

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

PRINTED: 12/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/13/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
(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 An offsite revisit was conducted and based on the acceptable POC the facility was deemed to be in compliance as alleged on 11/25/13.	{F 000}			

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

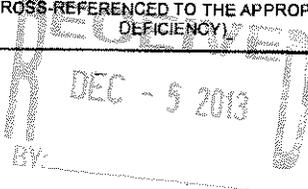
TITLE

(X6) DATE

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F 000	INITIAL COMMENTS A Recertification Survey was conducted 10/22/13 through 10/25/13 with deficiencies cited with the highest Scope and Severity of "F."	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by:	F 278		F 278 1. Care plans for both residents were updated on 10/23/13 by Ashley Kincaide LPN Infection control nurse to reflect assistance x1 with eating and to feed resident #3 if in bed but allow her to attempt to feed self when she is up in wheelchair. Nurse aide care plans also updated to reflect this on 10/23/13 by Ashley Kincaide LPN Infection control nurse. 2. A mandatory in service for all staff was conducted on 11/8/13 by Janet Caswell RN MDS Coordinator and Tamara McCarty LPN Assistant MDS Coordinator (See attached mandatory education). All ADL tracking sheets to be reviewed by 11/22/13 by Tamara McCarty LPN, Janet Caswell RN and Ashley Kincaide LPN to ensure correct coding. All residents who require assistance with feeding have the potential to be affected. Although no other residents were identified as being affected.

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

Charlene Roberts

TITLE

Interim Administrator

(X6) DATE

12-5-13

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F 278	<p>Continued From page 1</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure assessments were accurately coded on the Minimum Data Set (MDS) assessment to accurately reflect the resident's status for two (2) of fifteen (15) sampled residents (Residents #2 and #3).</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Assessment and Nursing Care Screening", with a revision date of 10/01, revealed the MDS Form is used to record information obtained during the nursing assessment.</p> <p>Interview, on 10/25/13 at 10:30 AM, with the Assistant Director of Nursing (ADON) revealed the person completing the Minimum Data Set (MDS) assessment is responsible to ensure accuracy of the assessment and, the facility had no policy related to this.</p> <p>1. Review of Resident #2's record revealed the resident was admitted to the facility on 01/03/13, with diagnoses which included Dementia and Cardiovascular Disease. Review of the Quarterly MDS, dated 08/31/13, revealed under Section G, the facility assessed Resident #2 to require two (2) person physical assist with eating. Review of the Comprehensive Care Plan dated 01/15/13, related to the resident required a mechanically altered diet, revealed Resident #2 was to be fed all meals and snacks by staff.</p> <p>Observation of Resident #2, on 10/23/13 at 8:35 AM, revealed that one (1) staff member assisted the resident to eat breakfast. Further observation of Resident #2 on 10/23/13 at 11:45 AM, and on</p>	F 278	<p>3. Laminated examples of ADL coding was placed in each break room on 11/15/13 by Tamara McCarty LPN and Janet Caswell RN.</p> <p>4. MDS staff will review ADL sheets when the MDS is due and if errors are noted they will make a note and educate staff individually at that time. This is will done by Tamara McCarty LPN Assistant MDS Coordinator and Janet Caswell RN MDS Coordinator. This will be done quarterly on each resident and will be observed weekly by the Unit Coordinators Michelle Teegarden LPN and Page Hambrick LPN.</p> <p>5. Weekly reporting to the QA Committee will be done by Janet Caswell, RN/MDS Coordinator or Tamara McCarty, LPN/MDS Assistant Coordinator to ensure the that weekly and quarterly monitoring and re-education of the staff maintains the proper coding of the MDS on an on-going basis.</p> <p>6. Compliance Date</p>	11/25/13	

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F 278	<p>Continued From page 2</p> <p>10/24/13 at 11:50 AM, revealed the resident's spouse assisted Resident #2 to eat lunch.</p> <p>2. Review of Resident #3's record revealed the resident was admitted to the facility on 02/25/02, and readmitted to the facility on 03/08/13, with diagnoses which include Depression, Anxiety and GERD. Review of the Quarterly MDS dated 09/18/13, revealed the facility assessed Resident #3 to require two (2) person assistance with eating. Review of the Comprehensive Care Plan dated 01/23/13, revealed an intervention had been added on 04/25/13 to assist the resident with meals.</p> <p>Observation of Resident #3 on 10/23/13 at 12:10 PM, revealed the resident was being assisted to eat the lunch meal by one (1) staff member. Further observation of Resident #3 on 10/24/13 at 5:47 PM, revealed the resident eating the dinner meal without assistance.</p> <p>Interview, on 10/25/13 at 9:48 AM, with Licensed Practical Nurse (LPN) #1, the MDS Assistant and the ADON revealed LPN #1 completed Resident #2's and #3's Quarterly MDS assessments. LPN #1 stated she utilized the "ADL Tracking form" which was coded to indicate Resident #2 and #3 required two (2) person physical assist for eating. She stated she knew this was not accurate for Resident #2's and #3's eating assistance; however, the "ADL Tracking form" was the facility's validation for what got coded on the MDS assessments. LPN #1 further stated she should have talked to the State Registered Nursing Assistants (SRNAs) regarding the assistance Resident #2 and #3 required with eating; and, documented her interviews. She stated she should have then coded the MDS assessments</p>	F 278			

