

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

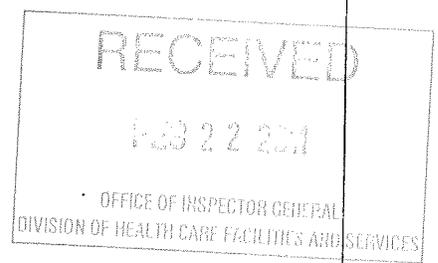
PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 02/01/11. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and staff interviews conducted on 02/01/11 it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments. The facility is licensed for one hundred and ten (110) beds and the census was one hundred (100) on the day of the survey. The deficiency has the potential to affect all smoke compartments, to include one hundred (100) residents, staff and visitors. The findings include: A tour of the facility conducted on 02/01/11 at	K 025	<u>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</u>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X8) DATE 2/22/2011
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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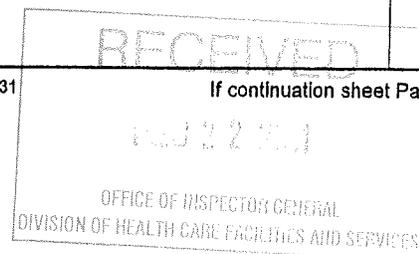
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K 025	<p>Continued From page 1</p> <p>1:30pm revealed all of the smoke partitions extending above the ceiling, were noted to be penetrated. Each smoke barrier was noted as having an unrated door that was left in the open position.</p> <p>An interview with the Maintenance Director on 02/01/11 at 1:30pm revealed he had never been in the attic and was not aware of the penetrations, or the existence of the doors.</p> <p>Reference : NFPA 101 Life Safety Code (2000 Edition) 8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions. 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be</p>	K 025	<p>K 025 F</p> <p>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The maintenance director repaired all penetrations noted in the smoke partitions extending above the ceiling by 2/24/2011. Smoke barrier doors (unrated) were replaced with fire rated doors by an outside vendor by 3/2/2011.</p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents have the potential to be affected.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Maintenance will be notified of outside vendors requiring attic access, once work is completed by outside vendor, the maintenance man will check the attic areas used for the need to repair any penetrations to the smoke barriers and shut any open fire doors.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained?</p> <p>The maintenance department will conduct a monthly inspection of the smoke partitions and fire doors and report results to the Safety committee monthly.</p>	3/16/11
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K 025	Continued From page 2 continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.	K 025		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to meet the requirements of Protection of Hazards, per NFPA Standards. This deficiency has the potential to affect all staff and one-hundred (100) residents and visitors. The facility is licensed for one-hundred and ten (110) beds and the census	K 029		

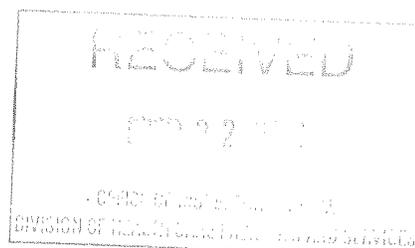
If continuation sheet Page 3 of 15

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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K 029	<p>Continued From page 3 was one-hundred (100) on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 02/01/11 at 11:00am revealed the door to the oxygen storage room, located in the West wing, did not have a self closing device installed on the door as required by NFPA standards. Further observations during the survey revealed the door to the central supply storage room located at the entrance to the Annex wing, and the door to the laundry storage room located in the basement, did not have self closing devices installed on the doors. This was confirmed by the Maintenance Director.</p> <p>Interview on 02/01/11 at 11:00am with the Maintenance Director revealed he was not aware of the code requirement in reference to the doors.</p> <p>Reference: NFPA 101 2000 Edition 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other</p>	K 029	<p>K 029 E 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Self closing devices were installed on the west wing oxygen storage room door, central supply door at the entrance to the annex wing and the door to the laundry storage room door in the basement by the maintenance director by 2/25/2011.</p> <p>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents have the potential to be affected.</p> <p>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The maintenance director will audit the following areas boiler/fuel-fired heater room, laundry area larger than 100 ft 2, soiled linen room, trash collection room, room larger than 50 ft 2 used for combustible supplies or hazardous materials for self/automatic closing doors and place self closing devices as indicated.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained?</p> <p>Maintenance will test self closing doors monthly for proper closure and report results in the Safety committee monthly.</p>	3/16/11



