

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

Second SOD

PRINTED: 12/09/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185451	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/23/2010
NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT L TELFORD DRIVE RICHMOND, KY 40475	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve food under sanitary conditions. Observation during the noon meal on November 22, 2010, revealed a State Registered Nurse Aide (SRNA) handled food with his/her bare hands.</p> <p>The findings include: Observation of the noon meal on November 22, 2010, at 12:15 p.m., in the dining room revealed SRNA #5 picked up, broke in half, and buttered a dinner roll with his/her bare hands. Interview with SRNA #5 on November 22, 2010, at 12:15 p.m., revealed the SRNA was unaware not to handle food with bare hands. The SRNA stated, "I never knew I wasn't supposed to handle</p>	F 371	<p>483.35 (i) Food Procure, store/prepare/serve/-sanitary</p> <p>1) SRNA #5 was noted to having conducted this deficit practice, with no adverse outcome noted to the residents.</p> <p>2) All residents have the potential to be affected, therefore a Dining Room Policy and Procedure has been devised to ensure staffs knowledge and understanding of how to promote a sanitary environment for the residents.</p> <p>3) An in-service was conducted by the Quality Assurance Nurse on 11/29/10 with the nursing staff regarding the Dining Room Policy and Procedure. The nursing staff has signed an acknowledgement and understanding regarding the Dining Room Process. The Dining Room process has been added to the nurse-aide orientation checklist for all new hires.</p> <p style="text-align: right;">cont'd</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Robert L. Skew* TITLE: Administrator DATE: 12/23/2010

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

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F 371	Continued From page 1 the rolls to put the butter on them. I guess I don't know how to do that then." An interview with the DON revealed no policy for safe food handling could be provided; however, a copy of an in-service for October 1, 2010, was provided. The DON stated no staff should touch a resident's food with his/her bare hands. A review of the in-service dated October 1, 2010, revealed SRNAs were trained on setting up resident trays. The in-service specifically stated, "Do not ever touch food items with your hands."	F 371	4) To ensure continued compliance, a Quality Assurance audit will be conducted on a monthly basis regarding the Dining Room Process by the Quality Assurance Nurse and reviewed by the Quality Assurance Team (interdisciplinary team).	11/30/10
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide effective housekeeping and maintenance services to maintain a safe functional, sanitary, and comfortable environment for the residents, staff, and the public. During the environmental tour on November 22-23, 2010, the following areas were in need of repair: drywall in resident rooms was noted to be chipped and cracked, the shower room had peeling paint on the ceiling, exposed pipes with sharp edges where a sink/tub had been removed, the wallboard was chipped, black mold-like substance was observed on the tiles, and shower curtains were missing around the tub and shower stall.	F 465	483.70 (h) Safe/Functional/Sanitary/Comfortable Environment 1) No resident was identified to have been affected by the deficit practice. 2) An audit of other facility areas (storage, resident rooms, offices, etc) was conducted to ensure no other areas were affected by the same deficit practices. 3) The shower room ceiling paint is scheduled to be painted by 12/31/10 The exposed pipe with the sharp edges is scheduled to be removed 12/31/10. A contractor was contacted on 12/16/10 for the removal of the black mold like substance on the tile. cont'd	

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F 465	Continued From page 2 The findings include: During the environmental tour on November 22-23, 2010, the following areas were in need of repair: The shower room had paint peeling off the ceiling. An exposed pipe with sharp edges was observed where sink/tub fixtures had been removed. Wallboard was chipped and in need of repair, and a black mold-like substance was observed on shower room tiles. Curtains were missing around the tub and shower stall, not allowing for resident privacy. Drywall was observed to be chipped and in need of repair in resident room 103 behind the bed and under the window ledge above the air conditioner, in resident room 113 behind the chair, in resident room 114 in the bathroom, and in resident room 206 on the wall where a chair had been. An interview with the Maintenance Supervisor on November 23, 2010, at 3:30 p.m., revealed staff was required to turn in maintenance request forms at the nurses' station when items needed repair. The Maintenance staff checked the boxes at the nursing stations twice every day. The Maintenance Supervisor stated repairs that involved resident safety were completed first.	F 465	3) cont'd The shower curtains were ordered on 12/16/10 and have to be special cut The drywall in the resident rooms were repaired on 11/30/2010. The wall board was replaced on 11/30/2010. 4) To ensure continued compliance, a Quality Assurance audit will be conducted on a monthly basis regarding facility appearance (operations) by the Quality Assurance Nurse and reviewed by the Quality Assurance (interdisciplinary team).	12/31/10	

TOPIC: Dining Room Process

Standard:

It is the policy of Telford Terrace to provide a comfortable, sanitary eating environment in order to promote an improved quality of life through adequate nutrition, hydration and the overall dining experience.