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F 278	Continued From page 3 correctly to indicate the correct assistance Resident #2's and #3's required and, in-serviced the staff on correctly coding on the "ADL Tracking form".	F 278			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility policy it was determined the facility failed to provide to ensure residents did not receive foods listed as allergies for one (1) unsampled resident (Unsampled Resident A) as evidenced by the resident receiving food identified on the meal card as an allergy, which resulted in the resident becoming distressed. The findings include: Review of the facility's policy titled, "Hydration and Nutrition" undated, revealed the following under the "Procedures" section: an ongoing assessment of ability to consume and assimilate food by residents was conducted by nursing personnel	F 325	F325 1. Resident was given a meal substitution on 10/24/13 by the nursing staff. 2. Telesa Earlywine, QA Director and Kim Mullins, Dining Services Manager observed meal preparation for tray preparation and accuracy to the resident meal cards to find no other residents affected on 11/19/13. There is potential for all residents to be affected.		

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F 325	<p>Continued From page 4</p> <p>and or the Registered Dietitian (RD); and, staff were to observe food for the desired effect or adverse response and document findings in the medical record when indicated.</p> <p>Record Review revealed Unsampled Resident A was admitted to the facility on 12/29/10, with diagnosis which included of Irritable Bowel Syndrome, Diverticulosis and Anxiety. Review of the Quarterly Minimum Data Sheet (MDS) dated 06/12/13, revealed the facility assessed Unsampled Resident A to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact. Review of Comprehensive Care Plan, dated 09/18/13, the goal was for nutritional needs to be met and no weight loss would go undetected. Interventions included the following: diet as ordered, provide food preferences and avoid food dislikes.</p> <p>Observation, on 10/24/13 at 12:30 PM, of the lunch meal, revealed Unsampled Resident A was served soup beans. Review of the resident diet card revealed soup beans was highlighted and listed as an allergy. Continued observation revealed Unsampled Resident A was making crying sounds and asking why he/she received soup beans. Interview, on 10/24/13 at 12:30 PM, at the time of the observation, revealed Unsampled Resident A was asking why he/she received soup beans.</p> <p>Interview, on 10/24/13 at 12:35 PM, with State Registered Nursing Assistant, (SRNA) #1 revealed staff looked at the meal ticket (diet card) and if a resident did not like their meal she called dietary for a substitution. She stated the residents do change their minds about their</p>	F 325	<p>3. Weekly QA observations will be completed by Teresa Earylwine, QAD, Janet Patton, QAA, Deanna Eads, DON, and Willas Gray, ADON.</p> <p>4. Weekly walk through performed by the QA Committee will include monitoring of meal card to check for accuracy on the meal service.</p> <p>5. Teresa Earylwine, QAD in-service all staff during madatory in-service on ensuring the accuracy of the tray cards and meals served at time of service delivery on 11/8/13.</p> <p>6. Weekly walk thru information and observations will be reported to the QA Committee weekly to ensure that the accuracy of the meal card and meal are being maintained on an on-going basis.</p> <p>7. Observation results will be passed to the Dining Services Manager, Kim Mullins to ensure accuracy is maintained at the time of meal preparation.</p> <p>8. Compliance Date</p>	11/25/13	

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NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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F 325 Continued From page 5
dislikes. She indicated Unsampld Resident A's soup beans would be substituted with soup.

Interview, on 10/24/13 at 2:30 PM, Un-sampled Resident A revealed this had been the first time he/she had received soup beans. Unsampld Resident A stated he/she did not like beans and the beans upset his/her stomach.

Interview, on 10/24/13 at 3:15 PM, with the Registered Dietitian (RD) revealed Unsampld Resident A had a strong dislike of soup beans and did not have an allergy to soup beans. She stated soup beans were listed under "allergy" on the diet card to get the attention of dietary staff so they would not to send soup beans to Unsampld Resident A, who strongly disliked the soup beans.

