

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

PRINTED: 01/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185187	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/12/2012
NAME OF PROVIDER OR SUPPLIER  GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104	
(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  A standard health survey was conducted 01/10/12 through 01/12/12. A Life Safety Code Survey was conducted on 01/12/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed.  An abbreviated survey was conducted 01/10/12 through 01/12/12 to investigate KY17458. The Division of Health Care Substantiated the allegation but found no regulatory violations related to the allegation.	F 000	Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy on Food Storage, it was determined the facility failed to store, prepare and serve food in a sanitary manner. The walk-in refrigerator revealed one milk crate that contained thirty-two cartons of milk. Twenty-five (25) of the thirty-two (32) containers of milk were expired. The walk-in freezer contained one carton each of frozen eggs, waffles and chicken	F 371	Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this  Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.  F-371  Address what corrective action will be accomplished for those residents found to have Been affected by the deficient practice;	

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

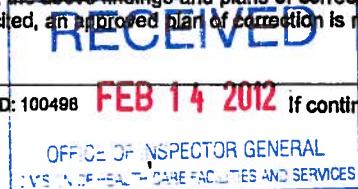
TITLE

(X6) DATE

*[Signature]*

*[Signature]* Administrator 2/2/12

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 30 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 371	<p>Continued From page 1</p> <p>breasts that were opened and exposed to air. Condensation was observed around the freezer door and ice build up on the incoming hose to the fan with ice bits falling into an open box of brownies. The facility failed to use appropriate hand washing in the kitchen, hand sanitizer was used instead of hand washing.</p> <p>The findings include:</p> <p>Observation during the initial kitchen tour, on 01/10/12 at 9:00 AM, revealed eighteen crates of milk. One of those crates contained thirty-two (32) cartons of milk, twenty-five (25) of those cartons were dated with an expiration date of 01/08/12. The walk-in freezer contained boxes of opened and uncovered frozen eggs, waffles and chicken breasts.</p> <p>Observation during the sanitation tour, on 01/11/12 at 2:35 PM, revealed the freezer door had frozen condensation around the door and ice buildup in the area near the fan. Ice particles were falling down into a box of frozen brownies.</p> <p>Observation of the tray line, on 01/12/12 at 11:40 AM, revealed the Kitchen Manager and a Dietary Aide used hand sanitizer in place of washing their hands with soap and water.</p> <p>Interview with the Dietary Manager (DM), on 01/10/12 at 9:00 AM, revealed the milkman was supposed to pick up expired milk in the refrigerator and that if expired milk was served to residents it could make them sick. The DM stated he knows food stored in the freezer should be covered to prevent freezer burn. He revealed food with freezer burn could have altered taste or</p>	F 371	<p>The 25 cartons of out dated milk were discarded immediately on 1/10/12 by the Dietary Manager. The carton of frozen eggs, waffles and chicken breasts were discarded immediately on 1/10/12 by Dietary Manager. All ice was removed from freezer door and the fan in walk in freezer and box of brownies discarded immediately on 1/11/12 by the Kitchen Manager. Hand sanitizer was removed from Kitchen by Dietary Manager on 1/12/12.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>All milk was inspected by Dietary Manager on 1/10/12 to ensure no other outdated milk was in the refrigerator. All boxes were inspected by Dietary Manager on 1/10/12 to ensure that all boxes were stored properly and closed correctly, and were moved out from under the fan on 1/10/12 by Dietary Manager.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>Kitchen Manager re-educated all dietary staff on 1/10/12 on how to properly store food in walk-in freezer and to ensure that food is not left open and exposed to air. Kitchen Manager re-educated dietary staff on 1/10/12 on inspecting the dates to ensure milk is not out of date and on ensuring that milk is rotated and inspected upon delivery. Kitchen Manager re-educated dietary staff on 1/11/12 on removing ice from freezer and fan to ensure no ice built up. A catch</p>	



