

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

PRINTED: 11/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185395	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2012
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NAME OF PROVIDER OR SUPPLIER REGIONAL MEDICAL CENTER OF HOPKINS COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 900 HOSPITAL DR. MADISONVILLE, KY 42431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A standard health survey was initiated on 11/07/12 and concluded on 11/08/12 with deficiencies cited at the highest scope and severity of a D. A Life Safety Code survey was initiated and concluded on 11/7/12 with deficiencies cited at the highest scope and severity of an F. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.

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, record review, and review of the facility's policy, it was determined the facility failed to provide care in a dignified manner for one (1) of seven (7) sampled residents. The facility failed to provide privacy during catheter (urinary drainage tube) care for Resident #2 which exposed him/her to the facility's ward clerk.

The findings include:

Review of the facility's policy regarding Privacy for Patients, Revised 12/03/09, revealed a resident is to be given privacy in treatment and care of personal needs. The staff shall provide for the resident in a manner that maintains privacy of their bodies, including toileting, bathing and other

F 000

F 241

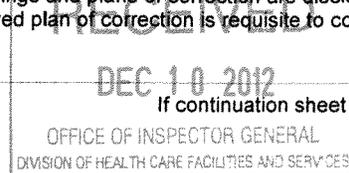
F241 - Corrective actions for the affected patient #2: The Unit Secretary that came into the room without knocking on the door was educated on how to properly enter a patient's room including knocking on the door and waiting for permission to enter. The RN who called the Unit Secretary to the room was educated to cover her patient when calling for someone to bring her supplies. This was completed by the director of nursing on 11/08/12 after the survey team exited. This education was also provided to the CNA. Staff also received verbal counseling at that time.

The director of nursing has randomly observed staff entering patient's rooms since the surveyors exited. The observations were to see if staff properly knocked and waited for permission to enter the room and provided for patient privacy when needed. All staff has followed policy during observation.

All patients admitted to the unit have the potential to be affected.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jerry Robertson</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/6/12</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 their 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 241

Continued From page 1 activities of personal hygiene.

Review of the facility's policy regarding Patient Dignity, Revised 05/03/11, revealed the nursing staff will provide dignity by providing for privacy during procedures by closing doors and pulling curtains between residents. The nursing staff will drape patients appropriately while performing procedures.

Review of the clinical record for Resident #2, revealed the facility admitted the resident on 10/30/12 with diagnoses of Metabolic Encephalopathy and Dementia. The facility assessed Resident #2 as having a severe cognitive impairment.

Observation of a skin assessment, a dressing change and urinary drainage catheter care for Resident #2, on 11/08/12 at 11:00 AM, with Registered Nurse (RN) #1 and Certified Nursing Assistant (CNA) #1 revealed the door to the resident's room was not closed during any of those procedures. CNA #1 and RN #1 removed Resident #2's sheet and brief to complete the skin assessment, dressing change, and the urinary drainage catheter care with the privacy curtain drawn in front of the entry door and to one side of the bed. The Ward Clerk (WC) entered the room without knocking or announcing herself, pulled opened the privacy curtain and could visualize Resident #2's naked torso and genitalia. Further observation revealed the WC proceeded to change the battery on the computer on wheels (COW) located in Resident #2's room. RN #1 and CNA #1 continued with the urinary drainage catheter care leaving the resident's genital area exposed to the WC. The WC commented to RN

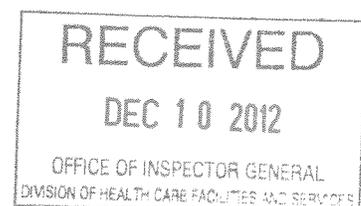
F 241

Listed below are the systemic changes to be put into place to prevent this from recurring:

Nursing staff and unit secretaries will receive an in-service on our Patient Dignity and Privacy for Patients policies that you referenced. Staff will be re-trained to knock and wait for permission to enter when going into a patient room and to close doors and drape patients appropriately during procedures. The director of nursing or clinical leader RN will conduct this training. This will be completed by 12/10/12.

