

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

PRINTED: 06/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185209	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	RECEIVED JUN 2012 OFFICE OF INSPECTOR GENERAL	(X3) DATE SURVEY COMPLETED 05/25/2012
NAME OF PROVIDER OR SUPPLIER RIVERSIDE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 BOX 39 CALHOUN, KY 42327		
(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 323 SS-D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the resident's environment remained as free of accident hazards as is possible related to staff not locking the medication cart during a medication pass for one resident (#4), in the selected sample of 16 residents. Observation during a medication pass, on 05/24/12 at 9:15 AM, revealed Certified Medication Aide (CMA) #1 pulled Resident #4's medication from the cart, entered the resident's room, and left the medication cart unlocked. During the administration of the medication, her back was turned to the cart and she was unable to visualize it. At 9:17 AM, CMA #1 returned to the medication cart and there were three residents in</p>	F 323	<p>This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverside Manor Health Care Center does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p> <p>F323</p> <ol style="list-style-type: none"> The licensed staff member responsible was counseled by the Staff Development Coordinator on 5/24/12 All licensed staff (nurses and CMA's) educated regarding policy for locking medication carts when away from them by the Staff Development Coordinator on 5/24/12, 5/25/12, and 5/28/12. <p>All licensed staff (nurses and CMAs) will have medication pass competency completed by Staff Development Coordinator on 5/24/12, 5/25/12, and 5/28/12 to validate security of medications.</p> <ol style="list-style-type: none"> The Pharmacy Representative will monitor medication pass on 6/2/12. 	7/9/12	

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

TITLE

(X6) DATE

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 323	<p>Continued From page 1 the hallway at that time.</p> <p>Findings include:</p> <p>A review of the facility's established policy and procedure, undated, revealed anytime staff stepped away from their cart, they were to lock it. That was to ensure the safety of residents and be in compliance with keeping medications secured.</p> <p>A record review revealed the facility admitted Resident #4 on 10/06/09 with diagnoses to include Diabetes Mellitus Type II, Hypertension, Renal Failure, and Late Effects of Cerebral Vascular Accident.</p> <p>Observation during a medication pass, on 05/24/12 at 9:15 AM, revealed CMA #1 pulled Resident #4's medication from the medication cart, entered his/her room, and left the medication cart unsecured. While administering the resident's medication, her back was turned to the cart and she was unable to visualize it. At 9:17 AM, she returned to the medication cart and there were three residents in the hallway near the medication cart.</p> <p>An interview with CMA #1, on 05/24/12 at 3:10 PM, revealed when she finished pulling the resident's medication and went into the room to administer the medication, she was suppose to lock the medication cart. She was trained if the cart was out of her sight, she could not leave it unlocked. CMA #1 revealed she pulled the medication cart in front of the resident's door, and turned her back on the cart to administer the resident's medication. CMA #1 admitted the medication cart was not in her sight. She</p>	F 323	<p>The Staff Development Coordinator will conduct monitoring/ observation of 10% of medication pass for 3 months. All new hires and yearly all licensed employees will be checked off by the SDC on medication administration which will include properly locking the medication cart.</p> <p>4. The results of the medication pass observations will be reported to the monthly Performance Improvement Committee for tracking and trending purposes with follow up action taken as needed.</p> <p>5. Completion Date: 7/9/2012</p>	7/9/12

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F 323	Continued From page 2 revealed her back was turned to the cart and she should have locked the cart before leaving it to administer the resident's medication. An interview with Licensed Practical Nurse (LPN) #1, on 05/25/12 at 1:27 PM, revealed it was not acceptable to leave the medication cart unlocked while going into a resident's room to administer medication. The medication cart was to be locked at all times when the staff stepped away from it. An interview with the Director of Nursing (DON), on 05/25/12 at 2:21 PM, revealed during medication administration the cart was to be locked anytime they were not with the cart. The staff were expected to lock the carts when they stepped away to administer medication or provide care to a resident.	F 323		7/9/12
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	F 514	<u>F514</u> 1. a. An order clarification was obtained from Dr. Wilhite on 5/24/12 for the order in question on resident #4 was obtained and implemented. b. June physician's orders and medication administration records reprinted correctly reflecting the medication as ordered for resident #4. c. Education for licensed staff (nurses and CMAs) regarding medication administration with skills competency check off completed by the Staff Development Coordinator and Unit Managers on 5/24/12, 5/25/12, and 5/28/12. d. Educational review of Renewed or Recapitulated Physician's Orders, Medication Records, and Treatment Records for licensed nurses completed by the Staff Development Coordinator on 5/24/12, 5/25/12, and 5/28/12 e. Medication Administration Record to Cart audit by PharmERICA	

