

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

PRINTED: 11/30/2012
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2012
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NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY. 42347
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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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F 000	INITIAL COMMENTS A recertification survey was conducted on 11/12/12 through 11/14/12 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "D".	F 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the care	F 280	1. Comprehensive and Nurse Aide Care Plan for Resident #2 revised on 11/13/12 to reflect full code status. Revision completed by Assistant Director of Nursing. 2. Assistant Director of Nursing and Charge Nurse reviewed all other residents' care plans on 11/13/12 to assure accuracy of code status. A revision was made if indicated.. 3. All licensed nursing staff and IDT will be re-educated by Director of Nursing on revising Comprehensive Care plans to reflect accurate code status and as resident's status changes. Education will be completed by 12/10/2012. 4. ADON will audit all new admissions/readmissions to facility for code status and accuracy of care planning code status. Audit will be completed weekly for one month. Then 25% of care plans will be audited monthly for one quarter. Code status of all residents will be reviewed quarterly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12/10/12
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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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F 280	<p>Continued From page 1</p> <p>plan was revised with the correct code status for one resident (#2), in the selected sample of 18 residents. Resident #2 was admitted to the facility on 11/01/12 with a code status of Do Not Resuscitate (DNR). The resident's code status was changed on 11/02/12 to full code per the resident's wishes. However, the facility failed to revise the resident's care plan with the updated code status.</p> <p>Findings include:</p> <p>The facility was unable to provide a care plan policy.</p> <p>A record review revealed the facility admitted Resident #2 on 11/01/12 with diagnoses to include Acute Kidney Failure NOS, Hypertension NOS, Convulsions, Esophageal Reflux, Stomach Ulcer NOS, Depressive Disorder NEC, Bone and Cartilage Disorder NEC, Chronic Pain NEC, Myalgia and Myositis NOS, SYST Lupus Erythematosus, Personal History UTI, History Methicillin Resistant Staph, Constipation NOS, and Impaction Intestine NEC. The facility assessed Resident #2 to be alert and oriented on the Admission Nursing Assessment, dated 11/01/12.</p> <p>A review of the admission orders, dated 11/01/12, revealed Resident #2's code status as DNR. Further review revealed the DNR status was discontinued on 11/02/12 and "resident full code" was documented.</p> <p>A review of the Resuscitation Designation Form, dated 11/01/12, revealed the DNR box was marked.</p>	F 280	<p>during the care plan meeting with any changes noted and care planned accordingly. Social Service or Assistant Director of Nursing will report results of the audits to the quality assurance committee quarterly.</p>	12/11/12

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F 280	Continued From page 2 A review of the resident's care plan, dated 11/01/12, revealed the resident's code status was "DNR." A review of the nurse's notes, dated 11/02/12 at 11:00 AM, revealed the resident had changed his/her mind about being DNR status and requested resuscitation if needed. A message was left for the physician regarding the resident's code status wishes. A review of the facility's communication form to the physician, dated 11/02/12, revealed, "resident has changed [his/her] mind and wanted to be a full code, and need an order to discontinue DNR status." A review of the physician's telephone order, dated 11/02/12 at 3:00 PM, revealed "discontinue DNR order, resident a full code." A review of the Resuscitation Designation Form, dated 11/02/12, revealed the full code box was marked with the resident's signature. An interview with Licensed Practical Nurse (LPN) #3, on 11/13/12 at 3:15 PM, revealed she received the order to change the code status from DNR to full code. LPN #3 stated she did not update the care plan to reflect the full code status; however, she should have. An interview with the Assistant Director of Nursing (ADON), on 11/13/12 at 3:15 PM, revealed the resident was made a full code after he/she was admitted to the facility. If the nurse received the order for the code status, then it was the nurse's	F 280			