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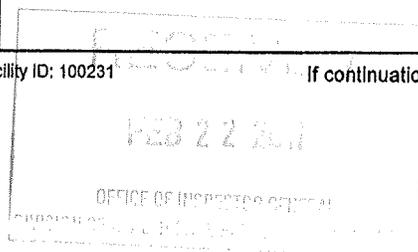
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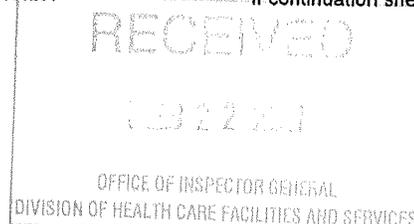
K 029	Continued From page 4 spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		



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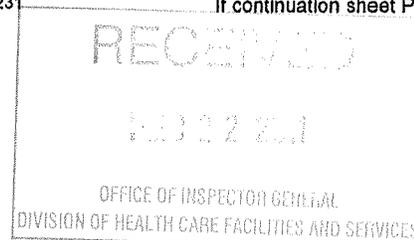
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K 038	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that exits were properly marked according to NFPA standards. This deficiency has the potential to affect two (2) of six (6) smoke compartments and approximately fifty (50) residents, staff and visitors. The facility has the capacity of one-hundred and ten (110) beds with a census of one-hundred (100) at the time of the survey. The findings include: Observation on 02/01/11 at 11:10am revealed the facility had delayed egress locks on a door leading from the end of the East hall to the exterior of the building, but did not display the proper signage for egress. This was confirmed by the Director of Maintenance during the observations Interview on 02/01/11 at 11:10am, with the Director of Maintenance, revealed he was unaware that the doors did not display the required signage. Observation on 02/01/11 at 11:35am revealed the facility had delayed egress locks on doors leading from the end of the Annex hall to the exterior of the building, but did not display the proper signage for egress. This was confirmed by the Director of Maintenance during the observations Interview on 02/01/11 at 11:35am, with the	K 038	K 038 F 1) <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> On 2/22/2011, the maintenance director tested and placed appropriate signage on the West Hall (incorrectly identified as East Hall) and Annex doors leading to the exterior of the building with delayed egress locks. 2) <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected. 3) <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> Doors with delayed egress locks in the facility will be audited for appropriate signage by the maintenance director by 2/25/2011. Signage will be replaced as needed. 4) <i>How will the facility monitor its performance to ensure that solutions are sustained?</i> The maintenance director will audit that signage for egress doors are in place and appropriate monthly and report to Safety committee monthly.	3/16/11



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K 038	Continued From page 6 Director of Maintenance, revealed he was unaware the doors did not display the required signage. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.	K 038		



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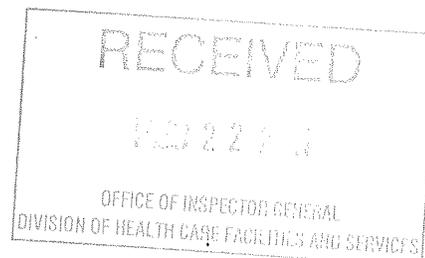
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K 038	Continued From page 7 Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 045 SS=F	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 provide illumination of the means of egress as required per NFPA standards. This condition affected the staff and one hundred (100) residents. The facility has the capacity for one hundred ten (110) beds with a census of one hundred (100) the day of survey. The findings include: Observation on 02/01/11 at 3:00pm revealed the emergency lighting in the exit access corridors throughout the facility could not be confirmed to have adequate lighting available in the event of a power outage. The facility did have an emergency generator that provided minimal	K 045		

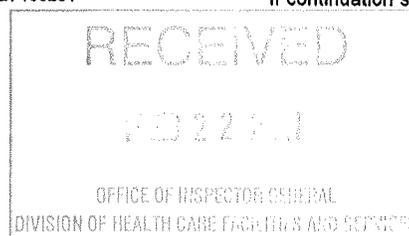


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K 045	Continued From page 8 power needs. Interview with the Director of Maintenance on 02/01/11 at 3:00pm, revealed he was unaware which lights or plugs actually worked, when the facility was powered only by the generator.	K 045	K 045 F 1) <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> Outside vendor tested and made any needed repairs to the emergency lighting in the exit access corridors throughout the facility by 3/2/2011. 2) <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected. 3) <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> Emergency lighting diagram completed by outside vendor by 3/2/2011 for facility to identify lights and outlets to use in the event of emergency power. 4) <i>How will the facility monitor its performance to ensure that solutions are sustained?</i> Emergency lighting will be tested monthly by the maintenance director in concurrence with the generator test. Results will be reported in Safety meeting monthly.	
K 051 SS=F	Actual NFPA Standard: 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 per NFPA 101, 7.8.1.3. 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 per NFPA 101, 7.8.1.4. An example of the failure of any single lighting unit is the burning out of an electric bulb per NFPA 101, A.7.8.1.4. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of	K 051		

