

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

PRINTED: 09/27/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2013
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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 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p><i>This Plan of Correction constitutes Professional Care Health and Rehabilitation's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</i></p> <p>F164</p> <p>1. Resident #11 MAR was secured as soon as it was brought to the attention of the ADON that she had left the residents medical record open and visible. ADON was educated by the DON on 9/12/13 and again on 9/20/13 on the deficiency regarding Personal Privacy and Confidentiality of a Resident's Medical record.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/3/13
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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 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's "Residents' Rights" information, it was determined the facility failed to ensure one (1) resident (#11), in the selected sample of eighteen residents, had the right to personal privacy and confidentiality of his or her personal and clinical records. Observation during a medication pass revealed the licensed staff left Resident #11's Medication Administration Record (MAR) open on top of the medication cart with the residents' information in full view of other residents and visitors.</p> <p>The findings include:</p> <p>A review of the facility's "Residents' Rights for Residents in Kentucky Long-Term Care Facilities", undated, revealed "the resident has the right to personal privacy and confidentiality of his or her personal and clinical records."</p> <p>Observation during a medication pass, on 09/12/13 at 8:40 AM through 9:00 AM, revealed the Assistant Director of Nursing (ADON) administered morning medications to Resident #11; however, the ADON left the resident's MAR in open view, uncovered on top of the medication cart which was in the hallway.</p> <p>An interview with the ADON, on 09/12/13 at 9:05 AM, revealed no explanation was provided as to why the MARs were left uncovered during the medication pass for Resident #11.</p> <p>An interview with the Director of Nursing (DON), on 09/12/13 at 10:30 AM, revealed she was made</p>	F 164	<p>2. All residents have the potential to be affected by the deficient practice identified. No other residents were identified during the Annual Survey to be affected by the deficiency. All nurses and medication aides were in serviced by the pharmacy consultant on 9/20/13 on the importance of protecting resident's medical record and personal/confidential information.</p> <p>3. All licensed nurses and certified medication aides were re-educated by the DON on providing privacy to all residents to include privacy of MAR during medication administration. In-service completed by the pharmacy consultant on 9/20/13. ADON or designated licensed nurse will observe medication passes for privacy of MARs daily for one week, then once a month for three months and then quarterly for 1 year to ensure compliance.</p> <p>4. ADON or designated licensed nurse will observe medication passes for privacy of MARs daily for one week, then once a month for three months and then quarterly for 1 year to ensure compliance. Results of the observations will be brought to the QA committee to ensure compliance.</p>	10/27/13	

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F 164	Continued From page 2 aware of the privacy issue regarding the MARs, with no further explanation provided.	F 164			
F 323 SS=E	483.25(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 by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure that the resident environment remains as free of accident hazards as is possible involving one (1) resident (#11), in the selected sample of eighteen (18) residents. During observation of a medication pass on 09/12/13, Resident #11's medications were left unsupervised on top of the medication cart, which was in the hallway. Additionally, two (2) drawers on the medication cart containing medications were left unlocked and unattended during the medication pass on 09/12/13. The findings include: A review of the facility's policy/procedure, "Medication Administration - General Guidelines", dated 02/01/10, revealed "during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of	F 323	F323 1. As soon as the deficient practice was brought to the attention of the ADON and DON the medication was secured and cart locked. ADON educated by the DON on 9/12/13 and all licensed nurses and medication aides were in serviced by the pharmacy consultant on 9/20/13 on proper storage of medications and the importance of locking the medication cart when not in use. 2. All residents have the potential to be affected by the deficient practice identified. No other residents were identified during the Annual Survey to be affected by the deficiency. All licensed nurses and medication aides were in serviced by the Pharmacy consultant on 9/20/13 on proper storage of medications and the importance of locking the medication cart when not in use.		