Policy :

- Meals are served three times per day in addition to snacks being offered three times daily between meals.
- Meal trays are delivered on meal carts by dietary staff members to the nursing staff where they are served to the residents in a timely manner.
- Residents who choose to eat outside their rooms are served in the designated dining areas while those that prefer a more private setting are served in their rooms.
- We will provide total assist feeder tables, follow-up (minimal assist) feeder tables, and independent dining tables (those that require no assist with their meals).
- Dining arrangements are determined by the resident's overall ability to eat independently or their need for assistance. Individual preferences of seating / dining arrangements are satisfied when possible.

Procedure :

- 1) Residents are positioned in an upright (90⁰) position to allow for proper body alignment and the prevention of choking or aspiration.
- 2) All residents are encouraged to sit in dining room chairs, when possible, rather than in wheelchairs.
- 3) Clothing protectors are provided to protect clothing from being soiled during the meal.
- 4) The resident's hands are cleaned with sanitary wipes prior to meal consumption.
- 5) Nursing staff must ensure that their hands are sanitized prior to serving each tray.

SUBJECT: Nursing Services

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TOPIC: Dining Room Process

- 6) Nursing staff must check all meal trays for appropriate content & texture as per diet order on the meal cards that are located on the trays while they are being served to the resident's. If a discrepancy is noted, dietary staff must be notified immediately so that it may be corrected.
- 7) Occupational therapy evaluations and adaptive equipment are provided as needed to promote and maintain independent eating practices.
- 8) When setting up meal trays, please ensure that food is not directly touched with bare hands. If food has to be touched, gloves must be worn.
- 9) Appropriate food items should be cut up, all containers are to be opened and condiments are to be offered. If a resident is not satisfied with their meal, substitutes should be offered.
- 10) Ensure that only one table is served at a time. Do not go on to another table even if one resident needs to be served.
- 11) Any refusals or poor intake is reported to the charge nurse.
- 12) Encourage residents to consume larger amounts of food and liquids.
- 13) Clean resident's hands, face, and clothing before exiting the dining room.
- 14) Quantity of food consumed and intake of liquids are to be recorded and monitored during each meal and snack pass.

Acknowledgement of Dining Room Policy and Procedure

I have received a copy of the Policy and Procedure regarding the Dining Room Process by my employer, McCready Manor, Inc. (McCready Manor and Telford Terrace), and I have read and acknowledge the understanding of the Dining Room Policy and Procedure.

Signature: _____

TELFORD TERRACE NURSE AIDE CHECKLIST FOR ORIENTATION

NAME:

- Tour of the facility
- Fire and Emergency Procedures and knowing what to do
- Safety requirements and procedures
- Read and understand facility policies
- Reporting time
- Absenteeism
- Uniforms
- Smoking policy
- Alcohol and Drug abuse policy
- Benefits
- Pay periods/days
- Door Alarms/codes
- Bathing
 - 1. Bed bath
 - 2. Tub bath
 - 3. Shower
- Bed making
 - 1. Occupied
 - 2. Unoccupied
- Comfort of Residents
 - 1. Use of lotions, massages, etc.
 - 2. Turning and repositioning of residents
- Mobility of residents
 - 1. Assisting a resident from a sitting to lying/lying to a sitting position
 - 2. Assisting a resident from chair to bed/bed to chair
 - 3. Assisting a resident in to a wheelchair

4. Assisting resident on to a stretcher
5. Assisting a resident with ambulation task
6. Assisting a resident with ROM exercises
7. Assisting a resident with use of lift

_____ ADL's

1. Assisting a resident with dressing
2. Assisting a resident with oral care
3. Assisting a resident with perineal care
4. Assisting a resident with nail care
5. Trimming fingernails and toenails

_____ Passing of ice

_____ Vital signs

_____ Answering resident's call-light/emergency light

_____ Cleaning of a resident's room

_____ Meal hours

_____ Dining Room Process

_____ Shift routine

_____ Record/chart recording

_____ Medication administration procedure (KMA's only) Appropriate administration of Eye drops, Nasal sprays, Ear drops, use of Nebulizer equipment, along with assessment and documentation, Fingersticks and use of Glucometer, administration of transdermal patches, PO medications, suppositories, inhalers, assessment and documentation of use of PRN medications & BOP sheet documentation.

