

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

PRINTED: 11/06/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185346</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERMITAGE CARE AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1614 PARRISH AVE, WEST OWENSBORO, KY 42301</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A Recertification Survey was conducted on 04/14/15 through 04/16/15. The facility was found to meet the minimum requirements for recertification with no deficiencies cited.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

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K 000	<p>INITIAL COMMENTS</p> <p>AMENDED</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1964, 1973 &amp; 1979.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 63 smoke detectors and 42 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1979.</p> <p>GENERATOR: Type II generator installed in 2005. Fuel source is Natural Gas.</p> <p>A Recertification Life Safety Code Survey was conducted on 04/16/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-two (92) beds with a census of seventy-eight (78) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000		



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

TITLE

(X6) DATE

*[Handwritten Signature]*

*NHA*

5/8/15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting if 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 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	Hermitage Care and Rehab Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety-two (92) beds and at the time of the survey, the census was seventy-eight (78).  The findings include:	K 029		1. The paper material and boxes were removed from the Human Resources Office on 4/16/15. Metal cabinets were purchased and installed on 4/17/15 in the Human Resources Office for future storage. No residents were affected by the alleged deficient practice. 5/15/15 2. The Maintenance Director performed a walk through on 4/16/15 to ensure there were no other areas or offices that had a hazardous amount of paper storage with the absence of a smoke resistant and self-closing door. No other areas were identified to have hazardous storage. 3. An in-service was provided to department managers on 4/16/15 by the Maintenance Director and the Administrator regarding the storage of paper or boxes in office areas that may create a hazardous storage area.

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K 029	<p>Continued From page 2</p> <p>Observation, on 04/16/15 at 12:54 PM, with the Maintenance Director revealed a hazardous amount of paper storage located in the Human Resource Office. The room did not have a door installed that was not equipped with a self-closing device to keep the door closed.</p> <p>Interview, on 04/16/15 at 12:55 PM, with the Maintenance Director revealed he was not aware the room would have to meet the requirements of protection from hazards.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 04/16/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/16/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.2 Protection from Hazards.</p> <p>Reference: NFPA 101 (2000 Edition) 9.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other 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:</p> <p>(1) Boiler and fuel-fired heater rooms</p>	K 029	<p>4. The department managers will monitor their office and storage areas with their weekly rounding to ensure they do not create a hazardous storage area. The Maintenance Director will perform a monthly audit of all <u>offices</u> and <u>storage areas</u> to ensure there is not paper or boxes that could create a hazardous storage area. If any area is identified as a hazardous storage area, the Maintenance Director will correct and report the findings to the Administrator and the Quality Assurance and Performance Improvement Committee. The Maintenance Director will bring the above stated audits to the monthly QAPI meeting for three months for recommendations and/or follow-up as needed.</p> <p>5. Corrective Action Date: 5/15/15</p>		

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K 029	<p>Continued From page 3</p> <p>(2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>)</p> <p>(3) Paint shops</p> <p>(4) Repair shops</p> <p>(5) Soiled linen rooms</p> <p>(6) Trash collection rooms</p> <p>(7) Rooms or spaces larger than 50 ft<sup>2</sup> (4.6 m<sup>2</sup>), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction</p> <p>(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.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8 Self-Closing Devices.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.1* A door normally required to be kept closed shall not be secured in the open position at any time and shall be self-closing or automatic-closing in accordance with 7.2.1.8.2.</p> <p>Reference: NFPA 101 (2000 Edition) 7.2.1.8.2 In any building of low or ordinary hazard contents, as defined in 6.2.2.2 and 6.2.2.3, or where approved by the authority having jurisdiction, doors shall be permitted to be automatic-closing, provided that the following criteria are met:</p>	K 029		

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K 029	Continued From page 4 (1) Upon release of the hold-open mechanism, the door becomes self-closing. (2) The release device is designed so that the door instantly releases manually and upon release becomes self-closing, or the door can be readily closed. (3) The automatic releasing mechanism or medium is activated by the operation of approved smoke detectors installed in accordance with the requirements for smoke detectors for door release service in NFPA 72, National Fire Alarm Code®. (4) Upon loss of power to the hold-open device, the hold-open mechanism is released and the door becomes self-closing. (5) The release by means of smoke detection of one door in a stair enclosure results in closing all doors serving that stair.	K 029		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety-two (92) beds and at the time of the survey, the census was seventy-eight (78).	K 054	1. The Smoke Detector Sensitivity Test was completed on 4/23/15 by FESCO. No residents were affected by the alleged deficient practice.  2. All other inspections performed by FESCO were reviewed by the Maintenance Director. There were no other discrepancies identified.  3. A spreadsheet will be maintained by the Maintenance Director with all vendors inspections to ensure they are completed timely.  4. The above stated spreadsheet will be maintained by the Maintenance Director and brought to the monthly Quality Assurance and Performance Improvement Committee to verify that all inspections are current.  5. Corrective Action Date: 5/15/15	5/15/15

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K 054	<p>Continued From page 5</p> <p>The findings include:</p> <p>Smoke detector record review, on 04/16/15 at 9:30 AM, with the Maintenance Director revealed the facility did not have documentation of a Smoke Detector Sensitivity Test being performed on the fire alarm smoke detectors within the last two (2) years.</p> <p>Interview, on 04/16/15 at 9:31 AM, with the Maintenance Director revealed he was not aware the facility did not have a current sensitivity test on the fire alarm smoke detectors.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 04/16/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/16/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 72 (1999 edition)</p> <p>7-3.2.1* Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency</p>	K 054		

