STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185138	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAZARETH HOME	2000 NEWBURG ROAD LOUISVILLE, KY 40205

(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 038	Continued From page 17 and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 038		

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Mary Haynes
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185138	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAZARETH HOME	2000 NEWBURG ROAD LOUISVILLE, KY 40205

(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 038	Continued From page 18 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. Reference: CMS S&C letter 5-38	K 038		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA	K 045	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents, staff, and visitors, in four of the thirteen smoke compartments, has been corrected. Corrective Action – new lamp Fixtures have been installed as	

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	185138	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
K 045	Continued From page 19 standards. The deficiency had the potential to affect four (4) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge. The findings include: Observation, on 05/01/13 between 9:00 AM and 3:00 PM, with the Facility Management revealed the exits located on the first floor South Stairwell, and the Sunrise Stairwell did not have a light installed outside to provide the required illumination for exit discharge. The exits were equipped with a light fixture with only one bulb installed. Interview, on 05/01/13 between 9:00 AM and 3:00 PM, with the Facility Management revealed he was not aware the exits did not have the required illumination for egress lighting. Reference NFPA 101 (2000 edition) 18.2.7 Discharge from Exits. Discharge from exits shall be arranged in accordance with Section 7.7. 18.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.	K 045	of 5/16/13, all required exit light fixtures now have two bulb fixtures. 2. Other residents, staff, visitors having the potential to be affected – Corrective Action – maintenance staff have inspected all facility exits for required lamination in accordance with NFPA standards. All found to be in compliance. 3. Systemic measures implemented to ensure deficient practice will not recur – Chief Financial Officer/Facility Director educated maintenance staff on June 12, 2013 regarding NFPA requirement for maintenance on illumination of means of egress. Maintenance staff will inspect all exit light fixtures monthly for proper operation. Documentation will be kept on file in maintenance department. 4. Results of maintenance inspections will be reported by Chief Financial Officer at Safety Committee meetings from a Quality assurance perspective. The Safety Committee will analyze the effectiveness of this system and determine if any	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185138	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 045	Continued From page 20 7.7 DISCHARGE FROM EXITS 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met: (1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for	K 045	further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/ actions at the Continuous Quality Improvement meetings.	6/13/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185138	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAZARETH HOME	2000 NEWBURG ROAD LOUISVILLE, KY 40205

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K 045	Continued From page 21 the enclosure of exits (see 7.1.3.2.1). Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following: (a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m). (b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames. (c) The foyer shall serve only as means of egress and shall include an exit directly to the outside. (3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure. Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6. Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3 The exit discharge shall be arranged and marked to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or	K 045		

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K 045	Continued From page 22 other effective means. 7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. 7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.) 7.7.6 Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met: (1) The roof construction has a fire resistance rating not less than that required for the exit enclosure. (2) There is a continuous and safe means of egress from the roof. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be	K 045		

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K 045	Continued From page 23 continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. Reference: NFPA 101 (2000 Edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.	K 045		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAZARETH HOME	2000 NEWBURG ROAD LOUISVILLE, KY 40205