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F 514	Continued From page 3 by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to maintain the clinical record for one resident (#4), in the selected sample of 16 residents, in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. During observation of a medication pass, on 05/24/12 at 9:15 AM, Certified Medication Aide (CMA) #1 administered Mucinex XR 600 milligrams (mg) by mouth (po) to Resident #4. A review of the resident's Medication Administration Record (MAR) revealed an order for Mucinex; however, further review of the physician's order, dated 05/01/12 through 05/31/12, revealed no documented evidence of an order for Mucinex. Findings include: A review of the facility's policy/procedure "Renewed or Recapitulated (Recap) Physician's Orders, Medication Records and Treatment Records," dated 10/31/06, revealed every 30 days physician's orders are validated that physician's orders are clear, complete, and signed order of a person lawfully authorized to prescribe. Physician's orders are reviewed and revised to include new orders, changed orders, or to discontinue orders that have occurred throughout the month. Print physician's orders in advance for nursing unit if using RCS or distribute recap orders from pharmacy. Validate the physician's orders for accuracy. Review new recapped orders with the old current orders. Add orders that are missing from the recap orders.	F 514	nurse and representative on 6/18/12 and 6/19/12. f. Every resident's Medication Administration Record review for accuracy of meds by Medical Records Coordinator, Staff Development Coordinator, and Unit Manager on 5/30/12 and 5/31/12. 2. Pharamerica will do a Medication Administration Record to cart audit on 6/18/12. The Staff Development Coordinator and Unit Managers will observe medication pass of licensed staff (nurses and CMAs) beginning 5/24/12. 3. Education review of Renewed or Recapitulated Physician's Orders, Medication Records, and Treatment Records for licensed nurses by the Staff Development Coordinator on 5/24/12, 5/25/12, and 5/28/12. 10% of physician orders and MARS will be reviewed monthly for the next 3 months to ensure accuracy of the rewrite process, by the Staff Development Coordinator, Medical Records Coordinator, Unit Manager, Director Of Nursing, and Shift Supervisor. 4. Results of the physician's orders/ Medication Administration Record monthly accuracy reviews will be reported to the monthly Performance Improvement Committee for tracking and trending	7/9/12

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F 514	<p>Continued From page 4</p> <p>This may include, but is not limited to telephone orders that were obtained since the last full physician's orders. Print MAR and TAR prior to the first of the month from RCS. Review the MAR and TAR with the recapitulated physician's orders. Identify any orders that have been added or discontinued. Compare the MAR or TAR to the current MAR or TAR to validate that order is the same from the physician's orders to MAR/TAR to MAR/TAR. If discrepancies are noted, investigate to determine the correct orders. Reconcile physician's order, the MARs and TARs. If physician's orders are irreconcilable, notify the physician and clarify the orders. Notify the designated date entry person for RCS to update the system.</p> <p>A record review revealed the facility admitted Resident #4 on 10/06/09 with diagnoses to include Diabetes Mellitus Type II, Hypertension, Renal Failure, and Late Effects of Cerebral Vascular Accident.</p> <p>Observation during a medication pass, on 05/24/12 at 9:15 AM, revealed CMA #1 administered Mucinex XR 600 mg tablet to the resident. During the reconciliation of the medication pass for Resident #4, there was no evidence of an order for Mucinex XR 600 mg po two times daily on the physician's orders, dated 05/01/12 through 05/31/12. Further review of the physician's orders, dated 03/01/2011 until now, revealed there was no order for the Mucinex XR 600 mg tablet two times daily.</p> <p>An interview with the Resident Care System (RCS) Coordinator, on 05/24/12 at 10:44 AM, revealed he was responsible for printing out the</p>	F 514	<p>purposes with follow up action taken as needed.</p> <p>5. Completion Date: 7/9/2012</p>	7/9/12