A new monitor called Transitional Care Unit Dignity/Privacy Audit will be done monthly. The director of nursing, clinical leader RN, or trained Charge RN will observe random staff enter patient rooms to assure staff provide care with dignity and provide for privacy by knocking on the door and waiting for permission to enter. This monitor will also observe that staff properly close the door and drape patients during procedures. For 3 months beginning on December 1, 2012, twenty staff observations will be completed each month. After 3 months we will complete at least 10 staff observations per month at least 9 months additional. Staff not performing appropriately will received additional education. If staff fails to comply after education they will receive disciplinary action. A copy of the audit tool is attached.

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F 241	Continued From page 2 #1 that she should have called sooner for the COW battery. Resident #2 did not grimace or appear to be aware of the activity taking place. Interview with RN #1, on 11/08/12 at 11:30 AM, revealed she knew the facility's policy on privacy and dignity was never to expose a resident during a procedure. RN #1 stated this was an invasion of the resident's privacy and the entire incident was inappropriate. The RN admitted she should have stopped the procedure, covered the resident, and asked the WC to leave. Interview with the WC, on 11/08/12 at 1:15 PM, revealed she did not look at the resident when she entered the room and just needed to replace the battery on the COW, so that the entries were not lost. Later in the interview the WC admitted she should have knocked and announced her entry to the nurse. She stated she was concerned about the COW going down and did not think about the resident's privacy. Interview, on 11/08/12 at 1:20 PM, with the Director of Nursing (DON) revealed the facility's policy was to always knock before entering a room and to always provide privacy during a procedure. The DON said he was uncertain what the RN, the CNA, and the WC were thinking. This incident was very inappropriate. This could have been very demeaning to a resident.	F 241	This audit information will be reported to the quality assurance committee by the director of nursing or clinical leader RN and be discussed at our quarterly QA meetings. This data will be used to guide further process improvement.	12/11/12	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	F441 - Corrective actions for the affected patient #2: The RN that was observed during the dressing change received education on how to perform dressing changes including hand washing before the procedure, after changing gloves, and at the completion of the procedure. This		



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F 441 Continued From page 3 of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, review of the facility's policy, and review of the Center for Disease Control (CDC) recommendations, it was

F 441 was done by the director of nursing on 11/08/12 after the survey team exited. She also received verbal counseling at that time.

The director of nursing has randomly observed staff change dressings since the survey team exited.

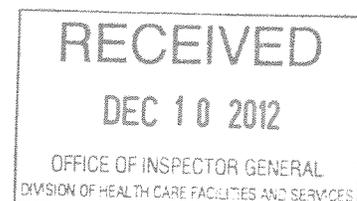
Patient #2 has shown no signs or symptoms of infection and has been discharged.

All patients that have dressing changes could potentially be affected.

Listed below are the systemic changes to be put into place to prevent this from recurring:

Licensed staff will receive an in-service on dressing changes and proper hand washing and they will be required to complete a competency demonstration to verify they understand proper procedure at the training. If gloves are removed, hands are to be washed. The director of nursing, clinical leader RN, and/or the infection control RN professional(s) will conduct this training and competency verification. This will be completed by 12/10/12.

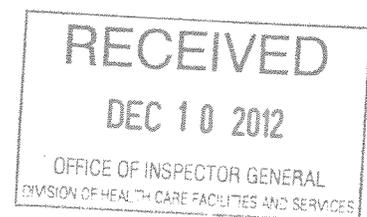
A new audit/monitor, called Dressing Change Monitor TCU, will be done monthly. The director of nursing, clinical leader RN, trained Charge RN, and/or the infection control RN professional(s) will observe random dressing changes to assure compliance with policy. For 3 months