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K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on interview and policy review, it was determined the facility failed to implement a proper Fire Safety Plan and Procedure Policy in the event of an emergency in accordance with NFPA standards. The deficiency had the potential to affect thirteen (13) of thirteen (13) smoke compartments, all residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to provide a written evacuation plan to ensure smoke compartments were correctly identified and the evacuation route was clearly posted. The findings include: Policy review, on 04/30/13 at 11:00 AM with the Facility Management revealed the facility's Fire Safety Plan and Procedure Policy did not have an internal evacuation floor plan labeled or posted indicating how to evacuate a smoke compartment or how to evacuate the building in an emergency. Interview, on 04/30/13 at 11:30 AM with the Facility Management revealed he was unaware the facility did not have a written plan for the evacuation of a smoke compartment or the building in the event of an emergency.	K 048	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents, staff, and visitors, in 13 smoke compartments has been corrected. Corrective Action – Facility Fire Safety Plan and Procedure Policy has been updated to include an internal evacuation floor plan, detailing smoke compartments, emergency exits and evacuation routes. Evacuation Floor Plan is posted near egress exit doors. This information was Communicated at Staff Town Hall meetings by CEO/Administrator scheduled for 5/22/13 and 5/23/13. Staff are provided training regarding evacuation routes and smoke compartments upon hire by staff development coordinator, during annual in-servicing conducted by staff development coordinator, and during monthly fire drills by Chief Financial Officer. 2. Other residents, staff, and visitors having the potential to be affected – all residents, staff, visitors had potential to be affected.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 048	Continued From page 25 Actual NFPA Standard: 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every healthcare occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. 19.7.2 Procedure in Case of Fire. 19.7.2.1* For health care occupancies, the proper	K 048	3. Chief Financial Officer/ Facility Director educated Maintenance staff on June 12, 2013 regarding NFPA Requirement of evacuation, relocation, and fire drills. 4. Fire drills are documented monthly by Chief Financial Officer and reported at Safety Committee from a quality assurance perspective. The Safety Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/actions at the Continuous Quality Improvement meetings. Please see response K 012	6/14/13

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K 048	Continued From page 26 protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy ' s fire safety plan. 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 19.7.2.3 All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and	K 048		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 050	1. No residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents, staff, visitors, in thirteen of the	

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K 050	Continued From page 27 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect thirteen (13) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times on all shift. The findings include: Fire Drill review, on 04/30/13 at 10:38 AM, with the Facility Management revealed the facility failed to conduct fire drills at unexpected times on all shift. The facility conducted fire drills monthly on all shifts; however, the times were within the same hours on all shifts. Interview, on 04/30/13 at 10:38 AM, with the	K 050	thirteen compartments has been corrected. Prospectively, all fire drill events will be conducted throughout the shift hours and at least 1 hour before or after the last drill time for that shift. The next four(4) quarters of scheduled fire drills noted. (see Attachment A) 2. Other residents, staff, and Visitors having the potential to be affected – all residents, staff, visitors had potential to be affected, however fire drills were being conducted and documented according to regulations per shift per quarter. 3. Chief Financial Officer/Facility Director educated maintenance staff on June 12, 2013 regarding NFPA requirement for fire drills and health care occupancies. 4. Fire drills are documented monthly by Chief Financial Officer and reported at Safety Committee from a quality Assurance perspective. The Safety Committee will analyze the effectiveness of this	

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K 050	Continued From page 28 Facility Management revealed he was not aware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator ' s position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are	K 050	system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/actions at the Continuous Quality Improvement meetings.	6/14/13

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

6/21/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185138	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAZARETH HOME	2000 NEWBURG ROAD LOUISVILLE, KY 40205

(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 050	Continued From page 29 conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
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, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of thirteen (13) smoke compartments, residents, staff and visitors. The facility has one hundred eighteen (118) certified beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to ensure the facility had complete sprinkler coverage installed to meet NFPA standards.	K 056	1. *No* residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents, staff, and visitors, in five (5) of the 13 smoke compartments has been corrected. Corrective Action -Kentuckiana Sprinkler Contractor has been engaged to install required modifications, Items 1-8 as identified on page 31 of form CMS-2567 to the existing sprinkler system, 6/14/2013. 2. Other residents, staff, visitors identified as having the potential to be affected – maintenance conducted a facility walk-through and no other areas identified as affected.	6/15/13

