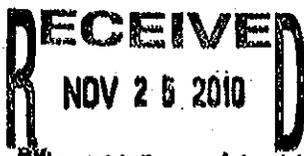


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/04/2010  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                 |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185277 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY COMPLETED<br><br>C<br>10/21/2010 |
| NAME OF PROVIDER OR SUPPLIER<br><br>HERITAGE HALL HEALTH & REHABILITATION CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>331 SOUTH MAIN STREET<br>LAWRENCEBURG, KY 40342   |   |
| (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:<br><br>A Recertification Survey and an Abbreviated Survey investigating ARO #KY00015460 and KY00015462 was conducted on 10/19-21/10 with deficiencies cited. ARO #KY00015460 and ARO #KY00015462 were found to be unsubstantiated.  | F 000  | <br>BY: F-323-Free-of-Accident Hazards<br><br>Padlocks were placed on shower room cabinets on D Hall and B Hall on October 26, 2010, by the Maintenance Director.<br><br>Environmental rounds were conducted by the Director of Nursing on 10/22/10. No additional environmental hazards were identified and no other residents were identified to have been affected by the deficient practice. In addition, on 11/23/10 and 11/24/10, a review of all residents were conducted by the Director of Nursing, Assistant Director of Nursing, Unit Coordinators and Physical therapy to ensure residents requiring assistive devices had assistive devices to prevent accidents. No residents were identified. |   |
| F 323<br>SS=E  | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure the residents' environment remained free from accident hazards as evidenced by unlocked cabinets that contained razors in two (2) of four (4) unlocked shower rooms.<br><br>The findings include:<br><br>Observation on initial tour on 10/19/10 at 10:15 AM revealed an unlocked cabinet containing razors in the unlocked whirlpool bathroom on D Hall. Further observation on the initial tour on 10/19/10 at 10:30 AM revealed an unlocked cabinet containing razors in the unlocked men's shower room on B Hall.<br><br>Interview on 10/21/10 at 3:10 PM with Certified Nurse Assistant (CNA) #6 revealed that razors in | F 323  |  | 11-25-10  |

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

*Dana Shavit*

TITLE

*Administrator*

(X6) DATE

*11-24-10*

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

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| F 323  | <p>Continued From page 1</p> <p>the unlocked cabinet in the unlocked whirlpool bath on D Hall D was "not safe". CNA #8 revealed that the cabinet had a slide latch which residents usually can't open. But observation on 10/19/10 at 10:15 AM revealed that the cabinet was not latched.</p> <p>Interview on 10/21/10 at 3:15 PM with Certified Nurse Assistant #7 revealed that the unlocked cabinet in whirlpool bath D used to be locked. She said there was a key someplace else but it was lost.</p> <p>Interview on 10/21/10 at 3:30 PM with Certified Nurse Assistant #8 revealed she believed residents could not pull the unlocked door open of the men's bathroom on B Hall because most residents on B Hall were in wheelchairs and Jeri-chairs and the doors were too heavy.</p> <p>Interview on 10/21/10 at 3:55 PM with Registered Nurse (RN) #1, the Director of Nursing (DON), revealed that "anything's possible" but she believed it was unlikely that the residents would get into either unlocked cabinet containing razors on D and B Halls. Still, the DON revealed that she would prefer that the cabinets were locked.</p> <p>Further interview with the DON on 10/21/10 at 4:10 PM revealed that there were several residents who wandered and lived on the D and B Halls. She provided the Elopement Risk Book, which contained the residents who wandered, for review at 4:15 PM.</p> <p>Review of the Elopement Risk Book on 10/21/10 at 4:20 PM revealed there were four (4) residents who wandered on the B Hall in the vicinity of the Men's Shower Bathroom and six (6) residents on</p> | F 323  | <p>F-323 Cont'd</p> <p>All residents including wandering residents will be supervised by the nursing staff while in the shower rooms in addition to all resident care areas to ensure that the resident's environment remains free from accident hazards.</p> <p>All shower room cabinets on all Halls, had padlocks placed on October 26, 2010, by the Maintenance Director.</p> <p>Environmental rounds were conducted on 10/22/10, by the Director of Nursing. No further resident hazards were identified. Environmental rounds will continue to be conducted by the maintenance staff and the safety committee monthly. Any concerns will be reported to the Administrator,</p> |   |