3/11/11



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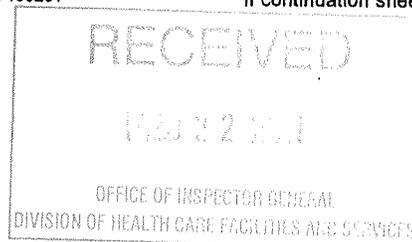
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K 051	Continued From page 9 tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the building's fire alarm system as required by the National Fire Protection Association (NFPA) Standard 72. This deficient practice affected two (2) smoke compartments, fifty two (52) residents, staff and visitors. The findings include: Observation during the Life Safety Code inspection on 02/01/11 at 10:37am revealed two (2) fire pull initiation devices located next to room #127, and #225 that were mounted higher than the required 4 1/2 ft maximum. In the interview with the Maintenance Director on 02/01/11 at 3:40pm, he indicated he did not realize the pull initiation devices were mounted too high.	K 051	K 051 F 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Fire pull initiation devices located next to room #127 and #225 were removed and remounted by an outside vendor by 2/24/2011 within the appropriate height guidelines for mounting of manual fire alarm boxes. 2) How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. 3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? Facility audit of all manual fire alarm boxes by outside vendor for appropriate height per life safety code completed by 2/24/2011. 4) How will the facility monitor its performance to ensure that solutions are sustained? No further monitoring is required at this time. In the event of remodeling in the future all mounted manual alarm fire boxes will be audited for appropriate height.	3/16/11
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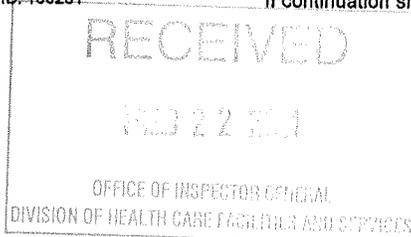
PRINTED: 02/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2011
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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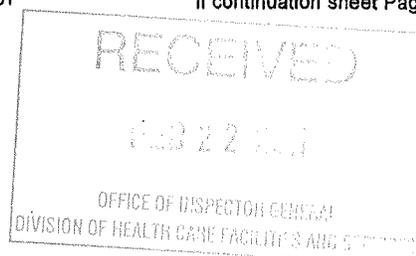
K 051	Continued From page 10	K 051		
K 072 SS=F	<p>Reference: NFPA 72 (1999 Edition) 2-8.1 Mounting. Each manual fire alarm box shall be securely mounted. The operable part of each manual fire alarm box shall be not less than 31/2 ft (1.1 m) and not more than 41/2 ft (1.37 m) above floor level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridors were maintained free from obstructions to full instant use in the case of fire or other emergencies according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 02/01/11 at 10:50am, revealed an electric wheelchair being charged in the North wing, between rooms 216 and 218. Further observation revealed a medicine cart located in the East wing, next to room 116 that was not in</p>	K 072		



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY			STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206	
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K 072	Continued From page 11 use. The observations were confirmed with the Maintenance Director. An interview, on 02/01/11 at 10:50am, with the Maintenance Director, revealed the wheelchairs and medicine carts were routinely left in the halls due to the lack of storage space. Observation on 02/01/11 at 11:15am revealed a slide bolt lock installed on the toilet room door located in room 207. Further observation revealed a slide bolt lock installed on the toilet room door located in the rehab gym located in the South wing. When interviewed, on 02/01/11 at 10:50am, the Maintenance Director indicated he was unaware that slide bolt locks were prohibited. Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 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 Reference: NFPA 101 (2000 edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable	K 072	K 072 F <i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> Electric wheelchair identified was removed from charging in the hallway by the nursing staff on 2/1/2011. The medicine cart was removed immediately by nursing staff from the hallway and stored in the medicine room at the main nursing station. The slide bolt locks were removed from the toilet room door in room 207 and therapy by the maintenance director on 2/1/2011. <i>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected. <i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> Staff will be educated by DNS on the appropriate place to store and charge wheelchairs when not in use by 3/8/2011. Licensed nurses will be educated by DNS on the storage of medicine and treatment carts in medication room when not in use by 3/8/2011. The interdisciplinary team completed a room audit for slide bolts on any doors on 2/15/2011. <i>4) How will the facility monitor its performance to ensure that solutions are sustained?</i> Storage of wheelchairs, medication/ treatment carts and use of slide bolts will be added to the non clinical rounds sheets for weekly monitoring by the interdisciplinary team and reviewed by the ED weekly.	
K 073 SS=F		K 073		3/10/11