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F 280	Continued From page 3 responsibility to update the care plan. The ADON reviewed the MD orders and stated the code status was changed from DNR to full code. The nurse who received the order did not update the care plan, but should have updated the care plan. An interview with Certified Nurse Aide (CNA) #1, on 11/13/12 at 3:40 PM, revealed she was assigned to the resident and was unaware of the resident's code status. CNA #1 reviewed the CNA care plan book as well as the admission care plan, but was unable to locate the code status. An interview with the Director of Nursing (DON), on 11/13/12 at 3:50 PM, revealed the care plan should have been updated when the code status changed. The nurse who received the order should have changed it.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to ensure one resident (#8), in the selected sample of 18 residents, was provided care in accordance with the care plan. Resident #8 was assessed by	F 282	1. Resident #8 alarm was turned on as soon as it was discovered not on. Charge Nurse educated family member on 11-12-12 about importance of safety devices and interventions and of need to turn alarms on before leaving after visit with resident. 2. Floor Nurses reviewed all other residents that use a safety alarm to ensure that the safety alarm was on and functioning.	

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F 282	<p>Continued From page 4</p> <p>the facility as a fall risk with a history of falls. During the survey, he/she was observed in bed without his/her safety alarm on and functioning.</p> <p>Findings include:</p> <p>The facility utilized the Resident Assessment Instrument (RAI) for development and implementation of care plans and was unable to provide evidence of a policy/procedure to address care plans. Additionally, there was no evidence of a policy/procedure to address safety alarms.</p> <p>A record review revealed the facility admitted Resident #8 on 09/18/12 with diagnoses to include Leg Fracture, Kyphosis, Ankle-Foot Deformity, Osteoporosis, and Memory Loss.</p> <p>Review of an admission Minimum Data Set (MDS) assessment, dated 09/24/12, revealed the facility assessed the resident to have impaired memory and required extensive assistance for bed mobility and transfer. Review of the assessment revealed numerous risk factors for falls such as a functional decline prior to placement, Left Foot drop for twenty-seven-years, Kyphosis, and poor safety awareness.</p> <p>Review of an incident report and the nurses' notes, dated 09/20/12 at 8:25 AM, revealed the resident was found on the floor by the bed, with no injury identified. A care plan was implemented for a sensor alarm to be placed beside the bed and bed side commode due to attempts of unassisted transfers.</p> <p>Review of an incident report and the nurses' notes, dated 10/23/12 at 11:05 AM, revealed</p>	F 282	<p>3. Director of Nursing will educate all nursing staff by 12/10/2012 regarding importance of following each residents' written Plan of Care including to ensure that safety alarms are on and functioning and to inform licensed nursing staff of any non-compliance of residents or family members of safety devices so education can be provided if needed or for re-assessment of alarms. All residents with alarming devices are observed throughout the shift during ADL Care, meal times, toileting tasks, and to ensure devices on and functioning properly.</p> <p>4. Assistant Director of Nursing or floor staff nurse will audit residents with safety alarms every shift for one week, then each shift three times a week for one week, then each shift two times a week for one week, then each shift weekly for one week to ensure alarms is on and functioning. Assistant Director of Nursing will report results of audit to the Quality Assurance Committee.</p>	12/11/12

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F 282	<p>Continued From page 5</p> <p>Resident #8 was observed sitting on the floor on his/her buttocks in front of the commode in his/her room. A Certified Nurse Aide (CNA) had assisted the resident to the floor when his/her knees gave way and his/her left foot slid, causing a loss in balance. No injury was noted. The resident was evaluated by therapy and a plan implemented for cues for mobility when standing.</p> <p>Review of the Daily Nursing Assistant Care Plan, dated November 2012, revealed under Special Instruction section "Utilize wireless motion sensor to bed, bed side commode areas at all times."</p> <p>Observation, on 11/12/12 at 1:45 PM, revealed Resident #8 sitting on the side of the bed. A sensor alarm was in place, but was not turned on and functioning. An interview with Resident #8, at the time, revealed a family member had been visiting and turned the alarm off while visiting due to the alarm sounding constantly during the visit. The visitor told Resident #8 that staff would check and turn the alarm back on. Resident #8 stated, "They didn't come and turn it back on."</p> <p>Observation, on 11/12/12 at 2:00 PM, 2:45 PM, and 3:10 PM, revealed the resident's alarm remained off and non-functioning. On 11/12/12 at 3:10 PM, Licensed Practical Nurse (LPN) #1 verified the resident's alarm was off and non-functioning. The LPN revealed all staff were responsible to ensure safety alarms were on and functioning.</p> <p>An interview with Certified Nurse Aide (CNA) #3, on 11/13/12 at 8:30 AM, revealed she was assigned to Resident #8, on 11/12/12, and was not aware the alarm was not on or functioning.</p>	F 282		