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F 441	<p>Continued From page 4</p> <p>determined the facility failed to ensure proper hand hygiene during a skin assessment and dressing change for one (1) of seven (7) sampled residents, Resident #2.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Hand Hygiene, Revised May 2011, revealed the purpose of hand washing is to remove dirt, organic material and transient organisms, thereby reducing the risk of pathogens before and after patient care. In addition the facility's policy stated to decontaminate hands before donning gloves and after removing gloves.</p> <p>Review of the current CDC Guidelines revealed hand hygiene was necessary after glove removal because hands could become contaminated through small defects in gloves from the outer surface of gloves used during removal. The CDC guidelines stated hand hygiene should be performed immediately after gloves were removed. The CDC recommends changing gloves when going from dirty to clean areas.</p> <p>Review of the clinical record for Resident #2, revealed the facility admitted the resident on 10/30/12 with diagnoses of Metabolic Encephalopathy and Dementia.</p> <p>Observation, on 11/08/12 at 11:00 AM, with Registered Nurse (RN) #1 and Certified Nursing Assistant (CNA) #1 during a skin assessment and dressing change revealed the RN changed gloves three (3) times without washing or decontaminating her hands. The RN used wipes to cleanse drainage from the resident's anus and</p>	F 441	<p>beginning on December 1, 2012, ten dressing changes will be observed each month (providing there is that number to change. Only a small number of patients have dressings to change on the unit. If ten are not available, the current number of dressing changes available will be observed). After 3 months we will observe five dressing changes per month at least 9 months additional. Staff not performing appropriately will received additional education. If staff fails to comply after education they will receive disciplinary action. A copy of the monitor and competency are attached.</p> <p>This audit information will be reported to the quality assurance committee by the infection control professional(s) and/or the director of nursing and be discussed at our quarterly QA meetings. This data will be used to guide further process improvement.</p>	12/11/12



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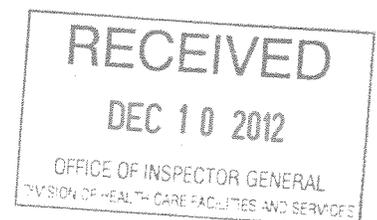
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F 441	<p>Continued From page 5</p> <p>then removed gloves and re-applied gloves without washing or sanitizing her hands. The RN then proceeded to remove the soiled dressing and again removed soiled gloves and re-applied gloves without decontaminating her hands between glove changes. The RN then washed the coccyx wound with skin cleanser and water using a wash cloth. The RN once again removed the soiled gloves and donned clean gloves and did not decontaminating hands between glove changes. The nurse then proceeded to apply a wound ointment and a 2 x 2 foam dressing to the resident's coccyx wound.</p> <p>Interview with RN #1, on 11/08/12 at 11:30 AM, revealed she knew what the facility's policy on hand washing stated but was unsure why she only washed her hands one time between glove changes during the procedure. The RN admitted she had changed her gloves several times during the procedure without decontaminating her hands between glove changes. She stated not properly decontaminating her hands between glove changes could make the resident's wound worsen and could spread germs to herself and other residents.</p> <p>Interview, on 11/08/12 at 1:20 PM, with the Director of Nursing (DON) revealed hand washing or decontaminating one's hands was the first step in starting a skin assessment or dressing change. The DON stated a facility policy was in place which stated, you take off your gloves, you wash your hands. In addition, the DON stated the lack of handwashing and decontaminating hands between dressing changes could cause transmission of pathogens.</p>	F 441		
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F 441	<p>Continued From page 6</p> <p>Interview with RN #3 Infection Control Specialist, on 11/08/12 at 1:45 PM, revealed she was aware of the CDC guidelines for decontaminating hands between glove changes during dressing changes and skin assessments. She acknowledged that she was not aware of any monitoring of any nurses' dressing change techniques since a nurse's initial hire. RN #3 stated working from dirty to clean could transfer organisms if one did not wash their hands between glove changes.</p> <p>Interview, on 11/08/12 at 1:50 PM, with RN #2 Infection Control Specialist revealed not performing hand hygiene between glove changes could cause organisms to transfer from one resident to another.</p>	F 441		
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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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: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: A wing of a two (2) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type I generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 11/07/12. Regional Medical Center of Hopkins Co. was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has twenty (20) certified beds with a census of seven (7) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jerry Robinson</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 12/6/12</i>
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K 000 Continued From page 1