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F 323	<p>Continued From page 3</p> <p>the resident's room, with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to personnel administering medications, all outward sides must be inaccessible to residents or others passing by."</p> <p>Observation during a medication pass, on 09/12/13 at 8:40 AM through 9:00 AM, revealed the Assistant Director of Nursing (ADON) turned her back on the medication cart to administer oral medications to Resident #11 in his/her room while the following medications were left unsupervised on top of the medication cart in the hallway: a bottle of Opti-Clear Eye Drops, a bottle of Artificial Tears Eye Drops, and a bottle of Flonase Nasal Spray. Further observation during this time revealed two (2) drawers on the right lower side of the medication cart were left unlocked. Observation revealed the two (2) drawers contained the following medications: two (2) nineteen (19) ounce containers of Metamucil powder, one eight (8) ounce bottle of Pepto Bismol, two (2) pints of Lactulose, three (3) twelve (12) ounce bottles of Mylanta Regular Strength, five (5) twelve (12) ounce bottles of Milk of Magnesia, one (1) pint of Docu Liquid, four (4) bottles of Promethazine 6.25 mg/5 ml for cough, seven (7) containers of Glycol (Miralax) 527 grams, and five (5) packets of Juvon Therapeutic Nutrition. Additional observation revealed there were two ambulatory residents in the room across the hall during this time as well as three residents passing by the medication cart, and four staff walked by the medication cart while being left unsupervised.</p> <p>An interview with the ADON, on 09/12/13 at 9:05 AM, revealed no explanation was provided as to</p>	F 323	<p>3. All licensed nurses and certified medication aides were re-educated on proper storage of all medications and locking of medicine carts when not actively using the cart. The in-service was completed 9/20/13 by the pharmacy consultant. The ADON or designated licensed nurse will observe medication passes for proper storage of medications and locking of the medication cart when not in use daily for one week, then once a month for three months and then quarterly for 1 year to ensure compliance.</p> <p>4. The ADON or designated licensed nurse will observe medication passes for proper storage of medications and locking of the medication cart when not in use daily for one week, then once a month for three months and then quarterly for 1 year to ensure compliance. Results of the observations will be brought to the QA committee to ensure compliance.</p>	10/27/13	

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F 323	Continued From page 4 why the medications were left unsupervised on top of the cart during the medication pass for Resident #11. Additionally, she was unable to provide an explanation regarding the unlocked drawers on the medication cart while she was in the room with Resident #11. An interview with the Director of Nursing (DON), on 09/12/13 at 10:30 AM, revealed she was made aware of the issue regarding medications being left on top of the cart as well as the two medication drawers being left unsupervised during medication pass. No further explanation was provided.	F 323			
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. 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 it was free of medication error rates of 5% or greater involving one (1) resident (#11), in the selected sample of eighteen (18) residents. Observation of a medication pass on 09/11/13 and 09/12/13 revealed there were thirty-five (35) opportunities with six (6) medication errors resulting in a 17% medication error rate related to timing. The findings include: A review of the facility's policy/procedure,	F 332	F332 1. Resident #11 had no adverse reactions from her medications being given late. ADON was re-educated by the DON on 9/12/13 and all licensed nurses and medication aides were re-educated by the pharmacy consultant on 9/20/13 on the regulation and importance of giving residents medications timely. 2. All residents have the potential to be affected by the deficient practice identified. All other residents were given their medications timely and no other residents were identified as being affected by the deficiency. All licensed staff and medication aides were re-educated by the pharmacy consultant on 9/20/13 on following medication pass times.		

