

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

PRINTED: 10/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186412	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2012
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NAME OF PROVIDER OR SUPPLIER LOURDES TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 LONE OAK ROAD PADUCAH, KY 42003
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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	F 000		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's admission packet, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one resident (#3), in the selected sample of eight residents. During the survey, Resident #3 was observed to have a urinary catheter drainage bag which was uncovered while in the room, and the urinary catheter drainage bag was visible from the main hallway.</p> <p>Findings include: A review of the facility's Admission packet, dated March 2006, revealed the facility's statement to residents regarding Resident Rights, to include Section R titled Dignity and Respect, and item #5,</p>	F 241	<p>On 10/11/12, staff was educated regarding dignity with catheter care and positioning of catheter bag during ambulation, while in bed or when up in chair in regards to Resident #3 and any future residents who have catheters.</p> <p>A new policy has been developed to ensure use of dignity bags and will be reviewed with staff at regularly scheduled staff meeting on 11/08/12.</p> <p>During resident interview process, the MDS Coordinator will confirm that catheters are in dignity bags and positioned appropriately. She will report lack of compliance to the DON on a case by case basis and appropriate follow up will be</p>	11/08/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kelly Bean</i>	TITLE <i>Nursing Home Administrator</i> (X6) DATE <i>11/2/12</i>
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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 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 000	INITIAL COMMENTS A standard recertification survey was conducted on 10/09/12 through 10/11/12 to determine the facility's compliance with Federal requirements. Deficiencies were cited with the highest S/S being an "E" and the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's admission packet, it was determined the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for one resident (#3), in the selected sample of eight residents. During the survey, Resident #3 was observed to have a urinary catheter drainage bag which was uncovered while in the room, and the urinary catheter drainage bag was visible from the main hallway. Findings include: A review of the facility's Admission packet, dated March 2006, revealed the facility's statement to residents regarding Resident Rights, to include Section R titled Dignity and Respect, and item #5,	F 241	On 10/11/12, staff was educated regarding dignity with catheter care and positioning of catheter bag during ambulation, while in bed or when up in chair in regards to Resident #3 and any future residents who have catheters. A new policy has been developed to ensure use of dignity bags and will be reviewed with staff at regularly scheduled staff meeting on 11/08/12. During resident interview process, the MDS Coordinator will confirm that catheters are in dignity bags and positioned appropriately. She will report lack of compliance to the DON on a case by case basis and appropriate follow up will be	11/08/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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F 241	<p>Continued From page 1</p> <p>stated "The right to be cared for in an environment that promotes maintenance or enhancement of your dignity and respect in full recognition of his or her individuality."</p> <p>A record review revealed the facility admitted Resident #3 on 09/13/12 with diagnoses to include Amyloidosis, Nephrotic Syndrome, and Chronic Stage III Kidney Disease.</p> <p>Observation, on 10/09/12 at 10:00 AM and 2:30 PM, revealed the resident's urinary catheter drainage bag was attached to the resident's bed and was easily visible to public view.</p> <p>Further observation, on 10/10/12 at 9:15 AM, 12:50 PM, and 2:00 PM, revealed the urinary catheter drainage bag was not covered and easily visible to public view.</p> <p>Interview with the Charge Nurse, on 10/10/12 at 2:45 PM, revealed the facility had no policy/procedure for covering catheter bags. Further interview with the Charge Nurse, at 3:45 PM, revealed her interpretation of item #5 under Dignity and Respect in the Resident's Admission packet included that residents would not be embarrassed, feelings would be cared for, and be private. She stated if a resident was embarrassed by the urinary catheter bag, it would be covered with a blanket or kept on the opposite side of the bed.</p> <p>Interview with the Director of Nursing (DON in training), on 10/10/12 at 4:05 PM, revealed her interpretation of item #5 under Dignity and Respect in the Resident's Admission packet included provision of excellent care with dignity</p>	F 241	<p>conducted. This will include counseling with staff and placing the catheter in a dignity bag. DON attends the quarterly QI meetings, and will report any instances of noncompliance each quarter.</p>	
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F 241	<p>Continued From page 2</p> <p>and respect. The DON explained dignity was to provide privacy, respect decisions, provide the best care they deserved. The DON stated the staff provided as much privacy as possible for elimination, whether going into the bathroom or via the urinary catheter. She recognized how it could be embarrassing for the resident, especially with a roommate. The DON stated she was not aware of a facility policy/procedure to address covering the urinary catheter bag; however, it would be a "good" policy for the facility to have. She revealed she could see how it was an issue regarding the resident's dignity and privacy.</p> <p>Interview with the Administrator, on 10/10/12 at 4:30 PM, revealed her interpretation of item #5 under Dignity and Respect in the Resident's Admission packet included to be respectful of someone's privacy, and to avoid making fun of another. The Administrator stated going to the bathroom was a private issue and the staff provided dignity and privacy as much as they could. The Administrator stated the physical placement of the facility being within the hospital and the residents having short term stays, the covering of the catheter bag had never been an issue and most residents were admitted to the facility from another area of the hospital and came with the catheter in place. The Administrator stated the practice of nursing or physical therapy for ambulation included hanging the resident's catheter bag on the lowest bar of the walker and was not covered.</p>	F 241		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or</p>	F 371		