K 025
SS=F
NFFPA 101 LIFE SAFETY CODE STANDARD

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

This STANDARD is not met as evidenced by:
Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, twenty (20) residents, staff and visitors. The facility is certified for twenty (20) beds, with a census of seven (7) on the day of the survey. The facility failed to ensure penetrations in the smoke partition were sealed with a material capable of maintaining the smoke resistance of the smoke barrier.

The findings include:

K 000

K 025

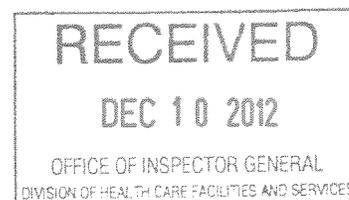
K25 - The expanding foam found in the smoke barrier was removed the day of the survey and the appropriate fire caulk was installed in its place. The entire smoke barrier on the Transitional Care Unit (TCU) was inspected on the day of the survey. No more expanding foam was found.

All patients admitted to the unit have the potential to be affected.

Listed below are the systemic changes to be put into place to prevent this from recurring:

There will be a monthly preventive maintenance (PM) activity entered into our PM system that will have one of two painter technicians inspect all smoke and fire walls on the unit. This will ensure that this material will not be used in the facility. Education was provided by the supervising engineer to the painter technicians on 11/08/12 indicating that expanding foam sealant is not to be used anywhere in the facility.

The PM program is electronic and is saved in a database. Monthly, the painter technicians will enter their findings and electronically sign. If any issues are found they will be documented and repaired



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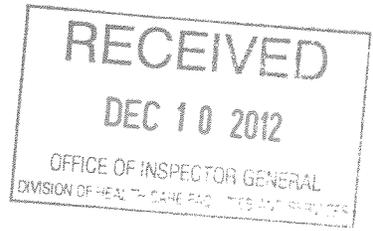
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K 025	<p>Continued From page 2</p> <p>Observation, on 11/07/12 at 2:00 PM, with the Director of Plant Operations and the Supervising Engineer revealed the smoke partition, extending above the ceiling located by room #601, had been penetrated by wires and sealed with unrated quick foam.</p> <p>Interview, on 11/07/12 at 2:00 PM, with the Director of Plant Operations and the Supervising Engineer revealed they were aware of the requirements for sealing penetrations in smoke barriers but not aware of who installed the quick foam.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration</p>	K 025	<p>immediately. This database information can be retrieved at any time. The results of the inspections will be reported to the QA committee quarterly by the director of support services or the supervising engineer. This data will be used to guide further process improvement.</p>	11/09/12
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K 025 Continued From page 3
into consideration, any vibration isolation shall
1. Be made on either side of the smoke barrier, or
2. Be made by an approved device designed for the specific purpose.

K 050 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:
Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, twenty (20) residents, staff and visitors. The facility is certified for twenty (20) beds with a census of seven (7) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times.

The findings include:

Fire Drill review, on 11/07/12 at 2:37 PM, with the Director of Plant Operations and the Supervising Engineer revealed the facility failed to conduct fire

K 025

K 050

K50 - On the day of the survey the director of support services and the OIG surveyor met with the security manager about the frequency of fire drills. Education was provided to the security manager by the director of support services. The drills will from this point forward be more random from one drill to the next. This revised fire drill schedule will ensure that fire drills are conducted with proper frequency for all patients. The initial drill was conducted on 11/16/12 at 8:15 pm.