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F 514	<p>Continued From page 5</p> <p>monthly physician's orders, MARs and TARs. On a daily basis the orders were received from the nursing stations, sorted, and put into the computer. The physician's orders were sent to the physician for signatures, and when they were returned, medical records placed the orders on the residents' charts. He could provide no explanation as to how the order for the medication was not on the physician's order nor on the MAR.</p> <p>An interview with Registered Nurse (RN) #1, on 05/25/12 at 1:27 PM, revealed during change-over, she took the old physician's orders and compared them to the new monthly physician's orders. She also compared the old and new MARs and TARs with the physician's orders. She revealed any new orders received, she compared them with the new physician's orders. She stated, in January 2012, she took over reviewing Resident #4's orders during the change-over. The resident received the medication from pharmacy each month and she wrote the medication on the MAR and did not write the order on the physician's orders.</p> <p>An interview with the Director of Nursing (DON), on 05/25/12 at 2:21 PM, revealed two weeks before the end of the month the new physician's orders, MAR and TAR were printed out and placed on the units. The change-over assignments were divided up between the nurses and they checked the current physician's orders with the previous month. They also checked the current physician's orders with the MARs and TARs. The night of change-over, the staff member came in and confirmed that the physician's orders matched the MARs and TARS.</p>	F 514		7/9/12

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F 514	Continued From page 6 After review of the MARs, it was noted the Mucinex was not on the MAR from March 2011 through October 2011, but it was on the MARs from that point until the present. The medication was given to the resident even though it was not on the MAR and she was assured by the staff that the resident received the medication. She could not provide an explanation as to how the medication was omitted from the physician's orders and the MARs when they were being checked for accuracy by the nursing staff and the consultant pharmacist.	F 514		7/9/12	

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{K 000}	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1962</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Type V (111)</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 05/24/12, and concluded on 05/25/12. Riverside Manor Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy nine (79) beds with a census of seventy eight (78) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	{K 000}	<p>This Plan of correction is prepared and submitted as required by law. By submitting this Plan of Correction, Riverside Manor Health Care Center does not admit that the deficiencies listed on the HCFA Form 2567 exist, nor does the Facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiencies. The facility reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the deficiency.</p>	7/27/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jeffrey Bentley* TITLE: Executive Director (X6) DATE: 8/13/12

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

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{K 000}	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level. A standard Life Safety Code follow-up survey was conducted on 07/25/12. Riverside Manor Health Care Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid.	{K 000}	<u>K 18</u> 1. The doors of rooms 11, 21, 22, 26,28,29,2,45,47,51,53 has been properly scaled by Maintenance Director, to ensure the resistance of passage of smoke.	7/27/12	
{K 018} SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, during the follow-up survey conducted on 07/25/12, it was	{K 018}	2. Maintenance Director inspected all rooms in the building for smoke gaps in the doors and any gates that would impede access to the rooms. 3. All doors shall be inspected quarterly for functionality and code compliance per Kindred Preventive Maintenance policy. Maintenance director will do inspections. 4. Maintenance Director will report any doors not in compliance with smoke passage code to Administrator. Administrator will track and trend and report findings to PI committee and appropriate action will be taken 5. Completion date 7/27/2012		

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{K 018}	<p>Continued From page 2</p> <p>determined the facility failed to ensure the deficiency cited on 05/25/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 07/09/12.</p> <p>The findings include:</p> <p>Observation, on 07/25/12 between 2:15 PM and 3:00 PM with the Maintenance Director, revealed the corridor door to rooms 11, 21, 22, 26, 28, 29, 2, 45, 47, 51, and 53 had a gap too large around the jamb and would not resist the passage of smoke. The gap on the sides of the door was larger than 1/8".</p> <p>Interview, on 07/25/12 between 2:15 PM and 3:00 PM with the Maintenance Director, revealed he was unaware the sides had the same gap requirements as the top of the doors.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.6.3 Corridor Doors.</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall</p>	{K 018}		7/27/12
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{K 018}	Continued From page 3 not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	{K 018}		7/27/12	
{K 025} SS=D	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	{K 025}			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER RIVERSIDE MANOR HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 190 EAST HWY. 136 BOX 39 CALHOUN, KY 42327	
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{K 025}	<p>Continued From page 4</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, during the follow-up survey conducted on 07/25/12, it was determined the facility failed to ensure the deficiency cited on 05/25/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 07/09/12.</p> <p>The findings include:</p> <p>Observation, on 07/25/12 at 2:20 PM with the Maintenance Director, revealed the smoke partition extending above the ceiling located in Hall 3 above room #52 was noted to have a penetrations by wires. The wire is on the left bottom of the wall located next to a large grey pipe. The hole is about a golf ball sized hole around a single wire.</p> <p>Interview, on 07/25/12 at 2:20 PM with the Maintenance Director, revealed he must have just overlooked it when he was repairing the smoke barrier..</p>	{K 025}	<p><u>K25</u></p> <ol style="list-style-type: none"> 1. Penetrations of smoke wall above ceiling located in Hall 3 above room #52 were properly sealed to prevent passage of smoke, by maintenance director. 2. Maintenance director will check the attic of the entire building for any penetrations in smoke partitions. 3. Attic partitions will be inspected quarterly and after phone/cable company has been in attic. Maintenance director will do inspection. 4. Maintenance director will report any non-compliance findings to Administrator. Administrator will track and trend findings and report to PI meeting with appropriate action taken. 5. Completion date 7/27/2012 	7/27/12