**F-323 Cont'd**

**Director of Nursing and QA committee and will be addressed immediately.**

**Padlocks were placed on all shower room cabinets on all the Halls on October 26, 2010, by the Maintenance Director.**

**Nursing staff will lock the cabinets after each use to ensure the safety of all residents. All residents, including all wandering residents will be supervised by nursing staff while in the shower rooms to ensure the safety of residents.**

**The Unit Coordinators will observe the shower rooms on each side every two hours during their rounds to ensure the cabinets in the shower rooms are secured when not in use and that residents are supervised at all times while in the shower rooms. Additionally, the Unit Coordinators will monitor the resident's environment and assistive devices for potential accident hazards during their daily rounds.**

**In-services for nursing staff was conducted by the Director of Nursing and Assistant Director of Nursing, on 10/21/10, 10/23/10, 11/3/10, 11/4/10 and 11/8/10. All new hires will be provided with an in-service during orientation.**

**F-323 Cont'd**

The Unit Coordinators on each unit will monitor the shower rooms every two hours during their rounds to ensure the cabinets are secured and residents are supervised while in the shower rooms. The Unit Coordinators will monitor resident's environment and assistive devices daily during rounds for potential accident hazards. The Director of Nursing and the Assistant Director of Nursing will monitor residents' environment and assistive devices weekly to ensure safety of the residents and that each residents assistive devices are appropriately utilized. Any issues will be addressed immediately when noted. All concerns will be reported to the Director of Nursing immediately. The Director of Nursing will report concerns to the facility Quality Assurance Committee.

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| F 323  | Continued From page 2   | F 323  |   |   |
| F 371<br>88=E  | <p>the D Hall in the vicinity of the Whirlpool Bathroom on D Hall. Some of the residents were in wheelchairs and some were ambulatory.</p> <p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -<br/>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br/>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review it was determined the facility failed to store and distribute food under sanitary conditions as evidenced by food stored in the freezer which was not labeled and dated, scoops and spoodles stored in drawers with their handles turned in opposite directions, two (2) spoodles stored wet and the mixer was covered and stored with crumbs in the bottom of the mixing bowl. Also, it was noted staff were storing personal food items in refrigerators on the Blue and Pink Units along with food items provided to residents for snacks.</p> <p>The findings include:<br/>1. Observation during initial tour on 10/19/10 at 9:20 AM revealed half of an angel food cake and half of a chocolate cream pie stored without being dated or labeled.</p> | F 371  | <p>F-371</p> <p>No residents were affected by the cited deficiency.</p> <p>Cake and pie were discarded on 10-21-10. Scoops, spoodles and mixing bowls were immediately rewashed and stored after completely dry on 10-21-10. A complete sanitation audit of the kitchen was conducted on 10/22/10, by the Dietary Manager. No other issues/concerns were identified. All food items that were not stored properly in the refrigerators at the blue and pink units were discarded on 10-21-10.</p> <p>All dietary personnel were in-serviced on 10-29-10 by the Dietary Manager and Registered Dietician. Proper sanitation practices and policies were reviewed regarding dating/labeling all food items; storing scoops/spoodles and all utensils after they have completely</p> | 11-5-10   |