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K 054	<p>Continued From page 6</p> <p>is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.</p>	K 054		

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K 054	Continued From page 7 Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.  The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. NFPA 101 LIFE SAFETY CODE STANDARD	K 054		
K 062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.8, 4.6.12, NFPA 13, NFPA 25, 9.7.5  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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety-two (92) beds and at the time of the survey, the census was seventy-eight (78).  The findings include:  Sprinkler testing record review, on 04/16/15 at 9:45 AM, with the Maintenance Director revealed the facility could not provide documentation that the gauges on the sprinkler system had been calibrated or replaced within the last five (5)	K 062	<ol style="list-style-type: none"> <li>Three gauges on the sprinkler system were replaced on 4/21/15 by Century Fire Protection. These three gauges were also dated to ensure quick reference of the date of replacement. No residents were affected by the alleged deficient practice. <b>5/15/15</b></li> <li>All other inspections were reviewed by the Maintenance Director for the sprinkler system and were found to be current and completed by Century Fire Protection.</li> <li>A spreadsheet will be maintained by the Maintenance Director with all vendors inspections to ensure they are completed timely.</li> <li>The above stated spreadsheet will be maintained by the Maintenance Director and brought to the monthly Quality Assurance and Performance Improvement Committee to verify that all inspections are current.</li> <li>Corrective Action Date: 5/15/15</li> </ol>	

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K 062	<p>Continued From page 8 years.</p> <p>Interview, on 04/16/15 at 9:46 AM, with the Maintenance Director revealed the facility depended on the testing contractor to keep the facility in compliance for all the test requirements pertaining to the sprinkler system.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 04/16/15. The findings were acknowledged by the Administrator and verified by the Director of Maintenance at the exit interview on 04/16/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 19.3.5.2* Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria: (1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system.</p>	K 062			

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K 062	<p>Continued From page 9</p> <p>(3) It shall be fully supervised. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7</p>	K 062			

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K 062	Continued From page 10 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction Investigation Maintenance 5 years or as needed Chapter 10  Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1	K 062		

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K 062	Continued From page 11 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves	K 062		

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K 062	Continued From page 12 Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING	K 066	1. A metal container with a self-closing cover was ordered on 4/16/15 and received and placed in the smoking area on 4/21/15 by the Housekeeping Supervisor. No residents were affected by the alleged deficient practice.	5/15/15

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K 066	<p>Continued From page 13 or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area was properly equipped for safe smoking, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect smokers using the smoking area. The facility has the capacity for ninety-two (92) beds and at the time of the survey, the census was seventy-eight (78).</p> <p>The findings include:  Observation, on 04/16/15 at 12:46 PM, with the Maintenance Director revealed the facility did not provide a metal container with a self-closing lid in which to dump ashtrays as required in the designated smoking area.</p>	K 066	<p>2. All ashtrays will be emptied in the metal container with a self-closing cover located in the designated smoking area by the housekeeping department.</p> <p>3. An in-service was provided to the housekeeping staff on 4/16/15 by the Housekeeping Director regarding the proper disposal of ash trays in the metal container with a self-closing cover.</p> <p>4. The smoking area will be monitored by the Housekeeping Director weekly for 4 weeks and then monthly for 2 months for proper disposal of ashtray's into a metal container with a self-closing cover. The Housekeeping Director will report findings to the Quality Assurance and Performance Improvement Committee for three months for recommendations and follow-up.</p> <p>5. Corrective Action Date: 5/15/15</p>	

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K 066	<p>Continued From page 14</p> <p>Interview, on 04/15/15 at 12:47 PM, with the Maintenance Director revealed he was not aware of the requirements for smoking areas.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 04/16/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/16/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.</p>	K 066		

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K 066	Continued From page 15 (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.  Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for ninety-two (92) beds and at the time of the survey, the census was seventy-eight (78).  The findings include:  Observation, on 04/16/15 at 10:10 AM, with the Maintenance Director revealed a power strip was plugged into another power strip located in the	K 147	1. The power strip that was plug into another power strip was removed by the Maintenance Director on 4/16/15 from the Minimum Data Set (MDS) office. The microwave was removed from the power strip and the power strip was removed from the Activities office by the Maintenance Director on 4/16/15. No residents were affected by the alleged deficient practice.  2. A 100% audit was completed by the Maintenance Director on 4/16/15 in all offices to ensure no other misuse of power strips. No others were identified.  3. An in-service was provided to all department managers and office personnel regarding the proper use of power strips on 4/16/15 by the Administrator and Maintenance Director.	5/15/15

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K 147	<p>Continued From page 16 Minimum Data Set (MDS) Office.</p> <p>Interview, on 04/16/15 at 10:11 AM, with the Maintenance Director revealed he was not aware the power strips were being misused.</p> <p>Observation, on 04/16/15 at 10:55 AM, with the Maintenance Director revealed a microwave was plugged into a power strip located in the Activities Office.</p> <p>Interview, on 04/16/15 at 10:56 AM, with the Maintenance Director revealed he was not aware the power strip was being misused.</p> <p>The census of seventy-eight (78) was verified by the Administrator on 04/16/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 04/16/15.</p> <p>Actual NFPA Standard:</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 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the</p>	K 147	<p>4. The Maintenance Director will audit all office space monthly to ensure proper use of power strips. Any discrepancies in the above stated audits will be reported to the Administrator. Above stated audits will also be addressed in the monthly Quality Assurance and Performance Improvement Meeting for recommendations or follow-up.</p> <p>5. Corrective Action Date: 5/15/15</p>	

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K 147	Continued From page 17 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 floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces  Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		