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F 371	Continued From page 2 decreased nutritive value.	F 371	pan was installed under walk in freezer fan on 1/12/12 to catch any falling ice from the fan. Dietary staff were re-educated by the Kitchen Manager on proper hand washing techniques and that hand sanitizer is not to be used in place of hand washing. A new freezer door was ordered to replace old freezer door on 1/17/12.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	Indicate how the facility plans to monitor its performance to ensure that solutions are sustained;  Kitchen manager will conduct daily QI audit on milk dates to ensure that all milk is within the expiration dates. Kitchen Manager will conduct daily QI audit to ensure food is stored and closed properly, so that it is not exposed to air. Kitchen Manager will conduct a QI audit to ensure there is no ice build on freezer door and condensing unit daily until freezer door is replaced. Any identified issues will be corrected immediately. The results of these daily audits will be reported to the QI committee weekly with appropriate corrective actions taken as necessary. These reports will be forwarded monthly to the Executive QI committee consisting of Medical Director, Administrator, and DON to identify any trends with further follow up action taken as necessary.  Completion Date : 2/24/12	2/24/12



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F 441	Continued From page 3  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to consistently implement their infection control program to prevent transmission of disease and infections. Observation during incontinent care and skin assessments revealed staff did not wash hands after removal of gloves and between tasks for two (2) of twenty-four (24) sampled residents. (Resident #8 and #9).  The findings include:  Review of the Incontinence care policy, dated 04/2007, revealed two lines that stated pericare will be given after each incontinent episode. Review of the perineal care policy, dated 02/2007, revealed only instructions on how to conduct the procedure with no instructions of hand washing or glove changes.  Review of the facility's Handwashing Policy, dated 04/2007, revealed personnel are required to wash their hands after removing gloves and when indicated between tasks and procedures to prevent cross contamination of different body sites.	F 441	F 441  <i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</i>  Residents #1, #8 and #9 are still currently living in the facility and free of any infectious process at this time. Certified Nursing Assistant #2, Licensed Practical Nurse #2 and the Unit Manager (LPN) have been re-educated by the Staff Development nurse on the appropriate hand washing process. In addition to the hand washing process, the appropriate time to change gloves with specific focus directed to hand washing when changing or removing gloves was emphasized. The second point discussed in the in-service was the importance of changing gloves to prevent cross contamination from a "dirty" surface to a "clean" surface. This principle applies to all areas of personal care, incontinence care, skin assessments, dressing changes, and etc. Soiled garments, soiled briefs or linens must be placed in an appropriate receptacle or trash bag, but never placed on or in a surface where the resident may wash their face or brush their teeth. This was completed on January 12, 2012.  <i>How the facility will identify other residents having the potential to be affected by this deficient practice;</i>  All the residents have the potential to be affected by this deficient practice.  <i>What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur;</i>		



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F 441	Continued From page 4  1. On 01/11/12 at 8:30 AM, observation of incontinent care for Resident #1 (after resident gave permission) revealed CNA #2 (certified nursing assistant) removed the soiled brief and placed it on top of the resident's sink. The brief was soiled with stool and urine. The CNA cleaned the resident's skin with a sanitary wipe and cloth towel. She then placed the soiled towel into the sink. A clean brief was applied and adjustments were made to the resident's clothing. The CNA touched the resident's clothing, wheelchair, and other equipment with the soiled gloves. The gloves were then removed and the CNA washed her hands.  Interview with CNA #2, on 01/11/12 at 8:45 AM, revealed the CNA did not realize she had not changed her gloves after she removed the soiled brief. She stated she was aware to change gloves between dirty and clean tasks and she should not have placed the soiled brief and towel in the resident's sink.  Interview with the Unit Manager (who was present during the incontinent care), on 01/11/12 at 8:50 AM, revealed she identified the CNA had not changed her gloves after removal of the soiled brief and had placed the soiled towel into the resident's sink. She stated she thought she could intervene and stop the CNA during the observation.  2. On 01/11/12 at 9:50 AM, observation during a skin assessment for Resident #9, revealed LPN #2 changed her gloves during the skin assessment but did not wash her hands after	F 441	On Jan 19, 2012, all staff members regardless of their department received with their payroll checks a copy of the hand washing/personal protective equipment (gloves) policy.  All nursing staff members were given a written test, asking questions regarding the appropriate hand washing/changing glove process and procedure on Jan 19, 2012. The staff members who did not make a passing grade on the test were given an opportunity to review the information distributed with their payroll checks. They were then required to re test and pass the test before being allowed to return to their scheduled shifts. The in-services and test were completed on Jan. 19, 2012 by the Staff Development Nurse  The Staff Development personnel have three "Skill Fairs" scheduled for the upcoming year. In these skill fairs there will be teaching stations each having its own topic or skill to be taught or observed. Each station will have a demonstration, test or learning materials that are specific to areas of on going education and/or proficiency testing. For example, hand washing, infection control, Glucometer testing, and documentation only to name a few. The Skill Fairs will be conducted March 2012, July 2012, and October 2012.  <i>Indicate how the facility plans to monitor its performance to ensure that the solutions are sustained;</i>	