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F 282	Continued From page 6 She stated family had visled on 11/12/12 and was in the hablt of turning the resident's alarm off during visits. An interview with CNA #1 and CNA #2, on 11/12/12 at 3:15 PM, revealed they had not checked on Resident #8 yet, but they usually were able to check on all of the residents by 4:00 PM. They stated the alarm ehould have been on and functioning. CNAs inltiated the Daily Nursing Asslstant Care Plan that the safety alarms were on and functioning. An interview with LPN #2, on 11/12/12 at 4:56 PM, revealed she was aware of other times when she assisted Resident #8 up to the bathroom, that the alarm was not on after the family member visited. She stated everyone was responsible to ensure safety alarms were on and functioning. An interview with the Director of Nursing (DON), on 11/12/12 at 4:50 PM, revealed she expected the CNAs to ensure care plans were followed to ensure safety alarms were on and functioning.	F 282			
F 323 SS=D	483.26(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced	F 323	1. Resident #8 had no negative outcome from alarm not being on and functioning. Resident #8 alarm was turned on as soon as it was discovered not on. Further investigation of non-functioning alarm revealed that family left off after visiting with the resident. 2. Floor nurses revicwed all other residents that use a safety alarm to ensure that the safety alarm was on and functioning.		

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F 323	<p>Continued From page 7</p> <p>by: Based on observation, interview, and record review, it was determined the facility failed to ensure the resident's environment remained free of accident hazards as is possible for one resident (#8), in the selected sample of 18 residents. A care plan intervention for the use of a safety alarm was in place for Resident #8; however, multiple observations, on 11/12/12, revealed facility staff failed to ensure Resident #8's safety alarm was on and functioning properly.</p> <p>Findings include:</p> <p>A policy/procedure addressing resident environment was not provided by the facility.</p> <p>A record review revealed the facility admitted Resident #8 on 09/18/12 with diagnoses to include Leg Fracture, Kyphosis, Ankle-Foot Deformity, Osteoporosis, and Memory Loss.</p> <p>Review of an admission Minimum Data Set (MDS) assessment, dated 09/24/12, revealed the facility assessed the resident to have impaired memory and required extensive assistance for bed mobility and transfer. Review of the assessment revealed numerous risk factors for falls such as a functional decline prior to placement, Left Foot drop for twenty-seven years, Kyphosis, and poor safety awareness.</p> <p>Record review revealed Resident #8 sustained a fall on 09/28/12 at 8:25 AM. The resident was found on the floor by the bed and a sensor alarm was implemented. The sensor alarm was to be beside the bed and the bed side commode at all</p>	F 323	<p>3. Director of Nursing will educate all nursing staff by 12/10/2012 regarding importance of following each resident's written plan of care for safety alarms are on and functioning to ensure resident's environment is free of accidents. Will also educate nursing staff to report to licensed nursing staff of any non-compliance of residents or family members of safety devices so education can be provided if needed or for re-assessment of alarms. All residents with alarming devices are observed throughout the shift during ADL care, meal times, toileting tasks, to ensure devices on and functioning properly.</p> <p>4. Assistant Director of Nursing or floor staff nurse will audit residents with safety alarms every shift for one week, then each shift three times a week for one week, then each shift two times a week for one week, then each shift weekly for one week to ensure alarm is on and functioning. Assistant Director of Nursing will report results of audit to the Quality Assurance Committee.</p>	12/11/12