_____ W/C Bed Alarms

_____ Lap buddy/Seatbelts

_____ O₂ Concentrator/E-Cylinder

_____ Scale

_____ Answering of the telephone and transferring of calls

- _____ C.N.A. Care Plan
- _____ Assigning out of W/C, Walkers, Bedside Commodes, etc.
- _____ MSDS Sheets
- _____ Proper technique for dealing with a combative resident
- _____ Blood spill kits
- _____ Post mortum care
- _____ Proper technique when a resident refuses care
- _____ What to do in a code situation
- _____ Dining Room assignment for the residents
- _____ Proper disposal of linen/trash
- _____ Correct am/pm care
- _____ Kardex book
- _____ Proper storing of personal items
- _____ Proper disposal of biohazard trash
- _____ Proper documentation of consumptions
- _____ Filling out inventory sheets
- _____ Procedures for new admission/readmission
- _____ How to set-up a tray dining room/resident's room
- _____ Checking for correct diet/supplements
- _____ Location of schedule
- _____ Reading of the schedule
- _____ Location of supplies

INSERVICE ATTENDANCE

DATE: 11/29/10

TIME: 0.50

TOPIC: New Policy and Procedure regarding
Dining Room Process

Signature	Title	Signature	Title
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NAME OF PROVIDER OR SUPPLIER TELFORD TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 ROBERT TELFORD BRIDGE RICHMOND, KY 40475
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K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on November 22, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
11 K 027 SS=F	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 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that a cross-corridor fire door and attic access door were maintained according to NFPA standards. This deficient practice would affect two (2) of two (2) smoke compartments, staff, and all the residents. The facility has the capacity for 50 beds with a census of 47 on the day of the survey. The findings include: During the Life Safety Code tour on November	K 027	K 027 NFPA 101 Life Safety Code Standard 1) No resident was identified to have been affected by the deficient practice. 2) An audit was conducted on 11/22/2010 to ensure no other areas were affected by the same alleged practice. 3) The cross-corridor fire door that was observed to be sticky was corrected on 11/22/10. A metal fire rated door was replaced in the attic on 11/23/10. 4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.	11/23/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert A. Kew TITLE: Administrator (X6) DATE: 12/17/2010

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K 027	<p>Continued From page 1</p> <p>22, 2010, at 11:20 a.m., with the Director of Maintenance (DOM), a latch in one door in a set of cross-corridor fire doors was observed to stick, making the door inoperable. The door would not reopen after testing. An interview with the DOM on November 22, 2010, at 11:20 a.m., revealed the latch would sometimes stick and the DOM would have to adjust the latch.</p> <p>An interview with the DOM on November 22, 2010, at 2:00 p.m., revealed the facility had one unapproved makeshift door in the fire/smoke barrier wall in the attic area. This type of access door is required to be of an approved device that is designed for the specific purpose to help prevent fire/smoke from spreading to other areas of the building in a fire situation. The DOM stated the DOM had not been made aware in the past that this access door was deficient.</p> <p>Reference: NFPA 80 (1999 Edition).</p> <p>15-1.4 Repairs. Repairs shall be made and defects that could interfere with operation shall be corrected immediately.</p> <p>15-2.1.1* Hardware shall be examined frequently and any parts found to be inoperative shall be replaced immediately.</p> <p>15-2.4.1 Self-closing devices shall be kept in proper working condition at all times.</p> <p>Reference: NFPA 101 (2000 Edition). 8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire</p>	K 027			

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K 027	Continued From page 2 barrier to the other. The fire protection rating for opening protectives shall be as follows: (3) 1/2-hour fire barrier - 20-minute fire protection rating	K 027		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the emergency battery-operated lighting located in the generator room was maintained according to NFPA standards. The findings include: During the Life Safety Code survey on November 22, 2010, at 11:30 a.m., an interview with the Director of Maintenance revealed the emergency battery-operated lighting located in the generator room was tested by another individual and no testing records were made available. An e-mail from the facility dated November 23, 2010, stated the individual that did the testing did not keep a record of this testing. Reference: NFPA 101 (2000 Edition). 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for	K 046	K 046 NFPA 101 Life Safety Code Standard 1) No resident was identified to have been affected by the deficient practice. 2) An audit was conducted on 12/10/10 by the emergency lighting equipment to ensure no other areas were affected by the same deficient practice. 3) A weekly generator log record was devised to ensure written documentation of visual inspections/ tests are obtained. The Director of Maintenance was been inserviced on 12/10/10 on the newly devised generator log record. 4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.	12/10/10