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F 332	<p>Continued From page 5</p> <p>"Medication Administration - General Guidelines", dated 02/01/10, revealed "medications are administered either 60 minutes before or after the scheduled time, except before or after meal orders, which are administered (based on mealtimes)."</p> <p>A review of Resident #11's Medication Administration Record (MAR), dated September 2013, revealed "Opti-Clear (Visine) Eye Drops, one drop to the right eye three times a day at 7:30 AM, 11:30 AM, and 4:30 PM; Artificial Tears Drops, instill one drop into each eye four times daily at 7:30 AM, 11:30 AM, 3:30 PM, and 7:30 PM; Fluticasone (Flonase) 50 micrograms (mcg) nasal spray, give one spray in each nostril twice a day at 7:30 AM and 8:30 PM; Metoprolol TRT 25 milligrams (mg), give one tablet orally (po) twice daily at 7:30 AM and 8:30 PM; Omeprazole 20 mg, give one capsule orally (po) twice daily at 7:30 AM and 8:30 PM; and Spironolactone 25 mg, give one tablet orally (po) twice daily at 7:30 AM and 8:30 PM."</p> <p>Observation of a medication pass for Resident #11, on 09/12/13 at 8:40 AM through 9:00 AM, revealed the Assistant Director of Nursing (ADON) administered Opti-Clear Eye Drops, one drop to the right eye; Artificial Tears Drops, one drop into each eye; Fluticasone 50 mcg nasal spray, one spray in each nostril; Metoprolol TRT 25 mg tablet po; Omeprazole 20 mg capsule po; and Spironolactone 25 mg tablet po.</p> <p>An interview with the ADON, on 09/12/13 at 2:45 PM, revealed she had to delay her medication pass due to stopping and assisting others to get residents up that morning. No further explanation was provided as to why medications were given</p>	F 332	<p>3. All licensed nurses and certified medication aides were re-educated by the pharmacy consultant on the importance of providing medications timely on 9/20/13. ADON or designated licensed nurse will observe medication passes to ensure all medications are administered per policy and regulation daily for one week, and then monthly for 3 months.</p> <p>4. ADON or designated licensed nurse will observe medication passes to ensure all medications are administered per policy and regulation daily for one week, and then monthly for 3 months. Results of the observations will be brought to the QA committee to ensure compliance.</p>	10/27/13	

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F 332	Continued From page 6 late. She stated she had an understanding about the medication error rate related to timing of the medications administered to Resident #11. An interview with the Director of Nursing (DON), on 09/12/13 at 10:30 AM, revealed she verbalized an understanding of the 17% medication error rate due to timing of the medication pass. No further explanation was provided.	F 332			
F 371 SS=E	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review it was determined the facility failed to ensure food was stored, prepared and distributed under sanitary conditions. Observations on 09/11/13 revealed the milk cooler with spilled milk with an overwhelming odor on the bottom of the cooler, food in the small reach in refrigerator without a date and some outdated items, the sanitizer bucket without the appropriate amount of sanitizer solution, the stove had areas of peeling black paint on the back splash and on the over the burner shelf and it also had a build up of dust on the shelf,	F 371	F-371 1. The fans identified as dusty during the survey were cleaned on 9/11/13. The milk cooler was cleaned on 9/11/13. Staff was in-serviced on 9/12/13 and again on 9/20/13 on proper use of hair restraints. The juice found to be out of date was removed on 9/11/13 when identified by the surveyor. The stove identified as having paint peeling off was recovered with stainless steel on 9/30/13. The sanitizer bucket identified as not having the appropriate levels of sanitizer was immediately removed and sanitizer added. The food identified without a date or outdated was immediately removed and discarded. All dietary staff was in-service on 9/20/13 by the Dietary Manager on all items listed as deficient practice in the facility CMS-2567.		