Interview, on 10/24/13 at 3:50 PM, with the Assistant Director of Nursing (ADON) revealed staff should look at the meal (diet) card for residents' dislikes and, if a resident did not like what was served the resident could be offered a substitute. She stated this was a two (2) fold problem as dietary sent the soup beans and nursing staff serving the meals did not check the meal (diet) card. The ADON indicated dietary and nursing staff should observe the meal (diet) card for dislikes and allergies to ensure residents did not receive these foods.

Interview, on 10/25/13 at 9:35 AM, with the Dietary Manager revealed that two (2) dietary staff highlighted residents' dislikes and allergies on the meal (diet) card. She stated the dietary staff assigned to the front of the service line called out the diet order, dislikes, and food allergies prior to the cook placing the food on the tray. The Dietary Manager stated the last person

F 325

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F 325	Continued From page 6 on the service line checked the food tray for accuracy with the meal (diet) card. She indicated this system was supposed to prevent residents from receiving disliked food and foods they were allergic to.	F 325			
F 371 SS-F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			
	<p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview it was determined, the facility failed to store and distribute food under sanitary conditions as evidenced by resident refrigerator temperature logs were not available for two (2) resident units and food was not labeled and dated with resident identification.</p> <p>The findings include:</p> <p>Observation, on 10/23/13 at 9:00 AM, revealed the resident refrigerator on Unit 3 had no evidence of a temperature log. Further observation revealed and a package of twelve (12) twin popsicles not labeled, dated with no resident identification.</p>		<p>F 371</p> <p>1. Thermometers were placed in refrigerators and freezers on 10/23/13 by Teresa Earywine Quality Assurance Director. All unlabeled food items were disposed of on 10/23/13 by Willas Gray Assistant Director of Nursing. Temp logs were placed on 10/23/13 by Teresa Earywine Quality Assurance Director.</p> <p>2. All residents have the potential to be affected by this practice. All refrigerators and freezers were checked and temp logs placed on 10/23/13 by Teresa Earywine Quality Assurance Director. All unlabeled food items were disposed of by Willas Gray LPN Assistant Director of Nursing on 10/23/13.</p>		

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F 371	<p>Continued From page 7</p> <p>Observation, on 10/23/13 at 11:10 AM, revealed the resident refrigerator on Unit 1 had no evidence of a temperature log. Observation of the freezer revealed it contained a bag of twenty-four (24) frozen popsicles not labelled, dated and with no resident identification.</p> <p>Interview, on 10/23/13 at 10:05 AM, with the Licensed Practical Nurse (LPN) Manager of Unit 3 revealed temperatures on the resident refrigerator had not been recorded daily. She stated refrigerator temperatures were looked at weekly during the facility's "walk through" performed by department heads and administration. She indicated refrigerator temperatures should be thirty-four (34) to thirty-eight (38) degrees Fahrenheit; however, did not know what the freezer temperature was supposed to be. The LPN Manager of Unit 3 stated if there was a problem with the refrigerator they would pack it with ice and call the maintenance department.</p> <p>Interview, on 10/23/13 at 3:15 PM, with the LPN performing Quality Assurance revealed the facility had "messed up" as there were no temperature log sheets on the resident refrigerators on Unit 1 and Unit 3; however, there should have been so daily temperatures could have been performed and documented.</p> <p>Interview, on 10/24/13 at 11:15 AM, with the Dietary Manager revealed popsicles were supplied from the dietary department and were sent on residents' meal trays. She stated the dietary department did not send large packages of popsicles in original containers to the units. The Dietary Manager stated one (1) dietary staff member was responsible for checking the</p>	F 371	<p>3. All staff were in-serviced on 11/8/13 by Teresa Earywine, QAD on temperature logs, labeling of food items and thermometers in the freezers and refrigerators. Dietary staff will check</p> <p>daily to ensure that all food is properly dated and labeled. Laminated signs were placed on the refrigerators 11/15/13. The 11-7 shift charge nurses will check the refrigerator and freezer temps daily.</p> <p>4. Unit Coordinators Michelle Teegarden LPN and Paige Hamlick LPN and all float nurses will check the logs daily to ensure 11-7 charge nurses are completing their duties. All staff involved will be in serviced by Teresa Earywine Quality Assurance Director. Teresa Earywine QA Director and Janet Patton Assistant QA Director will observe that these are completed weekly.</p> <p>5. QAD or QAA will report the results of the temperature log to the QA Committee weekly to ensure the proper temperature is maintained for safe handling of food.</p> <p>5. Compliance date</p>	11/25/13