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K 056	Continued From page 30 The findings include: Observation, on 4/30/13 between 9:00 AM and 3:10 PM, with the Facility Management revealed areas that did not have complete sprinkler coverage. The locations are as follows: 1) A raised ceiling in the corner of the Sunrise Dining Room did not have a sprinkler installed. 2) The showers stall of the Sunset Shower Rooms. 3) Two (2) closets located in the Sunset Shower Rooms. 4) Inadequate coverage of the Sunset Shower Rooms. 5) The showers stall of the Garden Side Shower room. 6) No sprinkler coverage in the high ceilings of the Maria Hall tray ceiling, Maria Hall skylight, and the Main Lobby. 7) Mixed temperature response sprinkler heads located in the Kitchen. 8) A sprinkler head within four (4) inches of the wall located in the closet of room 202. Interview, on 4/30/13 between 9:00 AM and 3:10 PM, with the Facility Management revealed he was not aware of the inadequate sprinkler coverage, or the mixed sprinkler heads. Further interview revealed he was not aware the sprinkler head was installed too close to the closet wall. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with	K 056	3. Systemic measures affected. implemented to ensure that practice will not recur – Chief Financial Officer educated maintenance staff on June 12, 2013 regarding NFPA 13 standard for installation of sprinkler system regarding complete sprinkler coverage requirement – Kentuckiana Sprinkler conducts quarterly inspection and testing of sprinkler system. Maintenance staff will also complete quarterly inspections of the facility sprinkler system. 4. Results of quarterly inspections will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. The safety committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/ actions at the Continuous Quality Improvement meetings.	6/15/13

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K 056	Continued From page 31 construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. 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. Reference: NFPA 13 (1999 Edition) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6	K 056		

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K 056	Continued From page 32 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)	K 056		

Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B	Maximum Allowable Distance of Deflector Obstruction (in.)
Less than 1 ft	0
1 ft to less than 1 ft 6 in.	21/2
1 ft 6 in. to less than 2 ft	31/2
2 ft to less than 2 ft 6 in.	51/2
2 ft 6 in. to less than 3 ft	71/2
3 ft to less than 3 ft 6 in.	91/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	161/2
5 ft and greater	18

For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).
Reference: NFPA 13 (1999 Edition)
5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.

Reference: NFPA 13 (1999 Edition)

7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of

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K 056	Continued From page 33 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 056		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to	K 062	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect residents, staff, and visitors, in 13 of 13 smoke compartments has been corrected. Kentuckiana Sprinkler contractor has been	

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K 062	Continued From page 34 maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect thirteen (13) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to perform an interior pipe inspection for the sprinkler system within the last five years. The findings include: Sprinkler testing record review, on 04/30/13 at 10:56 AM, with the Facility Management revealed the facility failed to perform an interior pipe inspection on the sprinkler system within the last five years. Interview, on 04/30/13 at 10:56 AM, with the Facility Management revealed he was not aware the contracted company had not done all of the required testing of the sprinkler system. Reference: NFPA 13 (1999 Edition) 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated	K 062	completed an interior pipe inspection on the sprinkler system. 2. Other residents, staff, visitors identified as having the potential to be affected - all residents, staff, and visitors had potential to be affected. 3. Systemic measures implemented to ensure deficient practice will not recur– inspection will be conducted every 5 years henceforth by a licensed sprinkler contractor according to policy. Documentation will be kept on file in maintenance office. 4. Results of licensed sprinkler contractor inspection will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. The Safety Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial	6/14/13

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K 062	Continued From page 35 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. Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and	K 062	Officer will report Safety Committee recommendations/ actions at the continuous quality improvement meetings. Licensed contractor will be engaged in 2018 to conduct inspection again.	

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K 062	Continued From page 36 by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather)	K 062		

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K 062	Continued From page 37 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Reference: NFPA 13 (1999 edition) 6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development.	K 062		

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K 062	Continued From page 38 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 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on flame retardant documentation review and interview, it was determined the facility failed to ensure that combustible decorations were used in accordance with NFPA standards. The deficiency had the potential to affect thirteen (13) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to provide documentation that personal and seasonal decorations had been treated or was flame retardant. The findings include: Flame retardant documentation review, on 04/30/13 at 11:34 AM, with the Facility Management revealed the facility did not have documentation that newly introduced personal or seasonal decorations for residents or staff had been treated with a flame retardant material. Interview, on 04/30/13 at 11:34 AM, with the Facility Management revealed he was not aware	K 073	Waiver will be requested to allow the use of the requirements found at 2012 LSC section18/19.7.5 furnishings, mattresses, and decorations including sections 18/19.7.5.6 which all the installations of combustible decorations on walls, doors and ceilings, per CMS S and C letter 12-21-LSC. See attached letter dated 5/24/13 requesting above referenced waiver.	5/24/13