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F 371	<p>Continued From page 7</p> <p>fans located in the kitchen area were dusty and kitchen staff were observed with hair not adequately restrained.</p> <p>The findings include:</p> <p>1. Observation during the initial tour of the kitchen, on 09/11/13 at 10:20 AM revealed the following:</p> <p>A. Review of a facility policy titled, "Food and Non-Food Storage", dated 2008, revealed "Foods that have been removed from their original containers are clearly marked with contents, dated and wrapped to exclude as much air as possible".</p> <p>Review of a facility policy titled, "Food Preparation and Safety", dated 2006, revealed "Leftovers are handled properly to prevent contamination. Leftovers are used within three (3) days or discarded". The policy additionally stated; "Leftovers are labeled, dated and refrigerated immediately at 41 F or below".</p> <p>The small reach in refrigerator revealed containers of pre-poured juice which had thickener added. One of the containers had no date or label and one had a date of 08/26/13 which was eighteen (18) days after it had been labeled and placed into the refrigerator.</p> <p>Interview with the Dietary Manager at the time of the observation revealed that three days was the limit for keeping food that had been removed from its original container and placed into another container. The evening aide should have discarded the items on the third day.</p>	F 371	<p>2. All residents have the potential to be affected by the deficient practice identified. All dietary staff were in-serviced by the Dietary Manager on 9/12/13 and again on 9/20/13 regarding the deficiencies identified on 9/11/13 during the facility annual survey.</p> <p>3. The dietary manager will check daily the milk cooler for cleanliness, the fans to ensure they are dust free, that the staff is using hair restraints appropriately, that no food or juice is outdated or without dates, and that the stove is without chipping paint. Any issues identified will be corrected immediately and appropriate corrective action taken with staff responsible for the deficient practice.</p> <p>4. The dietary manager will check daily the milk cooler for cleanliness, the fans to ensure they are dust free, that the staff is using hair restraints appropriately, that no food or juice is outdated or</p>	10/27/13	

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F 371	<p>Continued From page 8</p> <p>B. Review of a facility policy titled, "Food and Non-Food Storage", dated 2006, revealed "Refrigerators and freezers are cleaned regularly to prevent off-odors or flavors from contaminating food".</p> <p>The milk cooler floor was covered with spilled milk and had a strong odor of spoiled milk. The cooler cleaning schedule was initiated as cleaned on 09/11/13; however, the observation revealed spilled milk that had spoiled in the bottom of the cooler.</p> <p>An interview with the Dietary Manager on 09/11/13 at the time of the observation revealed the delivery person usually "dumped" cartons of milk into the cooler causing damage to the cartons with resulting leakage. The Dietary Manager stated who ever had initiated on 09/11/13 was responsible to have cleaned the spilled and spoiled milk from the cooler.</p> <p>An interview with the Registered Dietician, on 09/12 /13 at 2:30 PM, revealed spilled milk in the milk cooler had been a problem. The delivery person just dumped the delivery and the cartons would become damaged and spill milk in the cooler and was a waste. She stated she would expect facility staff to ensure the milk cooler was kept clean.</p> <p>C. Review of a facility policy titled, "Environmental Sanitation/Infection Control", dated 2006, revealed "All food service employees are trained in proper cleaning schedules and routines" and "Work surfaces are cleaned and sanitized at the start of each day, after each production period and after using potentially hazardous products such as raw meats".</p>	F 371	without dates, and that the stove is without chipping paint. Any issues identified will be corrected immediately and appropriate corrective action taken with staff responsible for the deficient practice. The results of the daily checks will be reported to the QA committee monthly for one year to ensure compliance.		

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F 371	<p>Continued From page 9</p> <p>The sanitizer bucket was tested at 10:23 AM and the test strip indicated no sanitizer was present in the sanitizer bucket water.</p> <p>Interview with the Dietary Manager at the time of the observation revealed the solution should test at least two hundred (200) parts per million and was supposed to be changed three times a day. The cook was responsible to ensure the water was changed and tested.</p> <p>D. A large fan on a stand that had a heavy build up of dust on the fan grill. A fan was also observed in the dish room with a heavy build up of dust.</p> <p>Interview with the Dietary Manager at the time of the observation revealed the fans were cleaned by maintenance when the dietary staff requested and the fans should have been cleaned.</p> <p>2. Review of a facility policy titled, Environmental Sanitation/Infection Control and dated 2010, revealed "A hair restraint that effectively covers head and/or facial hair is worn in food preparation areas. Hair is arranged to prevent contamination of food, equipment and utensils".</p> <p>A. Observation during the tray line service, on 09/11/13 at 11:30 AM revealed Kitchen Staff #1, #2 and #3 were preparing resident's meal trays from the tray line. The kitchen staffs' hair restraints did not adequately restrain their hair and were observed with hair sticking out from the hair restraint in the front of the head, the sides and the back.</p> <p>Interview with the Dietary Manager at the time of</p>	F 371			