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F 371	Continued From page 8 resident nourishment refrigerator on the units and, were responsible for labelling and dating all nourishments delivered to the units. Interview, 10/24/13 at 3:50 PM, Assistant Director of Nursing (ADON) revealed nursing staff were to identify any food that was brought in by family, check it against the diet order and label and date it with the resident's identifying information.	F 371		

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{K 000}	INITIAL COMMENTS Based upon implementation of the acceptable plan of correction, the facility was deemed to be in compliance effective 11/19/13 as alleged.	{K 000}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2013
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Plan Approval: 1965</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type III (000) Unprotected</p> <p>Smoke Compartments: Ten</p> <p>Fire Alarm: Complete Fire alarm System</p> <p>Sprinkler System: Complete Sprinkler System (Wet and Dry)</p> <p>Generator: Type II Diesel</p> <p>A standard Life Safety Code survey was conducted on 10/23/13. The findings that follow demonstrate compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Bourbon Heights Nursing Home was found to not be in compliance with the requirements for participation in the Medicare and Medicaid program. The census the day of the survey was one hundred eight (108) with the facility being licensed for one hundred twenty nine (129) beds.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) with the highest scope and severity at "F"</p>	K 000		

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BY _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Charles Roberts* TITLE: *Interim Administrator* (X6) DATE: *12/5/13*

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

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K 000	Continued From page 1 level.	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all areas were provided with sprinkler protection, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, twenty (20) residents, staff and visitors. The findings include: Observation on 10/23/2013 at 2:27 PM, revealed the facility had completed new construction in the Unit 3 shower room. Further observation revealed during construction the facility had completed a shower wall that prevented the sprinkler head from providing coverage to other areas of the shower room. All areas were to be sprinkler protected to prevent the spread of fire. The observation was confirmed with Maintenance Staff. Interview on 10/23/2013 at 2:27 PM, with Maintenance Staff, revealed the shower room construction had been completed within the last two (2) weeks and staff had not identified the lack of sprinkler coverage in the shower room.	K 012	K012 1. Installation of two (2) sprinkler heads in the Unit 3 shower room was completed by American Fire and Sprinkler on 11/6/2013. 2. No other areas of concern were found to be without proper sprinkler coverage per walk thru conducted on 10/23/13. 3. Future construction or remodeling will be monitored by maintenance and administration to ensure all areas are sprinkler protected to prevent the spread of fire. 4. Compliance Date 11/7/13	

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K 012 Continued From page 2
The findings were acknowledged by the Administrator at time of exit.

Reference: NFPA 101 (2000 edition)
19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.)
Exception:* Any building of Type I(443), Type I(332), Type II(222), or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:

(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.
(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.
(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.

K 012

Table 19.1.6.2 Construction Type Limitations

Construction Type	Stories			
	1	2	3	4
I(443)	X	X	X	X
I(332)	X	X	X	X
II(222)	X	X	X	X
II(111)	X	X*	X*	NP
II(000)	X*	X*	NP	NP
III(211)	X*	X*	NP	NP
III(200)	X*	NP	NP	NP
IV(2HH)	X*	X*	NP	NP

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K 012	Continued From page 3 V(111) X* X* NP NP V(000) X* NP NP NP X: Permitted type of construction. NP: Not permitted. *Building requires automatic sprinkler protection. (See 19.3.5.1.)	K 012		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors did not project into the corridor, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of ten (10) smoke compartments, twenty (20) residents, staff and visitors. The findings include: Observation on 10/23/2013 at 1:58 PM, revealed the Garden Dining Room Double doors projected into the corridor greater than seven (7) inches, when the doors were in the fully open position. The actual projections into the corridor were between eight (8) and ten (10) inches. Further observation revealed the doors were equipped	K 038		

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K 038 Continued From page 4
with self-closing hardware that had been deactivated. The findings were confirmed with the Maintenance Staff. Doors projecting into the corridor greater than seven (7) inches restrict exit egress in an emergency.

Interview on 10/23/2013 at 1:58 PM, with Maintenance Staff, revealed they were unsure why the self-closing hardware had been removed.

The findings were acknowledged by the Administrator at time of exit.

Reference: NFPA 101 (2000 edition)
7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.)
Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required width of a stair or landing when the door is fully open.