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F 371	<p>Continued From page 3</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions related to storage of dry mix products opened, unlabeled and undated, and observed in the dry storage area of the kitchen.</p> <p>Findings include:</p> <p>Review of the facility's policy/procedure titled #B006 Food And supply Storage Procedures, dated revised 03/11, revealed "Cover, label and date unused portions and opened packages. Use orange label, complete all sections on the label." Additionally, the policy/procedure revealed "Store foods in their original packages. Foods that must be stored in approved containers must have tight fitting lids. Label both the bin and the lid."</p> <p>An observation during the initial kitchen tour, on 10/09/12 at 10:30 AM, revealed an opened twenty-pound bag of hush puppy mix with the edges folded over, but not secured. There was no evidence of an open date on the mix. Additionally, a large clear plastic container was observed laying on a shelf and contained an unidentified</p>	F 371	<p>The two products were immediately discarded when discovered on 10/09/12. The Dietary Manager inserviced the cooks on 10/10/12 regarding the policy on labeling and dating opened containers of food so that this would not recur. On this date, the cooks were responsible for this task.</p> <p>On 10/30/12, the storeroom clerk position was filled and daily checks of opened food containers will be his duty This is included in the orientation process that is due to be completed on 11/09/12.</p> <p>The Executive Chef will perform spot checks during monthly inventory rounds and report any issues to the Dietary Manager.</p>	11/09/12

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F 371	<p>Continued From page 4</p> <p>dry mix. There was no evidence of a label or an open date on the clear plastic container.</p> <p>An interview with the Dietary Manager, on 10/09/12 at 10:30 AM, revealed the opened bag and plastic container should have been labeled and dated when opened. The staff who opened the dry mix was responsible to ensure it was labeled and dated after opening.</p>	F 371		

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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: 1981.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: Eight (8) stories, Type I (222).</p> <p>SMOKE COMPARTMENTS: The Transitional Care Unit was located on the sixth floor with Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1968 upgraded in 1981, with 496 smoke detectors and 32 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1968 and upgraded in 1981.</p> <p>GENERATOR: Three (3) Type I Caterpillar generators installed in 2004. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/09/12. Lourdes Transitional Care was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Twenty (20) beds with a census of Sixteen (16) on the day of the survey.</p>	K 000		

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K 000	Continued From page 1 The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 029 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</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 twenty (20) beds with a census of sixteen (16) on the day of the survey. The facility failed to ensure two (2) rooms with hazardous storage had the proper door closer for separation.</p>	K 029	Self-closing hardware was installed on both 10/10/12 doors.	

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K 029	<p>Continued From page 2</p> <p>The findings include:</p> <p>Observation, on 10/09/12 between 1:50 PM and 2:50 PM with the Facilities Director, revealed the discharge planner office had a substantial amount of combustibles and the storage room across from room# 623.</p> <p>Any room larger than 50 square feet with substantial combustible material must have a door that resists the passage of smoke and a closing device.</p> <p>Interview, on 10/09/12 between 1:50 PM and 2:50 PM with the Facilities Director, revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation.</p> <p>Interview, on 10/09/12 at 3:10 PM with the Administrator, revealed she relies on the Facilities Director for Life Safety Code throughout the facility. The Facilities Director has conducted Life Safety Code seminars to educate staff. She was unaware the areas were considered hazardous storage.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in</p>	K 029		
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K 029	Continued From page 3 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 50 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 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		

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K 038	<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 ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, eight (8) residents, staff and visitors. The facility is certified for twenty (20) beds with a census of sixteen (16) on the day of the survey. The facility failed to ensure the stairwell fire exit door at the south end would release and open in the stated fifteen (15) seconds.</p> <p>The findings include:</p> <p>Observation, on 10/09/12 at 2:45 PM with the Facilities Director, revealed the stairwell fire exit door at the south end had signage that stated the door would release after pressure was applied for fifteen (15) seconds. The door was observed to not open after pressure was applied.</p> <p>Interview, on 10/09/12 at 2:45 PM with the Facilities Director, revealed he was unaware the door was not functioning properly. He was aware the door was required to open once pressure was applied for fifteen (15) seconds.</p> <p>Interview, on 10/09/12 at 3:10 PM with the Administrator, revealed she relies on the Facilities Director for Life Safety Code throughout the facility. The Facilities Director has conducted Life Safety Code seminars to educate staff. She was</p>	K 038	<p>Facilities staff made an adjustment to the door hardware and the door is functioning properly. A preventative maintenance schedule will be utilized by Facilities staff to ensure compliance going forward.</p>	10/10/12
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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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unaware the door was not functioning properly.