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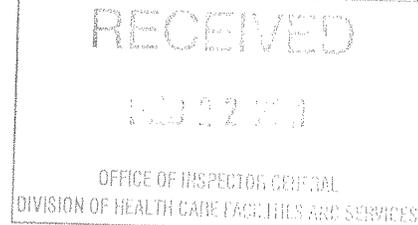
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K 073	Continued From page 12 character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency could affect all one-hundred (100) residents, staff and visitors. The facility is licensed for one-hundred and ten (110) beds and the census on the day of the survey was one-hundred (100). The findings include: Observation on 02/01/11 at 10:30am revealed hanging decorations were on the residents' doors in various locations throughout the facility. The Maintenance Director indicated the facility has a written policy for treating the decorations with a fire retardant spray, and can be reviewed when all other required paper work is reviewed.. Interview with the Maintenance Director on 02/01/11 at 2:30pm, during the review of the required paper work, confirmed they have a written policy for treating the decorations, but it was not followed for proper documentation with dates and room numbers indicated. 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 073 F <i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> All unapproved combustible door decorations were removed by the ADNS on 2/1/2011. <i>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected. <i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> The ED will notify residents and families in writing by 3/1/2011 to discourage the use of any combustible door decorations unless approved and treated with flame retardant spray by the maintenance department. <i>4) How will the facility monitor its performance to ensure that solutions are sustained?</i> Door decorations will be monitored weekly through non clinical rounds completed by the interdisciplinary team and reviewed by ED weekly. Maintenance will log any door decorations treated with the flame retardant spray and follow up per policy for future treatments and reported monthly during Safety Committee meeting.	
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		3/16/11



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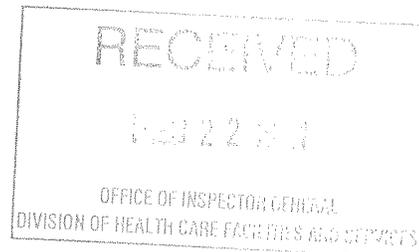
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K 147 SS=F	Continued From page 13 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. This deficient practice affected three (3) smoke compartments, staff, visitors and approximately eighty-seven (87) residents. The facility has the capacity for 110 beds with a census of 100 the day of the survey. The findings include: Observations on 02/01/11 at 2:00pm, with the Director of Maintenance revealed: 1. Junction boxes located in the West Wing attic, and the Annex attic, did not have approved covers. Interview with the Director of Maintenance on 02/01/11, revealed he has never been in the attic and was unaware of the open junction boxes. 2. Resident rooms 104, 207, and 325, all had unapproved extension cords in use. Interview with the Director of Maintenance on 02/01/11, revealed he was aware of the extension cords in use but was too busy to remove them all.	K 147	K 147 F <i>1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> Approved junction box covers were added to the West Wing and Annex attic areas by the maintenance director on 2/2/2011. Extension cords noted in rooms 104, 207 and 325 were removed by the ADNS on 2/1/2011. <i>2) How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> All residents have the potential to be affected. <i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> All junction boxes located in the attic were inspected by the maintenance director for coverage by 2/24/2011. All rooms were audited for extension cord use and removed as necessary by the interdisciplinary team on 2/15/2011. ED will notify all residents and families regarding the use of extension cords in the facility in writing by 3/1/2011. <i>4) How will the facility monitor its performance to ensure that solutions are sustained?</i> The maintenance director will audit the junction box covers in the attic monthly and report to safety committee monthly. The interdisciplinary team will monitor for the use of extension cords weekly in all rooms through non clinical rounds, reviewed by ED weekly.	3/16/11
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K 147	<p>Continued From page 14</p> <p>(1)Reference: NFPA 70 (1999 edition) 370.28(c) Covers.</p> <p>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.</p> <p>(2) Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>2. 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.</p>	K 147		
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