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F 441	<p>Continued From page 5</p> <p>removing her gloves. LPN #2 then examined Resident #9's peri-anal area and then examined the residents head, face, trunk and arms without washing hands or changing gloves.</p> <p>Interview with LPN #2, on 01/11/12 at 10:15 AM, revealed she should have washed her hands after she changed her gloves. She stated she did not realize she had gone from examining Resident #9's peri-anal area to his head without washing her hands. She stated she was just nervous. LPN #2 stated she knows it is not an accepted practice and that it could cause cross contamination.</p>	F 441	<p>One of the following nursing administrative team members which are the following: Safety Nurse, Infection Control nurse, Unit Coordinators, Q/I nurse and Weekend Supervisor will be assigned one day a week to conduct at least 3 hand washing audits that will be turned in to the Infection Control nurse when completed. The results of the audits will be reported weekly at the Infection Control Meeting. All failed audits will be addressed immediately by the administrative team member, who will re-education with an in-service on emphasizing the correct hand washing/changing of gloves procedure.</p> <p>A signed copy of the Inservice form will be forwarded to the staff development office. The audits will continue daily and will be completed by Feb 24, 2012.</p> <p>Audits will be submitted to the Infection control nurse for review at the weekly infection control meetings, and ultimately will be presented at the monthly Executive Q/I meeting with the Administrator, DON and the Medical Director. Any trends identified will be addressed as indicated.</p> <p><i>When the corrective action(s) be completed for each deficiency;</i></p> <p>Completion date will be Feb 24, 2012.</p>

2/24/12



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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: 1977</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: Eleven (11) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator, installed in October 2010. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/12/12. Greenwood Nursing and Rehab Center 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 seven (127) 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>Greenwood Nursing and Rehab Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Greenwood's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Greenwood Nursing and Rehab Center reserves the right to refute any of the deficiencies on this</p> <p>Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure, and/or any other administrative or legal proceeding.</p>	

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

TITLE

(X8) DATE

*Jonathan McGinnis*

*Administrator*

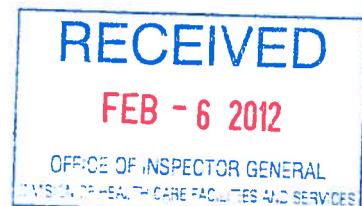
*2/2/12*

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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K 000	Continued From page 1 Fire)	K 000		
K 018 SS=E	Deficiencies were cited with the highest deficiency identified at " F " level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.          This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eleven (11) smoke compartments, residents, staff, and visitors. The	K 018	K 018 Steward and Richey have been contracted to Adjust and Replace Patient room doors to the following locations: 107, 108, 111, 112, 116, 207, 212, 217, 222, 303, 305, 306, 309, 311, 312, 313, 315, 317, 321, 321, 322, 323, 325, 326, 327, and 328.  AAA Systems have been contacted to inspect and verify that the above listed corridor doors to rooms and all other corridor doors to rooms meet Life Safety code K018.  Maintenance staff has been re-in-service by the administrator on 2/2/12 on the requirement of K-018  Maintenance director will do a monthly Q/I to verify that Corridor Doors to rooms meet the Clearance standards of K018. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, DON, and Medical Director.  Completion Date: 2/24/12	2/24/12