K 038
K038

1. Review of all other doors found Unit 3 Pipe Chase door to protrude into the hallway more than 7 inches. Self-closure hardware placed on this door by maintenance staff on 10/24/13.
2. The State Fire Marshall's office was contacted to review the need for doors on the Garden Dining Room as the doors with the self closing mechanism had been removed due to the hindrance of access to the area by the residents.
3. Tim Juett, Deputy State Fire Marshall visited the facility 10/25/13 to review doors and advise on potential approval to remove doors per his supervisor.
4. Phone call rec'd from Tim Juett on 10/31/13 requesting email sent to his attention for supervisor approval as conversation was acceptable between Tim and supervisor for removal of doors.
5. Email sent 11/4/13.
6. Doors removed 11/18/13.
7. Compliance date 11/19/13

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K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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 record review and interview, it was determined the facility failed to ensure fire drills were conducted at various times, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one hundred twenty nine (129) residents, staff and visitors.</p> <p>The findings include:</p> <p>Record review on 10/23/2013 at 4:02 PM, revealed multiple first (1) and second (2) shift drills were conducted at the same times for those shifts. Fire drills must be conducted during various times.</p> <p>Interview on 10/23/2013 at 4:02 PM, with maintenance staff revealed the facility did not have a policy for conducting fire drills at various times.</p> <p>The findings were acknowledged by the Administrator at time of exit.</p>	K 050	<p>K050</p> <ol style="list-style-type: none"> 1. Fire drills are completed at minimum quarterly on each shift to familiarize personnel with the signal and actions required under varied conditions. 2. The maintenance director or designee is responsible for conducting the fire drills at various times in collaboration with the Administrator to ensure that requirements to be held at unexpected times under varying conditions at least quarterly on each shift are met 3. Quality Assurance will monitor the fire drill sheets when turned in by maintenance to ensure that the times are varied each quarter for each shift. 4. Fire drills were conducted on 10/29/13 at 9:47 a.m. and 4:05 p.m. to ensure facility personnel were familiar with the signal and actions required under varied conditions 5. Compliance date 10/30/13

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K 050	Continued From page 6 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. 4.7.5* Simulated Conditions. Drills shall be held at expected and unexpected times and under varying conditions to simulate the unusual conditions that can occur in an actual emergency.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler systems were maintained, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect ten (10) of ten (10) smoke compartments, one hundred twenty nine (129) residents, staff and visitors. The findings include: Record review, on 10/23/2013 at 4:53 PM, revealed the facility could not produce documentation that a current internal pipe inspection of the facility sprinkler system had been conducted. The last internal pipe inspection for the sprinkler system was conducted on 08/06/2008. The findings were confirmed with the Administrator. Sprinkler systems must have internal pipe inspection conducted every five (5) years to ensure sprinkler systems will operate correctly during a fire. The Interview on, 10/23/2013 at 4:53 PM, with the Administrator, revealed she was unaware the facility was lacking a current internal pipe inspection for the sprinkler system. Reference: NFPA 25 (1998 edition) 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in	K 062	K062 1. American Fire and Sprinkler completed internal pipe inspection on 10/28/13 of wet and dry sprinkler system. 2. Maintenance will maintain calendar for required inspections to ensure compliance. 3. Compliance date	10/29/13

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K 062	Continued From page 8 obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. K 130 SS=D NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure vertical rolling fire doors were inspected and tested according to National Fire Protection Association (NFPA), the deficiency had the potential to affect one (1) of ten (10) smoke compartments, forty (40) residents, staff and visitors. The findings include: Observation on 10/23/2013 at 3:13 PM, revealed four (4) stained glass windows in the Chapel area were protected with vertical rolling fire doors. The vertical rolling fire doors were activated by fusible links. The observation was confirmed with the Maintenance Staff. Fire doors must be inspected and tested annually.	K 062 K 130	1. Total Comfort performed the required change of the fusible links on 11/13/13 to ensure proper working conditions of the rolling fire doors in the Chapel area. 2. Inspection of the rolling fire doors and changing of fusible links will be added to the yearly fire inspection. 3. Compliance Date 11/14/13	

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K 130	Continued From page 9 Interview on 10/23/2013 at 3:13 PM, with the Maintenance Staff, revealed they were unaware of an inspection or maintenance performed on the vertical rolling fire door. The findings were confirmed by the Administrator at time of exit. Reference: NFPA 101 (2000 edition) 4.6.12.2* Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. NFPA 80 (1999 edition) 15-2.4.3 All horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. 15-2.4.4 Fusible links or other heat-actuated devices and release devices shall not be painted. 15-2.4.5 Care shall be taken to prevent paint accumulation on	K 130			

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K 130	Continued From page 10 any movable part such as, but not limited to, stay rolls, gears, and closing mechanisms.	K 130		