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| F 371  | <p>Continued From page 3</p> <p>Interview with the Dietary Manager on 10/19/10 at 9:20 AM revealed the food items should have been labeled and dated before being stored.</p> <p>Review of the facility's policy titled refrigerated and frozen food storage 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>2. Observation during initial tour on 10/19/10 at 9:25 AM revealed two (2) drawers one (1) containing scoops and another containing spoodles. The handles of the scoops and spoodles were noted to be turned in different directions. Also, two (2) spoodles were noted to be stored in the drawer wet.</p> <p>Interview with the Dietary Manager on 10/19/10 at 9:25 AM revealed the scoops and spoodles should have the handles turned in the same direction to prevent staff from touching the food contact surface with their hands. He further indicated the spoodles should have been allowed to air dry prior to being stored due to the risk of bacteria growth.</p> <p>Review of the facility's policy titled "Storage of Unused Equipment and Dish Ware", revealed dish ware and utensils were to be thoroughly dried prior to storage.</p> <p>3. Observation on 10/19/10 at 9:50 AM revealed a refrigerator on the Pink Unit was used to store residents' snacks. Further observation revealed a plastic storage container which contained food items, but was not dated or labeled as to whom it belonged. A pudding cup container was noted to be stored in the refrigerator with the aluminum foil</p> | F 371  | <p>F-371 cont'd</p> <p>air dried and placing all handles in the same direction; and importance of assuring mixing bowls and all dishware is thoroughly cleaned and dry before storing.</p> <p>All nursing personnel were in-serviced by the Director of Nursing on 10-21-10, 10-24-10, 11-3-10 and 11-4-10 regarding the importance of not placing personal food items in the refrigerators designated for food for the residents and emphasized the importance of storing any food item designated for a resident properly. (Sealed, labeled and dated).</p> <p>Dietary Manager/Assistant Dietary Manager/and Head Cook will monitor storage and sanitation of kitchen items daily to assure they are stored correctly and are clean, dry, and dated. Sanitation training will be conducted upon hire and monthly for all dietary employees. Dietician will monitor condition of</p> |                      |

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| F 371  | Continued From page 4<br>lid up, which prevented it from properly covering the food.<br><br>Interview with Licensed Practical Nurse (LPN) #2 on 10/19/10 at 9:50 AM revealed the refrigerator was used to stored snacks for residents and if the staff had items which needed to be kept cold they would also use the same refrigerator. She further indicated the plastic container contained a staff member's lunch. However she was not sure whose, and the pudding had been used to assist residents with medication pass.<br><br>4. Observation on 10/19/10 at 10:05 AM revealed a refrigerator on the Blue Unit used to store residents' snacks. Further observation revealed a plastic storage container which contained food items, but was not dated or labeled as to whom it belonged. Also, items such as a plastic grocery bag which contained other plastic food storage containers of food, soda bottles with initials on the top, mayonnalse container labeled with a first name, three (3) frozen dinners in the freezer with no label or date and a Styrofoam drink container with initials on the lid. Residents' snacks such as ice cream, juices, and thickening agents were noted to be stored in the refrigerator also.<br><br>Interview on 10/19/10 at 10:05 AM with LPN #4 revealed nurses were allowed to store their food in the refrigerators along with resident foods. She further indicated the plastic food container and the grocery bag containing the food items belonged to staff as did the sodas, the mayonnalse, the frozen dinners and Styrofoam cup. | F 371  | F-371-cont'd<br>kitchen items during monthly sanitation audit.<br><br>Unit Coordinators will monitor refrigerators on each unit daily to assure proper storage of items. The Assistant Director of Nursing will check the refrigerators each Friday to assure compliance. Additional checks will be conducted by the Administrator and Director of Nursing every 2 weeks for 3 months and monthly thereafter.<br><br>Any noncompliance by an employee of this policy/practice will result in disciplinary action and will be reported to and monitored through the Quality Assurance Committee. |   |
| F 514<br>88=F  | 483.75(l)(1) RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE   | F 614  |   |   |