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{K 025}	Continued From page 5 Reference: NFPA 101 (2000 Edition). 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: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	{K 025}		7/27/12	
{K 047} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by:	{K 047}			

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{K 047}	Continued From page 6 Based on observation and interview, during the follow-up survey conducted on 07/25/12, it was determined the facility failed to ensure the deficiency cited on 05/25/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 07/09/12. The findings include: Observation, on 07/25/12 between 2:00 PM and 2:45 PM with the Maintenance Director, revealed egress paths to exits located in the Kitchen, and the Front Door, were not identified with directional and exit signage. The signs had been installed but the lights were not illuminated. Interview, on 07/25/12 between 2:00 PM and 2:45 PM with the Maintenance Director, revealed he was aware the electricians had not been to the facility to hook up the exit signs. The maintenance director called his electrician and verified he would be to the facility on 07/26/12 to hook up the electricity to the signs. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	{K 047}	<u>K47</u> 1. Exit sign and directional sign installed in the kitchen with continuous illumination. Exit sign installed at the front door with continuous illumination. 2. Maintenance director will inspect all exits in the building for proper exit signs. 3. Maintenance director will inspect monthly, all exit doors for proper signs and ensure signs are maintained. 4. Maintenance director will report any non-compliance findings to Administrator. Administrator will track and trend findings and report to PI meeting with appropriate action taken. 5. Completion date 7/27/2012	7/27/12	
{K 072} SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	{K 072}			

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{K 072}	<p>Continued From page 7</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, during the follow-up survey conducted on 07/25/12, it was determined the facility failed to ensure the deficiency cited on 05/25/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 07/09/12.</p> <p>The findings include:</p> <p>Observation, on 07/25/12 between 2:00 PM and 3:00 PM with the Maintenance Director, revealed chairs stored in the, Hall 2, back vending machine area. Further observation showed housekeeping carts and a scale were stored in the back hall and a fan was stored at the back of Hall 3.</p> <p>Interview, on 07/25/12 between 2:00 PM and 3:00 PM with the Maintenance Director, revealed he could not keep the corridors free and clear by himself. He stated it was a never ending battle that he does not feel he is getting any where with. The chairs were left in the corridor because the beauty shop was open that morning and the chairs were not returned to there storage area.</p> <p>Reference: NFPA 101 (2000 Edition)</p>	{K 072}	<p><u>K72</u></p> <ol style="list-style-type: none"> 1. Chairs in hall 2 by vending machine have been moved. Housekeeping carts removed from back hall. Scale removed from back hall. Fan was removed from Hall 3 2. Maintenance director surveyed building for any obstructions or impediments to full instant use of means of egress. 3. During daily rounds maintenance director will check for mean of egress obstructions or impediments. 4. During weekly rounds maintenance director will report all non-compliance findings to Administrator who will track and trend and report to monthly PI committee with proper action taken. 5. Completion date will be 7/27/2012. 	7/27/12	

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{K 072}	Continued From page 8 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.	{K 072}		7/27/12	
{K 130} SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, during the follow-up survey conducted on 07/25/12, it was determined the facility failed to ensure the deficiency cited on 05/25/12 during the standard survey, was corrected as outlined in the facility's plan of correction. The facility's alleged compliance date was 07/09/12. The findings include: Observation, on 07/25/12 at 2:55 PM with the Maintenance Director, revealed an unapproved lock (slide bolt type) installed on the exterior of the closet in room #28. Interview, on 07/25/12 at 2:55 PM with the Maintenance Director, revealed he must have over looked the lock on the closet door. He had not done his daily rounds in this room to ensure there was not slide bolt lock on the closet door. Reference: NFPA 101 (2000 Edition)	{K 130}	<u>K130</u> 1. Slide bolt removed from closet in room #28. 2. Maintenance director surveyed entire building for any latch or lock on the egress side of door. 3. During daily rounds maintenance director will monitor doors for locks or latches that would impede the means of egress. 4. Maintenance director will report any non-compliant issues to Administrator who will track and trend and report to PI committee with appropriate action taken. 5. Completion date will be 7/27/2012		

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{K 130}	Continued From page 9 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.	{K 130}		7/27/12	