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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	
(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 000}	INITIAL COMMENTS Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/27/13 as alleged.	{K 000}		

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

TITLE

(X8) 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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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 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 09/12/13. 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-nine (89) 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</p>	K 000		

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

TITLE

(X6) DATE

[Signature]

Administrator

10/3/13

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 (Fire).	K 000			
K 062 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on sprinkler testing record review, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 09/12/13 at 1:38 PM, with the Maintenance Supervisor revealed inadequate sprinkler coverage in the East and West Shower Rooms. The walls in the shower room would prevent the sprinkler from reaching all areas in this room.</p> <p>Interview with the Maintenance Supervisor, on 09/12/13 at 1:38 PM, revealed he was not aware of the improper sprinkler coverage.</p> <p>Reference: NFPA 13 1999 edition</p>	K 062	<p>K-062</p> <ol style="list-style-type: none"> No residents were affected by the deficient practice. The facility will add additional sprinkler heads to increase coverage and to meet the regulation as defined in NFPA 101 Life Safety Code Standards 5-5.5.2 and 5-5.5.3. All other areas of sprinkler coverage were not cited during the facility's annual survey on 9/12/13 and were found to meet the NFPA 101 Life Safety Code Standard 5-5.5.2 and 5-5.5.3. Extra sprinkler heads will be added to the East and West shower rooms to ensure adequate coverage by a licensed company. All other areas of the facility will be visualized to ensure the facility is in compliance with the Life Safety Code cited and ensure the facility is meeting the standard. Any areas of the facility that may be modified in the future will also be inspected by the facility Maintenance staff to ensure that adequate coverage is present to meet the standard NFPA 101 Life Safety Code Standard 5-5.5.2 and 5-5.5.3. 	10/27/13	

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K 062	Continued From page 2	K 062		
K 147 SS=F	<p>5-5.5.1*. Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred ten (110) beds with a census of eighty nine (89) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 09/12/13 between 1:00 PM and 3:00 PM, with the Maintenance Supervisor revealed;</p> <p>1) A refrigerator was plugged into a power strip located in the East West Nurses' Station Med Room.</p> <p>2) A hairdryer was plugged into a multi-plug adaptor located in the Beauty Shop.</p>	K 147	<p>K-147</p> <ol style="list-style-type: none"> The refrigerator found to be plugged in to a power strip located at the East West nurses station was corrected immediately by removing the power strip. The hair dryer found to be plugged in to a multi-plug adaptor located in the beauty shop was corrected on 9/18/13 by installing a 4-plex in the electrical socket. The power strip found to be plugged in to an extension cord was immediately corrected by removing the extension cord. All refrigerators were visualized on 9/17/13 to ensure they were not plugged in to power strips. The beautician was trained by the Administrator on 9/20/13 on not using multi-plug adaptors in the beauty shop. The Maintenance director visualized all areas of the facility to ensure no other extension cords were in use. 	

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K 147	<p>Continued From page 3</p> <p>3) A power strip was plugged into an extension cord located in the South Nurses' Station.</p> <p>Interview, on 09/12/13 between 1:00 PM and 3:00 PM, with the Maintenance Supervisor revealed he was not aware of the misuse of power strips, multi-plug adaptors, and extension cords.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adaptors.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or</p>	K 147	<p>3. The Maintenance Director or Maintenance Assistant will visualize all areas of the facility monthly to ensure refrigerators are not plugged in to power strips, that the beautician is not using multi-plug adaptors in the beauty shop and that extension cords are not in use.</p> <p>4. The results of the monthly audits will be brought to the QA committee monthly for 1 year to ensure compliance.</p>	10/27/13	

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K 147	Continued From page 4 floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		