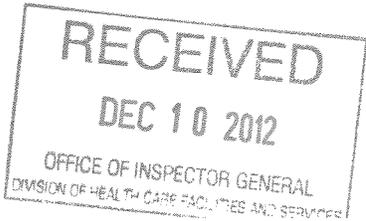
All patients admitted to the unit have the potential to be affected.

Listed below are the systemic changes to be put into place to prevent this from recurring:

The security manager is developing a schedule for continuing fire drills for the next year. The future drills will vary in time and day to accommodate the requirement for fire drill frequency. The fire dills will be conducted each shift, each quarter, at unexpected times. The drills will from this point forward be more random from one drill to the next.

The results of each fire drill will be given to the director of nursing. This along with education supplied to the security officers will ensure the proper fire drill frequencies are maintained. The security manager will educate the security staff to follow the schedule exactly for date and time.

The security manager will oversee the annual fire drill schedule to ensure that proper



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K 050 Continued From page 4
drills at unexpected times on all shifts.

Interview, on 11/07/12 at 2:37 PM, with the Director of Plant Operations and the Supervising Engineer revealed they were not aware the fire drills were not being conducted as required.

Reference: NFPA Standard NFPA 101 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 056 SS=F NFPA 101 LIFE SAFETY CODE STANDARD

If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect two (2)

K 050 frequency is maintained compared to the last drill. This schedule will be built by specific time for a full year. This schedule will be monitored on the regulatory board kept in plant operations.

The fire drill dates, times, and results will be reported at the quarterly QA committee by the security manager or the safety director. This data will be used to guide further process improvement.

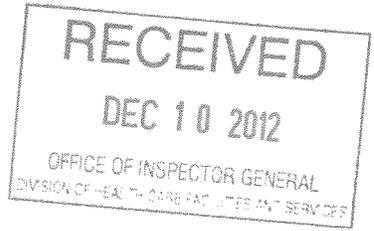
K 056 K56 - On the day of the survey, several of the sprinkler heads were inspected by plant operations. NFPA 13 states if the sprinkler head is less than 1 foot from the obstruction, the maximum allowable distance of the deflector above the bottom of the obstruction is 0 inches. Some of the sprinkler head deflectors were above the required height. On 11/19/12, all sprinkler heads in question were surveyed. Approximately half of the heads were within requirements and half needed adjustment to become compliant.

All patients admitted to the unit have the potential to be affected.

Listed below are the systemic changes to be put into place to prevent this from recurring:

In order to bring all sprinkler heads into compliance, plant operation staff will go into every restroom and adjust each

12/14/12



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K 056 Continued From page 5 of two (2) smoke compartments, twenty (20) residents, staff and visitors. The facility is certified for twenty (20) beds with a census of seven (7) on the day of the survey. The facility failed to ensure resident bathroom sprinklers were not blocked by light fixtures on the ceiling.

The findings include:

Observation, on 11/07/12 between 12:45 PM and 2:30 PM, with the Director of Plant Operations and the Supervising Engineer revealed the sprinkler heads located in resident room bathrooms were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads.

Interview, on 11/07/12 between 12:45 PM and 2:30 PM, with the Director of Plant Operations and the Supervising Engineer revealed they were unaware that sprinkler heads could have no obstructions below the deflector within 12 inches of the head. They also were unaware of how the sprinklers passed inspection for all these years.

Reference: NFPA 13 (1999 Edition)

5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.

Actual NFPA Standard: NFPA 101, 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.

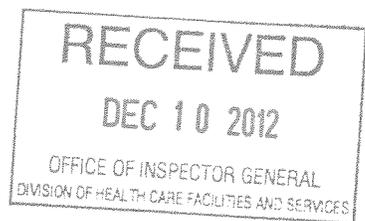
K 056 sprinkler head down until the deflector is 1/2" below the lowest point on the light fixture. This will exceed the requirement of NFPA 13 by 1/2".

All sprinklers noted to be out of compliance were adjusted on 11/12/12.