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| F 514 | <p>Continued From page 5</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review it was determined the facility failed to maintain accurate medical records for five (5) of five (5) residents with pace makers (Residents #2, #14, #19, #20, and #21). The facility failed to document that the pacemaker checks had been completed and were functioning properly.</p> <p>The findings include:</p> <p>Review of the clinical records for Residents #2, #14, #19, #20, and #21 revealed the five (5) residents had pace makers in place. Additional, record review found no documented evidence the facility had performed and obtained the results of pace maker checks for the five (5) residents.</p> <p>Review of the Care Plans for the five (5) residents revealed an intervention to monitor pace maker function per order.</p> <p>Review of the Physician's Orders for Residents</p> | F 514 | <p>F-514</p> <p>Resident #2's pacemaker checks were discontinued in February 2007 by a Physician order. Resident #2 has since been discharged from the facility.</p> <p>Resident #14 has a pacemaker defibrillator and is seen by his Physician at least every two months. The next check is due November 12, 2010.</p> <p>Resident # 19's pacemaker was last checked in July 2010 and is Scheduled to be checked again in January 2011.</p> <p>Resident #20's pacemaker was checked on October 12, 2010, and is scheduled to be checked again in November 2010. Resident # 20's pacemaker is checked each month.</p> | 11-30-10 |
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| F 514  | <p>Continued From page 6</p> <p>#2, #14, #19, #20, and #21 revealed no evidence of orders for pace maker monitoring.</p> <p>Observation, on 09/20/10 between 9:30 AM and 11:30 AM, revealed the Unit Manager for the Blue Unit made multiple telephone calls to obtain dates for the residents' most recent pace maker checks.</p> <p>Interview, on 09/20/10 at 10:21 AM, with the Blue Unit's Manager revealed the residents' pace maker checks were not maintained in the residents' clinical record. She explained the pace maker checks were documented on the calendar used to schedule appointments. She stated after each pace maker check the calendar was updated to show when the next pace maker check was due.</p> <p>Interview, on 09/21/10 at 10:57 AM, with Licensed Practical Nurse (LPN) #5 confirmed the facility's system to perform pace maker checks was to document the dates on the appointment calendar and not in the residents' clinical record.</p> <p>Interview, on 10/20/10 at 12:15 PM, with the Director of Nursing (DON) revealed the facility had no policy or procedure for pace maker checks. She stated the checks were documented in the laboratory book when scheduled.</p> | F 514  | <p>F-514 continued</p> <p>Resident #21's pacemaker was checked on October 18, 2010, and is scheduled again in December 2010.</p> <p>Residents #14, #19, #20 and #21's pacemakers are functioning properly, as per their pacemaker checks. Resident #2's pacemaker checks were discontinued and the resident has since been discharged from the facility.</p> <p>Each resident currently has a Physician order for the pacemaker checks. When the pacemaker checks are completed, the Nurse will document the date and the results of the pacemaker checks in the Nurses Notes, and on the Pacemaker Flow sheet located in the residents' clinical record. The Physician orders for pacemakers will be given to the MDS coordinator to ensure care plans are</p> |   |

**F-514 continued**

revised/updated as needed. A complete review of the medical records process was completed by the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Coordinators and Medical Records Director that included chart organization, accessibility, accuracy and completeness on 11/23/10. A complete chart audit will be concluded on 11/29/10, by the Director of Nursing, Assistant Director of Nursing, Unit Coordinators and the Medical Records Director to ensure accuracy and completeness of each medical record.

All residents with pacemakers have Physician's orders in place. The orders are transcribed in the TAR (treatment administration record) with the next due date. The Nurses will initial the TAR, document the date of the pacemaker check and the results in the Nurses Notes and on the Pacemaker Flow Sheet after each residents pacemaker check. The Physician orders for pacemakers will be given to the MDS coordinators to ensure care plans are revised/updated as needed. A complete review of the medical records process was completed by the Administrator, Director of

**F-514 continued**

**Nursing, Assistant Director of Nursing, Unit Coordinators and Medical Records Director that included chart organization, accessibility, accuracy and completeness on 11/23/10. A complete chart audit will be concluded on 11/29/10, by the Director of Nursing, Assistant Director of Nursing, Unit Coordinators and the Medical Records Director to ensure accuracy and completeness of each medical record.**