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F 323	<p>Continued From page 8</p> <p>times due to attempts of unassisted transfers.</p> <p>Observation, on 11/12/12 at 1:45 PM, revealed Resident #8 sitting on the side of the bed. A sensor alarm was in place, but was not turned on and functioning. An interview with Resident #8, at the time, revealed a family member had been visiting and turned the alarm off while visiting due to the alarm sounding constantly during the visit. The visitor told Resident #8 that staff would check and turn the alarm back on. Resident #8 stated, "They didn't come and turn it back on." Additional observation, at 2:00 PM, 2:45 PM, and 3:10 PM, revealed the resident's alarm remained off and non-functioning.</p> <p>On 11/12/12 at 3:10 PM, Licensed Practical Nurse (LPN) #1 verified the resident's alarm was off and non-functioning. The LPN revealed all staff were responsible to ensure safety alarms were on and functioning.</p> <p>An interview with Certified Nurse Aide (CNA) #1 and CNA #2, on 11/12/12 at 3:15 PM, revealed that Resident #8's alarm should have been on and functioning. CNA #1 and CNA #2 revealed they had not checked on Resident #8 since arriving to work at 3:00 PM.</p> <p>An interview with LPN #2, on 11/12/12 at 4:55 PM, revealed she was aware of other times when she assisted Resident #8 up to the bathroom, that the alarm was not on after the family member visited. She stated everyone was responsible to ensure safety alarms were on and functioning.</p> <p>An interview with the Director of Nursing (DON), on 11/12/12 at 4:50 PM, revealed she expected</p>	F 323			

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F 323	Continued From page 9	F 323		
F 431 SS=D	<p>the CNAs to ensure care plans were followed to ensure safety alarms were on and functioning.</p> <p>403.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<ol style="list-style-type: none"> No resident affected. Assistant Director of Nursing (or Director of Nursing) reviewed all scheduled II drugs were being kept in locked compartment and only authorized personnel had access to drugs. Administrator educated Director of Nursing on 11/26/12 on the proper storage of Scheduled II drugs in separate locked, affixed compartment. On 11/26/2012, a separate double locking cabinet has been permanently installed to wall in Director of Nursing office. Destruction of discontinued Scheduled II drugs will be destroyed by two licensed nurses, no less than monthly. Administrator or Corporate Nurse Consultant will audit monthly x3 months that Scheduled II drugs are being stored in separate locked affixed compartment. Results of the audit will be presented to the Quality Assurance Committee. 	11/27/12

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F 431	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure discontinued narcotics for disposition were securely maintained in accordance with accepted professional standards. Discontinued narcotics for disposition were observed being stored in the Director of Nursing's (DON) office in a desk drawer. During the survey, the DON's office was observed vacant with the door unlocked and opened.</p> <p>Findings include:</p> <p>Review of an undated facility policy, Medication Destruction, revealed "Discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed." Additionally, the policy/procedure revealed "Controlled substances are retained in a securely locked area with restricted access until the DON (or his/her designee) completes the controlled medication disposal."</p> <p>Observation, on 11/12/12 through 11/14/12, revealed the DON's office door to be open while the DON was not present in the room.</p> <p>During a general observation tour of the facility, it was determined discontinued medications, which included narcotics, were being stored in a single locked drawer of a desk in the DON's office.</p> <p>Observation, on 11/14/12 at 3:20 PM, revealed there were ten (10) Ambien 5 milligram (mg)</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
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F 431	Continued From page 11 tablets, sixteen (16) Tramadol 50 mg tablets, and two hundred and six (206) Hydrocodone tablets. An interview with the DON, on 11/14/12 at 3:20 PM, revealed she kept the discontinued narcotics in the desk drawer until she and another licensed staff destroyed the medication per facility protocol. The DON stated she knew the narcotics should have been stored in secured locked compartments other than a desk drawer. The DON verified her office was accessible when the door was left open and she was not present.	F 431			

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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: 1968 and 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, (68 sec.) Type III (200), (78 sec.) Type V (000).</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2009, with 16 smoke detectors and 129 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1978.</p> <p>GENERATOR: Type II generator installed in 2007. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/14/2012. Professional Care Health and Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 12/10/12

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 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 018 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, fifty-eight (58) residents, staff and visitors. The	K 018	1. The doors to resident rooms 43, 61, 62, 64 and 65 will be repaired to prevent the passage of smoke in to the rooms by the Maintenance Director by 1/30/13. 2. All doors in facility were checked by the maintenance Director on 12/4/12 to ensure no other doors in the facility were affected by the deficient practice. 3. The Maintenance Director was inserviced on the regulation by the Administrator on 12/4/12 and will add the inspection of all doors in the facility to his monthly preventative maintenance schedule to ensure all doors will resist the passage of smoke. 4. Administrator will audit monthly inspections beginning January 2013 and will report results at the QA meeting in January and not less than quarterly thereafter for one year.	1/30/13