Reference:
NFPA 101 (2000 edition)
7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.

(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.

(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(c) An irreversible process shall release the lock within 15

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FORM APPROVED
OMB NO. 0938-0391

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K 038	<p>Continued From page 6</p> <p>seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.</p>	K 038		

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K 038	Continued From page 7 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038		
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	K 050		

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K 050	<p>Continued From page 8</p> <p>announcement may be used instead of audible alarms. 19.7.1.2</p> <p>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 twenty (20) beds with a census of sixteen (16) on the day of the survey. The facility failed to vary the fire drills to ensure they are being conducted at unexpected times.</p> <p>The findings include:</p> <p>Fire Drill review, on 10/09/12 at 9:50 AM with the Facilities Director, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on second shift were conducted routinely between 8:00 PM and 8:25 PM, and third shift routinely between 11:35 PM and 11:49 PM.</p> <p>Interview, on 10/09/12 at 9:50 AM with the Facilities Director, 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.</p> <p>Interview, on 10/09/12 at 3:10 PM with the Administrator, revealed she relies on the Facilities</p>	K 050	<p>The staff on Transitional Care is scheduled on two, 12-hour shifts. Fire drills will be conducted at varying times on both shifts (7a – 7p and 7p – 7a) in order to comply with the requirement that they be at unexpected times on a quarterly basis.</p> <p>Reports of each drill will be forwarded to the Nursing Home Administrator.</p> <p>Staff responsible for performing the drills (Security) were reeducated regarding the requirement on 11/01/12.</p>	11/02/12

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K 050	Continued From page 9 Director for Life Safety Code throughout the facility. The Facilities Director has conducted Life Safety Code seminars to educate staff. Further interview revealed she was unaware of the need for unexpected times regarding the fire drills. Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure valves located in the facility sprinkler system were electronically supervised by a tamper switch 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 twenty (20) beds with a census of sixteen (16) on the day of the survey. The facility failed to ensure all water control valves were electronically supervised on the sprinkler system.	K 061		

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K 061	<p>Continued From page 10</p> <p>The findings include:</p> <p>Observation, on 10/09/12 at 2:56 PM with the Facilities Director, revealed the sprinkler system had three unsupervised valves at the sprinkler riser. The valves were not equipped with a tamper switch, but were secured with chains. The observation was confirmed with the Facilities Director.</p> <p>Interview, on 10/09/12 at 2:56 PM with the Facilities Director, revealed he was unaware all valves leading to the sprinkler system must be electronically supervised.</p> <p>Interview, on 10/09/12 at 3:10 PM with the Administrator, revealed she relies on the Facilities Director for Life Safety Code throughout the facility. The Facilities Director has conducted Life Safety Code seminars to educate staff. She was unaware the sprinkler riser was not properly supervised.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe</p>	K 061	<p>Tamper switches will be installed by end of day on 11/09/12.</p>	11/10/12

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K 061	Continued From page 11 valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061		
K 072 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access 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 twenty (20) beds with a census of sixteen (16) on the day of the survey. The facility failed to ensure a wheelchair, a container of pillows, and spot vital signs machines were properly stored out of the corridor when not in use.</p> <p>The findings include:</p> <p>Observation, on 10/09/12 between 10:15 AM and 1:50 PM with the Facilities Director, revealed a wheelchair, spot vital machines, a chair, and a thirty-two (32) gallon container full of pillows were stored in the corridor of the facility from 10:15 AM</p>	K 072	<p>Staff was reeducated regarding clear egress corridors at the staff meeting held on 11/02/12 10/18/12. Compliance rounds will be conducted by Facilities to spot check any</p>	

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K 072

Continued From page 12 to 1:50 PM.

Interview, on 10/09/12 between 10:15 AM and 1:50 PM with the Facilities Director, confirmed the items were stored in the corridor for over thirty minutes. He was unsure why the items were being stored in the corridor.

Interview, on 10/09/12 at 3:10 PM with the Administrator, revealed she relies on the Facilities Director for Life Safety Code throughout the facility. The Facilities Director has conducted Life Safety Code seminars to educate staff. She was aware items could only be stored in the corridor for thirty (30) minutes.

Reference: NFPA 101 (2000 Edition)
Means of Egress Reliability 7.1.10.1
Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

K 072

deficiencies and any issues will be reported to the NHA. Charge nurses have been given a copy of an article from The Joint Commission regarding "corridor clutter" and educated on their accountability for avoiding clutter in the egress hallways.