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K 073	Continued From page 39 decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were	K 074	1. No residents, staff, and visitors identified as affected. The practice identified as having the potential to be affected in one of 13 smoke compartments has been corrected – Corrective Action – required coordination in the Sunset shower room, installed shower curtains were relocated in accordance with NFPA 13 standards, and additional sprinkler heads have been installed effective 6/10/13. 2. Other residents, staff, visitors identified as having the potential to be affected – facility director inspected all shower rooms on 5/17/13,	

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K 074	Continued From page 40 in accordance with NFPA standards. The deficiency had the potential to affect one (1) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The findings include: Observation, on 05/01/13 at 11:55 AM, with the Facility Management revealed the privacy curtain to the shower located within the Sunset Shower Room did not have mesh of ½ inch at the top. The shower stall did not have a sprinkler head installed within the shower stall. Interview, on 05/01/13 at 3:32 PM, with the Facility Management revealed he was not aware the shower curtain did not have the required mesh at the top. NFPA 13 Cubicle curtains; Reference to: NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that	K 074	and found to be in compliance. 3. Systemic measures Implemented to ensure deficient practice will not recur –Chief Financial Officer educated maintenance staff on June 12, 2013 regarding NFPA 13 standard for installation of sprinkler system regarding complete sprinkler coverage requirement. Maintenance staff will inspect all shower rooms quarterly for compliance with NFPA 13 standards. 4. Results of maintenance inspections will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. The Safety Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/ actions at the Continuous Quality Improvement meetings.	6/14/13

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SYSTEM FOR HEALTH CARE FACILITIES AND SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185138	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAZARETH HOME	2000 NEWBURG ROAD LOUISVILLE, KY 40205

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K 074	Continued From page 41 extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to	K 076	1. No residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents in one of the thirteen smoke compartments has been corrected – corrective action, the oxygen was relocated to adjacent storage room which is in compliance with NFPA 99 oxygen storage requirement on 4/30/13. 2. Other residents, staff, visitors, identified as having the potential to be affected – maintenance staff inspected all oxygen storage areas for compliance with NFPA 99, no other compliance concerns identified. 3. Systems measures Implemented to ensure deficient practice will not recur – Chief Financial Officer/ Facility Director completed	

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K 076	Continued From page 42 ensure oxygen storage over 300 cu ft. was stored in a room with an ignition source not located below five (5) feet from the floor. The findings include: Observation, on 04/30/13 at 2:58 PM, with the Facility Management revealed twenty (20) "E" oxygen tanks in the oxygen storage room. The oxygen storage room had a light switch and two (2) plugs installed below five (5) feet from the floor. Interview, on 04/30/13 at 2:58 PM, with the Facility Management revealed he was unaware oxygen tanks were being stored in the room they were located in because he had moved them to the next room back. Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic	K 076	education of maintenance staff and staff development coordinator on NFPA 99 requirements for oxygen services areas as of June 12, 2013. Education of licensed staff for NFPA 99 conducted by staff development coordinator with a completion date of 6/14/13. Future orientation of staff will include this education by staff development coordinator. Maintenance staff will complete quarterly inspections of oxygen storage for compliance with NFPA 99 standards. 4. Results of maintenance inspections will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. The Safety Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be institute. In addition, Chief Financial Officer will Report Safety Committee recommendations/actions at the Continuous Quality Improvement meetings.	6/15/13

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K 076	Continued From page 43 sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on fire damper testing record review, and interview, it was determined the facility failed to	K 104	1. No residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents, staff, and visitors in 13 of our 13 smoke compartments has been	