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K 018	<p>Continued From page 2</p> <p>facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to ensure five (5) corridor doors to the resident rooms did not have a gap at the top of the door.</p> <p>The findings include:</p> <p>Observations, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed the corridor doors to rooms 61, 62, 65, 64, and 43 would not resist the passage of smoke around the jamb of the doors due to the gap at the top of the doors.</p> <p>Interview, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed he was aware the doors to the resident rooms could not have a gap at the top of the door but was unaware these five (5) doors had a gap.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms,</p>	K 018		

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K 018	Continued From page 3 bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018			
K 029 SS=F	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	K 029	1. Automatic door closers will be installed by the Maintenance Director on the north hall storage room, activities office and the beauty shop by 1/15/13 by the Maintenance Director. 2. All doors in the facility leading to potentially hazardous areas were checked by the Maintenance Director on 12/5/12 to ensure automatic door closers were in place and functioning properly.		

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K 029	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to ensure three (3) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed the north hall storage room, the activities office, and the beauty shop did not have a closer added to the door. This requirement is due to the storage of combustible items inside the areas.</p> <p>Interview, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a</p>	K 029	<p>3. The Maintenance Director was inserviced on the regulation by the Administrator on 12/5/12. The Maintenance Director will add the inspection of automatic door closers to his monthly preventative maintenance checklist.</p> <p>4. Administrator will audit monthly inspections beginning January 2013 and will report results at the QA meeting in January 2013 and not less than quarterly thereafter for one year.</p>	1/15/13

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K 029	Continued From page 6 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 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 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 60 ft ² (4.6 m ²), 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 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	1. The exterior exits at the south hall west exit, south hall dumpster exit, east hall exit and the kitchen exit will have light fixtures installed that contain two or more bulbs by the Maintenance Director by 1/30/13.	

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K 045	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at four (4) exits. The findings include: Observation, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed the exterior exits at the south hall west exit, south hall dumpster exit, east hall exit, and the kitchen exit only had a single light for illumination of the outside of the exit. Interview, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Interview, on 11/14/12 at 3:45 PM with the Administrator, revealed he was unaware all exits of the facility must have two (2) bulbs at every exit of the facility. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged	K 045	2. All exterior exits were viewed by the Maintenance Director on 12/5/12 and none were found to have single bulb fixtures. 3. The Maintenance Director was in-serviced by the Administrator on 12/5/12 on the regulation. The maintenance director will add to his monthly preventative maintenance schedule a review of the facility exits to ensure they are correctly lighted by two bulbs. 4. Administrator will audit monthly inspections beginning January 2013 and will report results at the QA meeting in January 2013 and not less than quarterly thereafter for one year.	1/30/13

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K 045	Continued From page 7 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.	K 045		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on interview and facility record review, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to ensure they conducted annual emergency lighting testing for the minimum requirement of testing of at least 1-1/2 hour duration annually. The findings include: Observation and record review, on 11/14/12 at 10:30 AM with the Maintenance Supervisor, revealed that the emergency lights, with battery backup, located throughout the facility had not been tested for 1-1/2 hours within the last year. Interview, on 11/14/12 at 10:30 AM with the Maintenance Supervisor, revealed he was unaware the lighting had to be tested annually for	K 046	1. Effective immediately emergency lighting is now being tested monthly for 30 minutes and annually for 1 1/2 hours. 2. Effective immediately emergency lighting is now being tested monthly for 30 minutes and annually for 1 1/2 hours. No residents were affected by the deficiency. 3. The Maintenance Director was in-serviced by the Administrator on 12/5/12 on the regulation. The maintenance director will add to his monthly preventative maintenance schedule to test emergency lighting monthly for 30 minutes and annually for 1 1/2 hours. 4. Administrator will audit monthly tests beginning January 2013 and will report results at the QA meeting in January 2013 and annually thereafter for one year.	1/1/13

