for Resident #14, on 01/19/12 at 2:50 PM, revealed Licensed Practical Nurse (LPN) #2 knocked on the resident's door, acknowledged the resident, pulled the privacy curtain between the resident's bed, completed hand hygiene, donned gloves and proceeded with the skin assessment and wound care without closing the window blinds. The resident's upper body clothing was removed for an upper body assessment with the window blinds opened. Then the lower body was undressed and wound care was performed on the resident's buttocks while the window blinds remained open.</p>	F 164	<p>accommodations, and the closing of the window blinds when wound care and or a skin assessment is performed.</p> <p>There were no incidents identified of deficient practice for providing privacy, including accommodations, medical treatment, and closing the window blinds.</p> <p>3 Education was completed by the Director of Nursing on January 19, 2012 regarding the facility policy and procedures for the privacy of during resident care and the resident's right, to personal privacy to the nursing staff (i.e. Nurses and C.N.A.). The Staff Development Coordinator will</p>	



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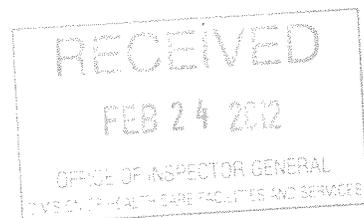
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F 164	Continued From page 2 Observation, of the Assistant Director of Nursing/Unit Manager (ADON/UM) #1, on 01/19/12 at 2:55 PM, revealed she entered the room of Resident #14 during the skin assessment and wound care and engaged in a conversation with LPN #2 and the resident without closing the window blind. Interview with Licensed Practical Nurse #2, on 01/19/12 at 3:20 PM, revealed she should have closed the window blinds prior to removal of the resident's clothing and wound care to the resident's buttocks. Interview with ADON/UM #1, on 01/19/12 at 3:25 PM, revealed she should have closed the window blinds upon arrival to Resident #14's room as LPN #2 completed the skin assessment and wound care. She reported the resident was not to be exposed to the window with the blinds open.	F 164	educate all department staff (i.e. nursing, housekeeping, dietary ect.) by February 28, 2012 on resident rights and privacy. The Director of Nursing or the assistant director of nursing will evaluate resident care and resident treatments for personal privacy, and the closing of the window blinds, daily for one week then bi-weekly for four weeks, then weekly for four weeks, and then monthly for three months on 20% of the residents receiving treatments. Audit forms will be completed to ensure 20% of the residents receiving treatments will be reviewed.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279			



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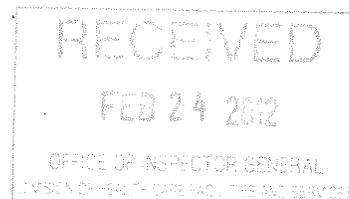
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F 279	<p>Continued From page 3</p> <p>§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the facility's Care Plan policy, it was determined the facility failed to develop a comprehensive plan of care for two (2) of twenty-four (24) sampled residents (#2 and #18). The facility did not use the results of assessments to develop individualized plans of care to meet the needs of Resident #2 and Resident #18 concerning Contact Isolation Precautions.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Care Planning", effective date 12-2010, revealed the plan of care will be individualized, based on the diagnosis, resident assessment and personal goals of the resident and his/her family. The planning for care, treatment and services will include documenting the plan for care, treatment and services. The plan of care will be individualized to meet the needs of the resident and shall address the the learning needs of the resident and/or family.</p> <p>1. Record review for Resident #2 revealed an original admission date of 10/19/11 and a readmission date of 01/06/12 with diagnoses of</p>	F 279	<p>4 The compliance audits will be forwarded to the weekly at Risk meeting for review by the assistant director of nursing. Any violations will be reported by the director of nursing to the Administrator at the daily morning meeting. A Quality Assurance meeting will be held on March 14th, 2012 to review the findings and effectiveness of the audits. The results of the audits will continue to be forwarded to the quarterly quality assurance committee by the director of nursing for review with the medical director and administrator.</p>	