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K 104	Continued From page 44 ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect thirteen (13) of thirteen (13) smoke compartments, residents, staff and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to provide documentation that the smoke/fire dampers were tested within the last four (4) years. The findings include: Fire damper testing record review, on 04/30/13 at 11:30 AM, with the Facility Management revealed the facility did not have documentation that fire/smoke dampers had been tested within the last four (4) years. Interview, on 04/30/13 at 11:30 AM, with the Facility Management revealed he was not aware of the requirements for fire/smoke damper testing. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Reference: NFPA 101 (2000 Edition)	K 104	corrected – Corrective Action – Koorsen Fire and Security company has been engaged to inspect and test fire/smoke dampers. Completed 6/13/13. 2. Other residents, staff, visitors, identified as having the potential to be affected – all residents, staff, and visitors had potential to be affected. 3. Systemic measures Implemented to ensure deficient practice will not recur – Chief Financial Officer/Facility Director completed education of maintenance staff on June 12, 2013 regarding NFPA standard for 4 year testing of fire/smoke dampers. Policy has been amended to include testing of fire/smoke dampers every 4 years Inspection and testing will be conducted every 4 years henceforth by licensed contractor. Documentation will be kept on file in maintenance office. 4. Results of inspection by	

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K 104	Continued From page 45 8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) 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 meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall	K 104	Licensed contractor will be reported by Chief Financial Officer at Safety Committee meeting from a quality assurance perspective. The Safety Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. n addition, Chief Financial Officer will report Safety Committee recommendations/actions at the Continuous Quality Improvement meetings. Licensed contractor will be engaged in 2017 to conduct inspection again.	6/14/13

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K 104	Continued From page 46 meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 104		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on generator testing record review, observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect thirteen (13) of thirteen (13) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to provide documentation for the generators monthly transfer times. The facility also failed to ensure the generator was installed to NFPA standards. The findings include:	K 144	1. No residents, staff, visitors, identified as affected. The practice identified as having the potential to affect residents in 13 out of 13 smoke compartments has been corrected – Corrective Action - transfer times while testing the generator will be documented by maintenance staff each month. Nixon Power Company has Inspected battery charger on generator and verified that battery charger is not connected directly to the generator batteries. Meiners Electric Company installed an emergency battery light in generator room on 5/16/13. Nixon Power Company installed a new remote annunciator at 2nd floor nursing office, work was completed on 5/31/2013. 2. Other residents, staff, visitors, identified as having the potential	

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K 144	Continued From page 47 Observation, on 04/30/13 at 10:47 AM, with the Facility Management revealed the facility did not document the transfer times monthly while testing the generator. Further observation revealed the battery charger was connected directly to the generators battery. Further observation revealed the generator room was not equipped with an emergency battery light. Further observation revealed the generator was not equipped with a remote annunciator located outside the generator room in a location that could be readily observed. Interview, on 04/30/13 at 10:47 AM, with the Facility Management revealed he was not aware documentation of the transfer time was required. He was not aware the battery charger could not be connected directly to the battery or the room was required to have an emergency battery light installed in the event the generator failed to start. In addition, he was not aware a remote annunciator was required. Reference: NFPA 110 (1999 Edition). 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers ' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator.	K 144	to be affected – all residents, staff, and visitors had potential to be affected. 3. Systemic measures implemented to ensure deficient practice will not recur – Chief Financial Officer/ Facility Director educated maintenance staff on June 12, 2013 regarding NFPA 99 Requirement for testing, monitoring, and maintenance of generator. Maintenance staff conduct weekly testing of generator. Facilities Director will review monthly the required testing, inspection and maintenance documentation as required per standards in NFPA 99 concerning Emergency Generator operations. Documentation is kept on file in maintenance department. 4. Results of inspections will be reported by Chief Financial Officer at Safety Committee meetings from a quality assurance perspective. The Safety Committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted.	6/14/13

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K 144	Continued From page 48 A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2] Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment	K 144	In addition, Chief Financial Officer will report Safety Committee recommendations/ actions at the Continuous Quality Improvement meetings.	