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K 018	<p>Continued From page 2</p> <p>facility is licensed for one hundred twenty eight (128) beds and the census was one hundred twenty seven (127) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 01/12/12 between 9:30 AM and 12:30 PM, with the Maintenance Director revealed the corridor doors to rooms 107, 108, 111, 112, 116, 207, 212, 217, 222, 303, 305, 306, 309, 311, 312, 313, 315, 317, 321, 322, 323, 325, 326, 327, and 328 had a gap too large around the jamb and would not resist the passage of smoke.</p> <p>Interviews, on 01/12/12 between 9:30 AM and 12:30 PM, with the Maintenance Director confirmed the observation of the doors having too large a gap that would not resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor</p>	K 018		



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NAME OF PROVIDER OR SUPPLIER  GREENWOOD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5079 SCOTTSVILLE RD. BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 018	Continued From page 3 doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA 101 LIFE SAFETY CODE STANDARD	K 018			
K 025 SS=F	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	K 025	K025  Facility Maintenance staff removed old duct work that was not sealed on the inside and Superior Drywall have been contracted to		



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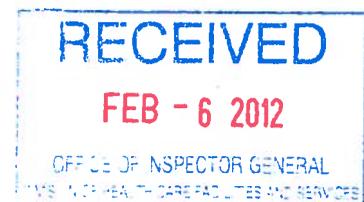
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K 025	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect eleven (11) of eleven (11) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred twenty eight (128) beds with a census of one hundred twenty seven (127) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/12/12 between 9:30 AM and 12:30 PM, with the Maintenance Director revealed penetrations in the smoke partition extending above the ceiling at the 211 Cross Corridor doors to be penetrated by old duct work that was not sealed on the inside. The use of flammable Kwik Foam to seal penetrations was also noted in all smoke partitions.</p> <p>Interview, on 01/12/12 between 9:30 AM and 12:30 PM, with the Maintenance Director revealed they were not aware of the penetrations. They were also not aware Kwik Foam was not a suitable product for use in smoke partitions.</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</p>	K 025	<p>remove all Kwik Foam and reseal all 11 smoke compartments.</p> <p>AAA Systems have been contacted to inspect and verify that the old duct work has been removed and all Kwik foam has been removed along with no open passages in the 11 smoke compartments to meet Life Safety code K025.</p> <p>Maintenance staff has been re-in-service by the administrator on 2/2/12 on the requirement of K-025</p> <p>Maintenance director will do a monthly Q/I to verify that all 11 smoke compartments have no opening to meet the Life safety code standards for K025. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, DON, and Medical Director.</p> <p>Completion Date: 2/24/12</p>	2/24/12



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K 025	Continued From page 5 building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (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 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 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 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027	K027  Maintenance staff installed self closing device to Dietary Dry storage and Medical Records.  AAA Systems have been contacted to inspect and verify that self closing device was installed to Dry storage and Medical records doors. AAA System will also re-inspect and verify if other doors need self closing device.  Maintenance staff has been re-in-service by the administrator on 2/2/12 on the requirement of K-027		



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K 027	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of eleven (11) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred twenty eight (128) beds with a census of one hundred twenty seven (127) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/12/12 between 9:30 AM and 12:30 PM, with the Maintenance Director revealed the door to the dry storage area in the Kitchen, and the door to the Medical Records Office did not have a self closing device.</p> <p>Interview, on 01/12/12 between 9:30 AM and 12:30 PM, with the Maintenance Director revealed they were not aware the Dry Storage Room, or the Medical Records Office were considered a hazardous storage area.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in</p>	K 027	<p>Maintenance director will do a monthly Q/I to verify that self closing device is install on the Dry Storage room door and Medical records doors to meet the Life safety code standards for K027. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, DON, and Medical Director.</p> <p>Completion Date: 2/24/12</p>	2/24/12