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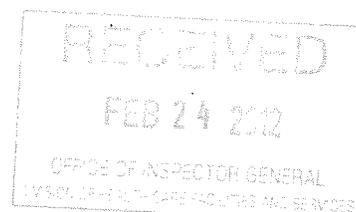
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F 279	<p>Continued From page 4</p> <p>Respiratory Failure, Pneumonia, Sepsis, and Multi-Drug-Resistant (MDR) Acinetobacter in the sputum.</p> <p>Review of the comprehensive plan of care dated 01/06/12 did not reveal a care plan to address the contact isolation precautions the resident had been placed on. Review of the Interim Plan of Care developed on admission on 01/06/12 did not reveal a plan of care for contact isolation precautions.</p> <p>Observation of Resident #2, on 01/18/12 at 11:00 AM, revealed a "Contact Precautions in Addition to Standard Precautions" sign outside the door of the resident's room. A visitor wearing an isolation gown was sitting in a chair next to the resident who was sitting in a wheelchair in the resident's room. The Contact Precaution sign was observed outside the resident's room through out the three (3) days of the survey.</p> <p>2. Record review for Resident #18 revealed an admission date of 01/19/12 with diagnoses of a Right Hip Fracture and a Pressure Ulcer on the back with Methicillin Resistant Staphylococcus Aureus (MRSA).</p> <p>Review of the Interim Plan of Care for Resident #18, dated 01/19/12 and developed on admission, revealed a plan of care for contact isolation was not included.</p> <p>Observation, on 01/20/12 at 1:20 PM, revealed a "Contact Precautions in Addition to Standard Precautions" sign outside the door of Resident #13's room.</p>	F 279	<p>1. On January 19, 2012, Resident #2 and #18 interim plan of care and comprehensive plan of care were reviewed by the Minimum Data Set Coordinator. Updates were completed by the minimum data set coordinator to include individualized plans of care to meet the needs of the residents concerning contact isolation precautions.</p> <p>2. A list of all resident on contact isolation was completed by the director of nursing 1-23-2012. A review of all individualized comprehensive plans of care and a review of the interim plan of care was completed and updated by the minimum data set coordinator 1-23-12.</p>	3/1/12 3-15-12 pu adm by PB 3/1/12	



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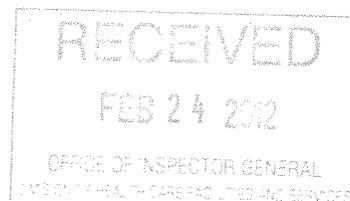
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F 279	Continued From page 5 Interview with Registered Nurse (RN) #12, on 01/12/12 at 2:00 PM, revealed she was uncertain if Resident #2 should be on respiratory precautions or contact precaution, The RN stated respiratory and contact precautions are probably the same depending on the variable. She wore gloves, a gown and a mask in the care of Resident #2 because the resident had a bacteria in the sputum and trach tube. Interview with the MDS Coordinator, on 01/20/12 at 5:50 PM, revealed the facility usually does not do an isolation care plan and all residents are on the same precautions for contact isolation. The MDS Coordinator when asked, said some residents may require a mask for feeding and some may not, depending on the bacteria and the location of the bacteria. I can see how this could be confusing to the staff and to visitors. The MDS Coordinator said there should be a care plan for isolation so that the staff knows how to care for the residents. During interview with the Director of Nursing (DON), on 01/20/11 at 6:30 PM, it was revealed it would be a prudent thing to have a written individualized plan of care for each resident.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	3. All licensed staff and the minimum data set coordinators will be educated on the facility policy and procedures regarding the development of individualized plans of care by the regional reimbursement consultant by 2-29-2012. The director of nursing and the assistant director of nursing will review all plans of care for new admissions and readmissions with contact isolation and any resident that requires contact isolation during their stay at the facility. All results will be forwarded to the weekly at risk meeting for follow up by the director of nursing and or the assistant director of nursing.	