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K 046	Continued From page 3 not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 record review, the facility failed to conduct fire drills correctly as required. The facility did not ensure that staff was prepared for response to incidence of fire under different staffing levels and conditions to include resident levels of alertness and this failure affected all residents and staff in the facility. The facility has the capacity for 50 beds with a census of 47 on the day of the survey.	K 050	K 050 NFPA 101 Life Safety Code Standard 1) No resident was identified to have been affected by the deficient practice. 2) An audit of fire drills was conducted on 12/10/10 to ensure no other areas were affected by the same deficient practice. 3) An in-service was conducted on 12/10/10 with the Director of Maintenance regarding conduction of fire drills on all shifts and at unexpected times. A fire drill was conducted on 12/11/2010 at 2:00am on the 3rd shift unexpectedly to		

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K 052	<p>Continued From page 5</p> <p>deficient practice would affect two (2) of two (2) smoke compartments, staff, and all the residents. The facility has the capacity for 50 beds with a census of 47 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on November 22, 2010, at 12:25 p.m., with the Director of Maintenance (DOM), a test of the fire alarm automatic dialer panel revealed when placed in trouble from phone line failure the unit did not send a trouble signal to a continuously occupied location within the facility. The main fire alarm control panel and other panels in the facility revealed all systems were normal. The fire alarm monitoring company did notify the facility of this phone line failure. An interview with the DOM on November 22, 2010, at 12:25 p.m., revealed the facility's fire alarm contractor had fixed this problem in the past but was unsure why the system was not working correctly.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>1-5.4.4 Distinctive Signals. Fire alarms, supervisory signals, and trouble signals shall be distinctively and descriptively annunciated.</p> <p>1-5.4.6 Trouble Signals. Trouble signals and their restoration to normal shall be indicated within 200 seconds at the locations identified in 1-5.4.6.1 or 1-5.4.6.2. Trouble signals required to indicate at the protected premises shall be indicated by distinctive audible signals. These audible trouble signals shall be distinctive from alarm signals. If an intermittent signal is used, it shall sound at</p>	K 052	<p>K 052 NFPA 101 Life Safety Code Standard</p> <p>1) No resident was identified to have been affected by this deficient practice.</p> <p>2) An audit of fire alarm panels was conducted on 11/24/10 to ensure no other areas were affected by the same deficient practice.</p> <p>3) An audible trouble signal log was devised to ensure monthly inspections were conducted. The Director of Maintenance was in-serviced regarding the audible trouble signal log on 12/10/10. American Fire and Security corrected the low audible error signal on 12/14/10.</p> <p>4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.</p>	12/14/10	

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K 052	<p>Continued From page 6</p> <p>least once every 10 seconds, with a minimum duration of 1/2 second. An audible trouble signal shall be permitted to be common to several supervised circuits. The trouble signal(s) shall be located in an area where it is likely to be heard.</p> <p>3-8.1* Fire Alarm Control Units. Fire alarm systems shall be permitted to be either integrated systems combining all detection, notification, and auxiliary functions in a single system or a combination of component subsystems. Fire alarm system components shall be permitted to share control equipment or shall be able to operate as standalone subsystems, but, in any case, they shall be arranged to function as a single system. All component subsystems shall be capable of simultaneous, full load operation without degradation of the required, overall system performance.</p> <p>5-5.3.2.1.6.2 The following requirements shall apply to all combinations in 5-5.3.2.1.6.1: (1) Both channels shall be supervised in a manner approved for the means of transmission employed. (3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes. (8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally.</p> <p>5-2.6.1.4 Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions:</p>	K 052			