**All in-services for all Nurses was conducted by the Director of Nursing, on 10/21/10, 10/24/10, 11/3/10 and 11/4/10.**

**All newly hired nurses will be in-serviced during their orientation.**

**The ADON (Assistant Director of Nursing) will review the Nurses Notes and the Pacemaker Flow Sheets of all residents with pacemakers, monthly for three months, to ensure the documentation is complete and correct. The ADON will review pacemaker documentation quarterly thereafter.**

**The Medical Records Director will conduct monthly audits of all medical records to ensure**

**F-514 continued**

**accessibility, accuracy, organization and completeness. The Assistant Director of Nursing will conduct chart audits on each new admission and on one (1) unit each week for five (5) weeks and quarterly thereafter. Any concerns will be reported to the Director of Nursing and through the QA Committee and will be addressed immediately.**

**Any issues will be addressed immediately when noted. The monthly and quarterly audits conducted by the ADON will be provided to the Director of Nursing and reported to the facility Quality Assurance Committee.**

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| K 000         | INITIAL COMMENTS<br><br>A Life Safety Code survey was initiated and concluded on 10/21/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".  | K 000 | <div style="border: 2px solid black; padding: 5px; display: inline-block;"> <p style="font-size: 2em; margin: 0;">RECEIVED</p> <p style="margin: 0;">NOV 11 2010</p> </div> <p>No Residents were affected by the cited Life Safety Code Deficiencies.</p>                            |         |
| K 050<br>SB=F | <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to conduct fire drills at various times, according to NFPA standards. The deficiency has the potential to affect all residents.</p> <p>The findings include:</p> <p>Review of the fire drill log on 10/21/2010 at 11:38 AM, revealed third (3rd) shift fire drills were conducted on 07/30/2010, 04/26/2010, and on 01/30/2010 at 11:15 PM. This review of the log was confirmed with the Maintenance Director.</p> <p>Interview on 10/21/2010 at 11:38 PM, with the Maintenance Director, revealed that he conducted</p> | K 050 | <p>K-050</p> <p>Fire drills will be conducted on each shift at varied time. A fire drill was conducted on 10-31-10 for the 11PM to 7AM shift at 3:00 A.M. The Administrator will continue to review each fire drill and assure they are conducted on each shift at varied times.</p> | 11-1-10 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Dana Gravitt TITLE Administrator (X6) DATE 11-1-10

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 60 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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185277 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>10/21/2010 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>HERITAGE HALL HEALTH & REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>381 SOUTH MAIN STREET<br>LAWRENCEBURG, KY 40342 |
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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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K 050 Continued From page 1  
the fire drills for the third (3rd) shift at 11:15 PM, due to him having to come in late after work to conduct the fire drills.

K 050

Reference: NFPA 101 (2000 edition)  
19.7.1.2\* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions.  
When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.

K 070

K 070 88=D NFPA 101 LIFE SAFETY CODE STANDARD  
Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8

K-070

The portable space heater was removed 10-21-10. No other portable space heaters were discovered during completion of rounds by the maintenance staff on 10-22-10. Any space heater that is requested for use in non-sleeping

10-23-10

This STANDARD is not met as evidenced by:

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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| K 070  | Continued From page 2<br>Based on observation and interview, it was determined the facility failed to ensure space heaters used in the facility were of the approved type, according to NFPA standards. The deficiency affected one (1) smoke compartment.<br><br>The findings include:<br><br>Observation on 10/21/2010 at 10:10 AM, revealed a space heater was being used in the Human Resources office. The observation was confirmed with the Maintenance Director.<br><br>Interview on 10/21/2010 at 10:10 AM, with the Maintenance Director, revealed the facility had no documentation for the heater, stating its temperature range.<br><br>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies.<br>Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).<br>NFPA 101 LIFE SAFETY CODE STANDARD | K 070  | K-070 cont'd<br><br>staff/employee areas will be inspected by the Maintenance staff. Maintenance staff will assure device does not exceed 212 degrees F and is in safe working condition. Heater will be logged and re-checked quarterly. Maintenance staff will monitor facility for any unapproved space heaters during weekly rounds. Any concerns with space heaters will be addressed immediately. |  |
| K 072<br>SS-D  | 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.<br>7.1.10  | K 072  | K-072<br><br>The table in the main alcove was removed on 10-21-10. Complete tour of facility on 10-22-10 revealed no other impediments to an exit. Exits will be monitored during daily maintenance rounds. Any Concerns will be resolved immediately.  | 10-23-10                                     |