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K 046	<p>Continued From page 8 1-1/2 hours.</p> <p>Interview, on 11/14/12 at 3:45 PM with the Administrator, revealed he was unaware of the duration of the annual testing of battery lights.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>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 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</p>	K 046			

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K 046	Continued From page 9 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, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times. The findings include: Fire Drill review, on 11/14/12 at 10:40 AM with the Maintenance Supervisor, revealed the fire drills	K 050	1. Effective immediately facility fire drills are now being conducted at random times on all shifts. 2. Effective immediately facility fire drills are now being conducted at random times on all shifts. No residents were affected by the deficiency. 3. The Maintenance Director was in-serviced by the Administrator on 12/5/12 on the regulation. The maintenance director will complete or ensure that the monthly fire drills are conducted at random for all shifts and documented as such. 4. Administrator will audit monthly fire drills beginning January 2013 and will report results at the QA meeting monthly for three months and then quarterly for one year to ensure compliance.	1/13/13	

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K 050	Continued From page 10 were not being conducted at random times on all shifts. Fire drills on first shift were conducted roulnely between 9:48 AM and 10:14 AM, second shift roulnely between 3:12 PM and 3:36 PM, and third shift roulnely between 6:59 AM and 6:13 AM. Interview, on 11/14/12 at 10:40 AM with the Maintenance Supervisor, revealed he was unaware the fire drills were not being conducted as required. The Maintenance Supervisor was unaware of the time separation on each shift to consider the times unexpected. Interview, on 11/14/12 at 3:45 PM with the Adminlstrator, revealed that they have a plant operations revlewer that reviews the fire drills to ensure they are being conducted correctly. The plant operations reviewer reviewed the fire drills to ensure they were being conducted correctly. Reference: NFPA 101 (2000 edllion) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times undor varied conditions on all shifts.	K 050			
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056	1. The facility ordered replacement light fixtures on 12/10/12 to replace the fixtures identified in the Statement of deficiencies as being located with-in one foot of a sprinkler head.		

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K 056	<p>Continued From page 11 supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures.</p> <p>The findings include:</p> <p>Observations, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed the sprinkler heads located in the clean linen side of the laundry, admissions, ice machine room, and the common area in the west hall were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in the resident rooms # 30, 31, 29, 27, 22, 3, 6, 9, 10, 11, 12, 13, 14, 15, 16, and 17.</p> <p>Interview, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed he was unaware that the light fixtures</p>	K 056	<ol style="list-style-type: none"> The Maintenance Director audited the entire facility on 12/10/12 and found no other sprinkler heads blocked by light fixtures other than what was identified in the statement of deficiencies. The Maintenance Director was in-serviced by the Administrator on 12/5/12 on the regulation. Light fixtures have been ordered and will be installed by 1/30/13. After installation of the replacement fixtures the Administrator and Maintenance Director will ensure that the work was completed in accordance with the regulation and will report the completion of the work at the facilities next Quality Assurance meeting. 	1/30/13

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K 056	<p>Continued From page 12 could block the spray pattern of the sprinkler head.</p> <p>Interview, on 11/14/12 at 3:45 PM with the Administrator, revealed he was unaware of the required spacing for the lights from the sprinkler head since they were lower than the deflector plate of the sprinkler head.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.6.2.2 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. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>of Deflector Obstruction (In.)</th> </tr> </thead> <tbody> <tr> <td>(B) Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (In.)	(B) Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056		
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K 056	Continued From page 13	K 056			
K 064 SS=F	<p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers per NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to ensure the fire extinguishers throughout the facility were mounted below five (5) feet above the surface of the floor.</p> <p>Findings include:</p> <p>Observations, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed the wall mounted, portable fire extinguishers located throughout the facility were mounted above the maximum allowable height of five (5) feet above the finish floor.</p> <p>Interview, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor,</p>	K 064	<ol style="list-style-type: none"> 1. The fire extinguishers, identified during the annual survey, were moved on 12/10/12 by the Maintenance Director and remounted below the maximum allowable height of 5 feet above the floor. 2. The Maintenance Director audited the entire facility on 12/10/12 and found no other fire extinguishers mounted above 5 feet from the floor. 3. The Maintenance Director was in-serviced by the Administrator on 12/5/12 on the regulation. The maintenance director will ensure any fire extinguishers that are moved, recharged, added or replaced are mounted 5 feet or less from the floor. 4. The maintenance director will audit the placement of fire extinguishers quarterly for one year and report the findings to the QA committee for compliance. 	1/1/13	