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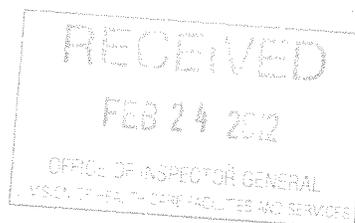
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F 309	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the facility's policy, it was determined the facility failed to follow the physician's orders for wound care treatments for one (1) of twenty-four (24) sampled residents, Resident #3. Resident #3 had a physician's order for wound treatments every three days and as needed; however the treatment record indicated the area was healed and there was no order to discontinue the treatment. The findings include: Record review of the facility's policy on Physician Orders, not dated, revealed it did not include directions to staff on healing of wounds and/or obtaining orders for initiation or discontinuation of treatments. Record review for Resident #3 revealed orders dated 01/03/12, to cleanse the area to coccyx with normal saline, apply Exuderm and change every three (3) days and as needed, and check placement every shift. Apply Skin Prep to both heels every shift. Review of Resident #3's treatment log for the month of January 2012 revealed the treatment to the coccyx was discontinued on 01/14/12 and documented as "Healed". Observations Resident #3's skin assessment, on 01/18/12 at 2:54 PM, revealed Registered Nurse (RN) #2 placing ointment to resident #3's coccyx, which was observed red, blanchable, and with no open areas.	F 309	4. All contact precaution care plans audit results will be forwarded to the quarterly Quality assurance committee by the director of nursing for review and follow up by the administrator and the medical director. An initial Quality Assurance meeting will be held on 3-14-12 to review effectiveness of the POC and compliance. F 309 1. The director of nursing notified the physician on 1-19-2012 that resident #3's wound had healed. The director of nursing received an order to discontinue the wound treatment by the physician. 2. The director of nursing and the Assistant director of nursing reviewed all wounds with treatment	3/14/12 3-15-12 Rn Rdm by RB 3-1-12



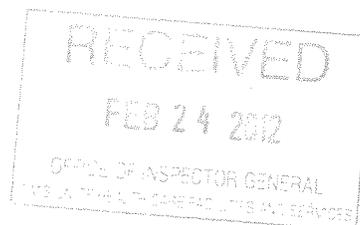
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F 309	Continued From page 7 Interview with RN #1, on 01/20/12 at 4:50 PM, revealed when a wound was documented as healed, the nurse was suppose to call the Doctor to receive an order to discontinue the treatment, write the order down on a telephone order slp and highlight healed on the Treatment Administration Record. Review of Resident #3's orders, revealed no new orders dated 01/14/12 or through the survey dates of 01/18/12 through 01/20/12 to discontinue the treatment or that the wound was healed. Interview with the Director of Nursing (DON), on 01/20/12 at 6:25 PM, revealed nurses were responsible after healing a wound, to call the Doctor to receive orders to discontinue the treatment. The DON stated the night shift nurse who completes the audits would not catch this discrepancy because the nurses audit the orders given and not the treatment records.	F 309	orders to identify any wounds that did not follow the physician orders. No deficient practice was identified by the director of nursing and or the assistant director of nursing. 3. All clinical licensed staff will be educated by the staff development coordinator on or before 2/29/12 regarding the policy and procedure for following physician orders and discontinue of physician orders when an area has healed. By 2-29-2012, the assistant director of nursing, or the unit supervisor will review daily wound care treatment records to ensure the physician orders are followed.		



4. All record and chart review of physician orders and wound care treatments will be forwarded to the daily clinical meeting. All results from the chart reviews will be evaluated by the director of nursing daily. The director of nursing will forward to the quarterly quality assurance committee results of the daily record and chart audits for the administrator and the medical director review and follow up plan. An initial Quality Assurance committee meeting will be held on 3/14/12 to review POC compliance and effectiveness.



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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: 1973, 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS Nine (9) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator, installed in 1984. Fuel source is Natural Gas.</p> <p>A standard Life Safety Code survey was initiated on 01/18/12 and concluded on 01/19/12. Signature Health Care of East Louisville was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	{K 000}	<p>K 056</p> <ol style="list-style-type: none"> 1. A quote was obtained from Century Fire Systems and approved for the instillation of the sprinkler heads to meet the standard for NFPA 13 1999 edition; sprinkler heads were installed by Century on 4/4/12 on the 100 Main Entrance. 2. The facility was evaluated by the regional plant operations on 3/28/12 to identify any other deficient practice for sprinklers not being installed under exterior roofs or canopies exceeding 4 ft in width. No other deficient practice was identified. 	4/19/12

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

TITLE

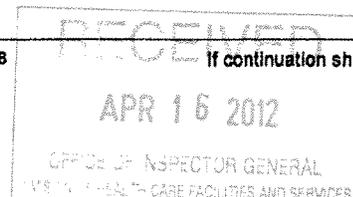
(X8) DATE

Francis [Signature]