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| K 072              | <p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were free and clear of obstructions, according to NFPA standards. The deficiency affected one (1) smoke compartment and nine (9) residents.</p> <p>The findings include:<br/>Observation on 10/21/2010 at 9:20 AM, revealed a table was located in the main exit alcove. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/21/2010 at 9:20 AM, with the Maintenance Director, revealed he had not identified the table as an impediment to the exit before the Life Safety Code survey.</p> <p>Reference: NFPA 101 (2000 edition)<br/>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.<br/>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Penetrations of smoke barriers by ducts are protected in accordance with 8.3.8.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained according to NFPA</p> | K 072         | <p>K-104</p> <p>On 11-9-10 a technician serviced all fire/smoked dampers. The fusible links were removed and replaced, and the dampers were operated to assure that they closed and latched. The moving parts were lubricated. The fire/smoke damper preventative maintenance has been added to the Maintenance log and will be performed at least every 4 years.</p> | 11-10-10             |
| K 104<br>SS-F      |  | K 104         |   |                      |

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| K 104         | <p>Continued From page 4 standards. The deficiency affected six (6) smoke compartments, staff, and all residents.</p> <p>The findings include:</p> <p>Observation on 10/21/2010 at 11:45 AM, revealed a fire/smoke damper located in the duct work, in the A Hall. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/21/2010 at 11:45 AM, with the Maintenance Director, revealed that no maintenance documentation was kept on the fire/smoke dampers. Further interview, with the Maintenance Director, revealed that he did have fusible links on hand for the fire/smoke dampers if they were to be needed.</p> <p>Reference: NFPA 90A (1999 edition)</p> <p>3-4.7 Maintenance: At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p> | K 104 |   |          |
| K 147<br>85=0 | <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>  | K 147 | <p>K-147</p> <p>The extension cords were removed from Room E-9 on 11-9-10 after installation of new plugs. Complete</p> | 11-10-10 |

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| K 147 | <p>Continued From page 5</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 according, to NFPA standards. The deficiency affected one (1) smoke compartment and fourteen (14) residents located in the smoke compartment.</p> <p>The findings include:</p> <p>Observation on 10/21/2010 at 10:54 AM, revealed in resident room E9, four (4) extension cords were in use. The extension cords were being used to power the resident's television, radio, and a charger for an electric wheelchair. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 10/21/2010 at 10:54 AM, with the Maintenance Director, revealed the facility does not allow extension cords to be used in the facility and he was unaware of the use of the extension cords in resident room (E9).</p> <p>Reference: NFPA 70 (1999 edition) 400-8. Uses Not Permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> <li>(1) As a substitute for the fixed wiring of a structure</li> <li>(2) Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</li> <li>(3) Where run through doorways, windows, or similar openings</li> </ul> | K 147 | <p>K-147 cont'd</p> <p>tour of facility by maintenance staff was conducted on 10-22-10 and no additional extension cords were found. Residents and family members will be instructed upon admission that use of extension cords are prohibited. Maintenance staff will monitor rooms for extension cords during daily rounds. If extension cords are found they will be removed.</p> |  |
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| K 147              | Continued From page 6<br>(4) Where attached to building surfaces<br>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.<br>(5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors<br>(6) Where installed in raceways, except as otherwise permitted in this Code | K 147         |   |                      |