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K 052	Continued From page 7 (1) *Communicate immediately with persons designated by the subscriber A-5-2.6.1.4(1) The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.	K 052		
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 an interview, the facility failed to maintain their sprinkler system by NFPA standards. This deficient practice would affect two (2) of two (2) smoke compartments, staff, and all the residents. The facility has the capacity for 50 beds with a census of 47 on the day of the survey. The findings include: During the Life Safety Code tour on November 22, 2010, at 11:30 a.m., an interview with the Director of Maintenance (DOM) at the facility's sprinkler room revealed the DOM was aware the gauges to the sprinkler system had to be replaced or recalibrated every five years, however, the DOM stated the gauges were supposed to be replaced on their last quarterly inspection but the contractors had forgotten to bring the gauges.	K 062	K 062 NFPA 101 Life Safety Code Standard 1) No resident was identified to have been affected by the deficient practice. 2) An audit of the automatic sprinkler systems/gauges was conducted on 12/14/10 to ensure reliable operating condition/testing. 3) A weekly sprinkler system gauge log was devised on 12/15/10. The Maintenance Director was in-serviced on 12/15/10 regarding the sprinkler system gauge log. American Fire and Security replaced the gauges on 12/14/10. A contractor was contacted on 12/14/10 to fix all sprinkler heads in the	

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K 062	Continued From page 8 During the survey light fixtures were observed to be blocking sprinkler heads in the soiled linen and medical records room. These light fixtures would prevent the water pattern from completely developing in case of a fire. An interview with the DOM on November 22, 2010, at 12:15 p.m., revealed the DOM was not aware the light fixtures were too close to the sprinkler heads. Reference: NFPA 25 (1998 Edition). 2-3.2* Gauges. Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. 2-2.4.2 Gauges on dry, preaction, and deluge systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Exception: Where air pressure supervision is connected to a constantly attended location, gauges shall be inspected monthly. Reference: NFPA 13 (1999 Edition). 5-5.5.2.1 Continuous or noncontinuous 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. 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.	K 062	identified locations. 4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.	12/14/10

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K 076 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. This deficient practice would affect one (1) of two (2) smoke compartments, staff, and all the residents. The facility has the capacity for 50 beds with a census of 47 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on November 22, 2010, at 12:00 p.m., with the Director of Maintenance (DOM), 17 E size oxygen and 14 M-6 tanks were noted to be stored in the oxygen storage room. These tanks were within five feet of combustible storage. Oxygen cylinders while in storage and in quantities greater than 300 cubic feet must be kept five feet from combustibles. An interview with the DOM on November 22, 2010, at 12:00 p.m., revealed the DOM was not aware of this requirement. Quantities less than 300 cubic</p>	K 076	<p>K 076 NFPA 101 Life Safety Code Standard</p> <p>1) No resident was identified to have been affected by the deficient practice.</p> <p>2) An audit of oxygen cylinders was conducted on 12/10/10 to ensure no other areas were affected by the same deficient practice.</p> <p>3) A designated area will be marked for the storage of oxygen cylinders away from combustible items while maintaining a minimum of 5 feet to any combustible storage. An in-service was conducted on 12/15/10 with facility staff related to the designated storage of oxygen cylinders. A precautionary sign was placed on the door entering the oxygen room listing "caution oxidizing gas(es) stored within, no smoking".</p> <p>4) To ensure continued compliance a Quality Assurance audit will be conducted on a monthly basis.</p>	12/15/10
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K 076	<p>Continued From page 10 feet may follow the requirements of S&C-07-10.</p> <p>Reference: S&C-07-10</p> <p>Up to 300 cu ft of nonflammable medical gas can be located outside of an enclosure (per smoke compartment) at locations open to the corridor such as at a nurse ' s station or in a corridor of a healthcare facility.</p> <p>This amount of nonflammable medical gas per smoke compartment is not considered a hazard if the containers are properly secured, such as in a rack to prevent them from tipping over or being damaged. In this case the medical gas is considered an "operational supply" and not storage. If the cylinders are placed in a corridor they should be placed so as not to obstruct the use of the corridor. This amount of medical gas is in addition to those cylinders contained in "crash carts" and in use on wheelchairs or gurneys.</p> <p>The term "PRN" means "as needed." An individual cylinder placed in a patient room for immediate use by a patient is not required to be stored in an enclosure and is considered in use. It should be secured to prevent tipping or damage to the cylinder. If the resident does not need the use of oxygen for an extended period of time, such as several days, then the medical gas container should be removed from the room and properly secured in an approved storage room.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3)</p>	K 076			

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K 076	Continued From page 11 (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 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 ¼ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076		