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K 064	Continued From page 14 revealed that he was unaware of the height limitations for wall mounted portable fire extinguishers and acknowledged that they were mounted above the height of five (5) feet above the finish floor. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 6 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064		
K 074 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the	K 074	1. Replacement shower curtains have been ordered as of 12/5/12 with mesh openings of 1/2 inch on the diagonal to replace the curtains identified as not having 1/2 inch mesh openings on the diagonal. The replacement curtains will be installed by 1/30/13. 2. The Maintenance Director audited the entire facility on 12/10/12 and found no other shower curtains with less than 1/2 inch mesh openings on the diagonal.	

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K 074	Continued From page 15 method cited in 10.3.2 (3), 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to ensure shower curtains had the proper mesh for full sprinkler coverage. The findings include: Observation, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed one (1) privacy curtain in the shower room on the east hall and three (3) curtains in the west hall shower room had mesh that was smaller than 1/2 inch on the diagonal. Interview, on 11/14/12 between 12:30 PM and 3:30 PM with the Maintenance Supervisor, revealed he was aware the shower curtains must contain mesh with 1/2 inch on the diagonal but new curtains were just ordered of the wrong type.. Interview, on 11/14/12 at 3:45 PM with the Administrator, revealed he was aware of the proper size of curtain for the shower rooms but	K 074	3. The Maintenance Director was in-serviced by the Administrator on 12/5/12 on the regulation. The maintenance director will ensure any replacement shower curtains ordered meet the standard of having 1/2 inch mesh openings on the diagonal. 4. The maintenance director will audit the shower curtains quarterly for one year and report the findings to the QA committee for compliance.	1/30/13

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K 074	Continued From page 16 was unaware the curtains of the wrong type of mesh were installed in the shower rooms. NFPA 13 Cubicle curtains; Reference to: NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99	K 076	1. The oxygen tanks stored in the west hall storage area and north hall storage area will be stored alone and with no other combustible materials. These storage areas will be free of all combustibles and the oxygen tanks will be greater than 5 feet away from the light switch. The light switches will be relocated and this will be completed by 1/30/13.	

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K 076	Continued From page 17 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred ten (110) beds with a census of eighty-six (86) on the day of the survey. The facility failed to store oxygen over 300 cu ft. 5 feet away from any combustibles and ensure electrical sources were five (5) feet from the floor. The findings include: Observation, on 11/14/12 at 10:30 AM with the Maintenance Supervisor, revealed thirty-one (31) oxygen tanks stored in the storage room on the north hall and twenty-five (25) tanks stored in the west hall storage room. The oxygen tanks were being stored within five (5) feet of combustible items and electrical outlets were not five (5) feet from the floor on the north hall. Interview, on 11/14/12 at 10:30 AM with the Maintenance Supervisor, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials and ignition sources must be five (5) feet from the floor once	K 076	2. The Maintenance Director audited the entire facility on 12/10/12 and found no other areas where oxygen tanks were being stored. 3. The Maintenance Director was serviced by the Administrator on 12/5/12 on the regulation. The maintenance director will ensure any new or replacement oxygen tanks are stored in the oxygen storage areas which will be free of combustibles and has a light switch that is greater than 5 feet from the oxygen. 4. The maintenance director will audit the facility for proper oxygen storage quarterly for one year and report the findings to the QA committee for compliance.	1/30/13

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K 076	<p>Continued From page 18</p> <p>the storage equals over 300 cubic feet in a smoke compartment.</p> <p>Interview, on 11/14/12 at 3:45 PM with the Administrator, revealed he was unaware of the oxygen storage requirements once the total amount per smoke compartment reached over 300 cu ft.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m³ (300 ft³) but less than 85 m³ (3000 ft³) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.</p>	K 076		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185276	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2012
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 076	Continued From page 19 (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076			