In order for plant operations to make sure this does not become an issue in the future, a quarterly survey of the unit will be conducted by the supervising engineer or a maintenance technician to ensure the sprinklers are in compliance.

The results of this monitor will be reported at the quarterly QA committee by the supervising engineer or the director of support services. This data will be used to guide further process improvement.

11/13/12



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K 056 Continued From page 6
Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.
Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:
(1) Sprinklers installed throughout the premises
(2) Sprinklers located so as not to exceed maximum protection area per sprinkler
(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.

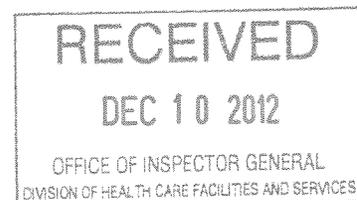
Reference: NFPA 13 (1999 edition)

5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.

Reference: NFPA 13 (1999 ed.)
5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.
Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)

Maximum Allowable Distance	
Distance from Sprinklers to	of Deflector

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K 056 Continued From page 7
above Bottom of
Side of Obstruction (A) Obstruction (in.)
(B)

Less than 1 ft	0
1 ft to less than 1 ft 6 in.	21/2
1 ft 6 in. to less than 2 ft	31/2
2 ft to less than 2 ft 6 in.	51/2
2 ft 6 in. to less than 3 ft	71/2
3 ft to less than 3 ft 6 in.	91/2
3 ft 6 in. to less than 4 ft	12
4 ft to less than 4 ft 6 in.	14
4 ft 6 in. to less than 5 ft	161/2
5 ft and greater	18

K 056

K 147 SS=D
For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m.
Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).
NFPA 101 LIFE SAFETY CODE STANDARD
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 147
K147 - On the day of the survey, the power strips that were found to be out of compliance were removed from the unit. The medical equipment (glucometer) was then plugged directly into a wall outlet. Medical equipment must be plugged directly into a wall outlet.

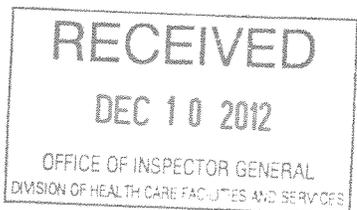
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, sixteen (16) residents, staff, and visitors. The facility is certified for twenty (20) beds with a census of seven (7) on the day of the survey. The facility failed to ensure the proper use of power strips.

The findings include:

All patients admitted to the unit have the potential to be affected.

Listed below are the systemic changes to be put into place to prevent this from recurring:

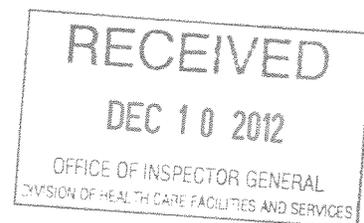
The nursing staff will receive an in-service on the prohibited use of any extension cords or power strips and will be educated that all medical equipment must be plugged directly into a wall outlet. This will be done by the director of nursing or clinical leader RN by 12/10/12.



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K 147	<p>Continued From page 8</p> <p>Observation, on 11/07/12 at 1:09 PM, with the Director of Plant Operations and the Supervising Engineer revealed medical equipment plugged into a power strip that was plugged into another power strip located the Nurses' Station.</p> <p>Interview, on 11/07/12 at 1:09 PM, with the Director of Plant Operations and the Supervising Engineer revealed they were aware of the proper use of power strips, but not aware of who plugged the power strips into each other or who plugged the medical equipment into the power strips.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p>	K 147	<p>The safety director is adding inspection for power strips/extension cords to his safety survey. This will be conducted monthly by the security manager or designated security officer and will be included with the monthly fire drill. If any prohibited items are found, they will be removed immediately.</p> <p>The results of this monitor will be reported at the quarterly QA committee by the safety director or security manager. This data will be used to guide further process improvement.</p>	12/14/12



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K 147 Continued From page 9
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