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K 027	Continued From page 7 accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 027		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by:	K 062		

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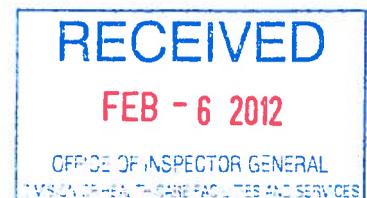
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HEALTH CARE FACILITIES AND SERVICES

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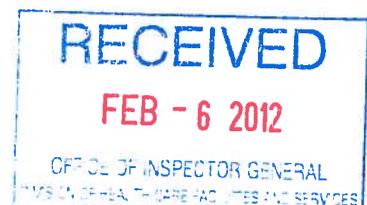
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K 062	Continued From page 8 Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect eleven (11) of eleven (11) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred twenty eight (128) beds with a census of one hundred twenty seven (127) on the day of the survey.  The findings include:  Observation, on 01/12/12 at 11:40 AM, with the Maintenance Director revealed insulation had fallen on the sprinkler heads located in the attic throughout the facility.  Interview, on 01/12/12 at 11:40 AM, with the Maintenance Director revealed he was unaware of the fallen insulation laying on the sprinkler heads.  Reference: NFPA 13 (1999 Edition)  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062	K-062  Eagle Fire Protection have been contracted to correct the insulation from not falling on the sprinkler heads in the 11 smoke compartments.  AAA Systems have been contacted to inspect and verify that all attic sprinkler heads have no insulation fallen on them in all 11 smoke compartments.  Maintenance staff has been re-in-service by the administrator on 2/2/12 on the requirement of K062  Maintenance director will do a monthly Q/I to verify that there is no fallen insulation on the sprinkler heads in the 11 smoke compartments in the attic to meet the Life safety code standards for K062. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, DON, and Medical Director.  Completion Date: 2/24/12	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance	K 147		2/24/12



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K 147	<p>Continued From page 9 with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of eleven (11) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred twenty eight (128) beds with a census of one hundred twenty seven (127) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/12/12 between 9:30 AM and 12:30 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> <li>1) An extension cord was plugged into a power strip in the Telephone Room.</li> <li>2) An air conditioning unit was plugged into a power strip located in the Rehab Physicians Office.</li> <li>3) A refrigerator and microwave were plugged into a power strip located in the Medical Records Office.</li> <li>4) A microwave, and a heated label press were plugged into a power strip that was plugged into a multi plug adaptor located in the Housekeeping Office.</li> </ol>	K 147	<p>K147</p> <p>JB Electrical was contracted to install new electric outlet in the Telephone room. Power strips were removed from Rehab Physician office, Medical Records, and Housekeeping office.</p> <p>AAA systems have been contacted to verify that Telephone room, Rehab Physician office, Medical Records and housekeeping office has no power strips in there locations.</p> <p>Maintenance staff has been re-in-service by the administrator on 2/2/12 on the requirements of K147</p> <p>Maintenance director will do a monthly Q/I to verify that any power strips in use, are only used on low voltage items so that the facility can meet the Life safety code standards for K147. The results of these audits will be reviewed in the monthly Executive Q/I committee meeting for the next 3 months with the Administrator, DON, and Medical Director.</p> <p>Completion Date: 2/24/12</p>	2/24/12



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K 147	Continued From page 10  Interview, on 01/12/12 between 9:30 AM and 12:30 PM, with the Maintenance Director revealed they were not aware of the extension cords and power strips being misused.  Reference: NFPA 99 (1999 edition)  3-3.2.1.2 D  Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