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K 144	Continued From page 49 location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Reference: NFPA 99 (1999 Edition) Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all	K 144		

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K 144	Continued From page 50 appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. (b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures. Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's	K 144		

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K 144	Continued From page 51 recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Reference: NFPA 101 (2000 edition) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter,	K 144		

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NAZARETH HOME	2000 NEWBURG ROAD LOUISVILLE, KY 40205

(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 144	Continued From page 52 uninsulated or insulated exhaust pipes, and other heat-producing equipment. 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer. 5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures. Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted	K 144		

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K 144	Continued From page 53 in this room.	K 144		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of thirteen (13) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred eighteen (118) beds with a census of one hundred fifteen (115) on the day of the survey. The facility failed to maintain proper use of power strips, and multi-plug adaptors. The findings include: Observations, on 04/30/13 between 9:00 AM and 3:10 PM, with the Facility Management revealed: 1) A power strip was plugged into a multi-plug adaptor located in room 302. 2) A power strip was plugged into another power strip; also a refrigerator was plugged into a power strip located in room 311. 3) Three (3) I.V. pumps and a feeding tube pump were plugged into a power strip located in the Rehab Central Medication Room. 4) Two (2) floor type hair dryers were plugged into a power strip located in the 2nd Floor Beauty	K 147	1. No residents, staff, visitors identified as affected. The practice identified as having the potential to affect 5 of 13 smoke compartments has been corrected – Corrective Actions: Item 1 – multiplug adaptor in room 302 was removed and the power strip was plugged directly into wall receptacle on 4/30/13. Item 2 – both power strips located in room 311 were removed and refrigerator plugged directly into wall receptacle on 4/30/13. Item 3 – in rehab central medication room, power strip removed and three (3) IV pumps and feeding pump were plugged directly into wall receptacle on 4/30/13. Item 4 – Second floor beauty shop, power strip	

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K 147	Continued From page 54 Shop. 5) A refrigerator was plugged into a power strip located in the Social Services Office. 6) Three (3) lift battery chargers were plugged into a power strip located in the 2nd Floor Copy Room. 7) Medical equipment was plugged into a multi-plug adaptor located in room 298. 8) A power strip was plugged into another power strip located in room A206. Interview, on 04/30/13 between 9:00 AM and 3:10 PM, with the Facility Management revealed he was not aware the power strips and multi-plug adaptors had been 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. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around 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	removed and hair dryers plugged directly into separate wall receptacles on 4/30/13. Item 5 – In social service office, power strip removed and refrigerator plugged directly into wall receptacle on 4/30/13. Item 6 – In 2nd floor copy room – power strip removed and three lift battery chargers were plugged directly into wall receptacles on 4/30/13. Item 7 – In room 298, multi-plug adapter removed and disposed and medical equipment plugged directly into wall receptacle on 4/30/13. Item 8 – Room A-206, a power strip was removed and remaining power strip was plugged directly into wall receptacle on 4/30/13. To promote compliance, staff received education at scheduled Town Hall meetings on 5/22/13	

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K 147	Continued From page 55 Reference: NFPA 70 (1999 edition) Reference: NFPA 70 (1999 edition) 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception. Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings	K 147	and 5/23/13 per Administrator/CEO on electrical wiring and equipment use in accordance with NFPA 70. 2. Other residents, staff, visitors identified as having the potential to be affected – environmental services and facility staff director inspected all resident rooms on 4/30/13 for use of electrical wiring and equipment use in accordance with NFPA 70, facility was noted to be in compliance. 3. Systemic measures implemented to ensure deficient practice will not recur – Chief Financial Officer/Facility Director provided education to Director of Environmental Services as of 6/12/13 regarding task of monthly rounds, inspections, and resident rooms. Director of Environmental Services will conduct monthly rounds to ensure proper usage of equipment and electrical wiring in accordance with NFPA 70. Documentation will be on file in maintenance office. 4. Results of inspections will be reported by Chief Financial Officer at Safety Committee	6/14/13

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K 147	Continued From page 56 (4) Where attached to building surfaces	K 147	meeting from a quality assurance perspective. The safety committee will analyze the effectiveness of this system and determine if any further actions to maintain compliance needs to be instituted. In addition, Chief Financial Officer will report Safety Committee recommendations/ Actions at the Continuous Quality Improvement meetings.	

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