Administrator

4/16/12

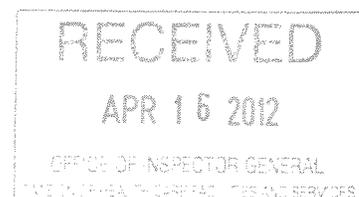
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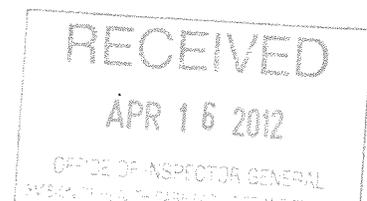
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/27/2012
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220	
(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 000}	Continued From page 1 Fire) Deficiencies were cited with the highest deficiency identified at " F " level. A standard Life Safety Code follow-up survey was conducted on 03/27/12. Signature Health Care of East Louisville was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	{K 000}		
{K 056} SS=D	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 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, during the follow-up survey conducted on 03/27/12, it was determined the facility failed to ensure the deficiency cited on 01/18/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 03/15/12.	{K 056}	3. On 3/28/12 the regional plant operations director educated 100% of the facility plant operations team on the requirement of NFPA 13 (1999) edition that sprinklers must be installed under exterior roofs or canopies exceeding 4 ft. in width. Exception is the following: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	



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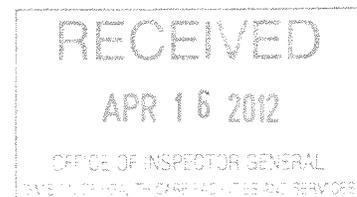
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{K 056}	Continued From page 2 The findings include: Observation, on 03/27/12 at 9:00 AM, with the Regional Plant Operations Director and the Maintenance Director revealed the porch roof located at the 100 Main Entrance did not have sprinkler protection. Interview, on 03/27/12 at 9:00 AM, with the Regional Plant Operations Director and the Maintenance Director revealed the sprinkler company was told to install the sprinkler under the 100 Main Entrance porch, but must have just missed it. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs 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}	The facility administrator and regional plant operations director will ensure any new construction and or additions and or renovations will be reviewed for compliance to meet the sprinkler for any exterior roof exceeding the four foot in width with NFPA 13.		
{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, during the follow-up survey conducted on 03/27/12, it was determined the facility failed to ensure the	{K 062}	4. The regional plant operations director will forward any new construction and or renovations to the quarterly quality assurance committee for review and compliance of life safety code NFPA 13.		



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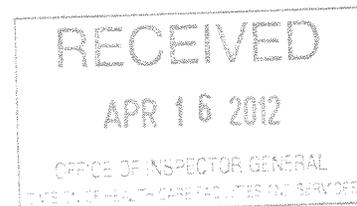
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{K 062}	Continued From page 3 deficiency cited on 01/18/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 03/15/12. The findings include: Observation, on 03/27/12 at 9:30 AM, with the Regional Plant Operations Director and the Maintenance Director revealed mixed response sprinkler heads were located in the kitchen. Interview, on 03/27/12 at 9:30 AM, with the Regional Plant Operations Director and the Maintenance Director revealed the sprinkler company contracted to change the sprinkler heads, did not stock the correct sprinkler heads, and had to back order them. The date of their arrival was unknown. 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. 2-2.1.1* Sprinklers shall be inspected from the	{K 062}	K062 1. A quote was obtained and approved from Century Fire systems to replace sprinkler heads in the kitchen to match all response head sprinklers in the dietary department. The sprinkler heads were installed by Century on 4/13/12 and a fire watch was implemented during instillation. 2. On 3/28/2012 the plant operations director performed a 100% inspection of all smoke compartments and sprinkler heads to ensure the reliable operating condition and all heads matched in each smoke compartment. No other deficient practice was identified.	4/14/12



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{K 062}	Continued From page 4 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 temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	{K 062}	3. On 3/28/2012 the plant operations director educated 100% of the plant operations team regarding NFPA 101 life safety to include the difference between a quick response and a slow response sprinkler head. The department understands the two sprinklers cannot be located in the "same" smoke compartment. Each compartment must have the same sprinkler head. The facility plant operations director will audit weekly x four weeks then monthly to ensure that the sprinklers are dust free, lint free, paint free, and that sprinkler heads are not mixed.		



4. The facility plant operations director will report any weekly and or monthly non-compliance audits immediately to the administrator for immediate follow up and correction. The administrator will report in the quarterly quality assurance committee, compliance and non-compliance audits to the committee and the medical director for further review and follow up.

