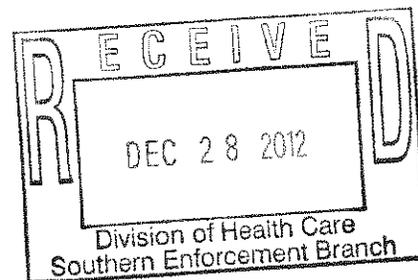


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185148	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/29/2012
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 287 N ELEVENTH ST WILLIAMSBURG, KY 40769	
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F 000	INITIAL COMMENTS	F 000		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to accommodate residents' preferences related to food. Residents #8 and #17, and the group interview revealed the residents were not provided with mayonnaise for the chicken sandwiches at the noon meal on 11/27/12.</p> <p>The findings include: Review of the menu spreadsheet for the noon meal on 11/27/12, revealed mayonnaise was not listed to be given to any of the residents unless the residents were on a calorie-restricted diet. The mayonnaise was listed on the menu spreadsheet for additional calories for residents on a calorie-restricted diet.</p>	F 246	— See Attached POC	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Garboe TITLE: Administrator (X6) DATE: 12/26/12

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 246	<p>Continued From page 1</p> <p>Observation of the lunch meal in the dining room at 11:40 AM on 11/27/12, revealed staff went to the kitchen and asked for mayonnaise for Resident #8's chicken sandwich.</p> <p>Interview with Resident #8 at 11:45 AM on 11/27/12, revealed the resident had not received mayonnaise on the resident's lunch tray. The resident stated staff went to the kitchen and requested mayonnaise for the chicken sandwich after the resident asked staff for mayonnaise.</p> <p>Observation of Resident #17's lunch tray at 11:30 AM on 11/27/12, revealed the resident had a chicken sandwich with lettuce, tomato, and onion. However, there was no mayonnaise on the tray for the sandwich.</p> <p>Interview with Resident #17 at 11:30 AM on 11/27/12, revealed the resident had mayonnaise packets "stashed" in the resident's clothes chest. The resident stated he/she keeps all the extra condiments from meal trays in order to have condiments available when they were not sent on the tray. The resident further stated he/she could not have eaten the chicken sandwich without the mayonnaise because the sandwich was dry. However, Resident #7 stated he/she would have asked for the mayonnaise if he/she had not had some mayonnaise in the chest.</p> <p>A group interview with nine residents on 11/27/12, at 3:30 PM, revealed residents often received meal trays without condiments. The residents stated the chicken sandwich served on 11/27/12, at the noon meal was dry and needed mayonnaise; however, there was no mayonnaise on the residents' trays. The residents stated they</p>	F 246			

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F 246	Continued From page 2 could have asked for mayonnaise, and staff would have gone to the kitchen and requested mayonnaise for them. An interview was conducted with the Registered Dietitian (RD) at 10:15 AM on 11/29/12. The RD stated mayonnaise should have been on the tray for all the residents. However, the RD stated it was an oversight that the mayonnaise was not listed on the menu spreadsheet.	F 246			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329			

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F 329	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and a review of facility policies, the facility failed to ensure the drug regimen for one of twenty-four sampled residents included adequate monitoring and was free from unnecessary drugs. Resident #1 received an anti-seizure medication without adequate indication for the use of the medication.</p> <p>The findings include:</p> <p>A review of the Protocol for Review & Reduction of Psychoactive Medications and the Pharmacy Drug Regimen Review Policies, no dates given, revealed the Consultant Pharmacist would review the medication regimen for each resident on a monthly and as needed basis and the Interdisciplinary Team, including the resident's physician, would make every effort to ensure residents were receiving appropriate medications according to their individualized needs.</p> <p>A review of the "Nursing Drug Handbook 2011" reference manual revealed Valproic Acid was used for seizures and mania, and the prevention of migraine headaches. The manual further indicated that levels of the drug should be monitored and that therapeutic levels were between 50 and 100 micrograms (mcg) per milliliter (ml).</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 05/09/04, with diagnoses that included Dementia with anxiety, Psychosis, Depression, Aphasia, Failure to Thrive, and Huntington's Disease. A</p>	F 329		

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F 329	<p>Continued From page 4</p> <p>review of the medication regimen for Resident #1 revealed the resident received 125 milligrams of Valproic Acid (anti-convulsant) daily at 5:00 PM, for Anxiety/Huntington's Disease. A review of the lab results revealed the resident's Valproic Acid level on 05/22/12, was 16 mcg/ml (subtherapeutic) and on 11/07/12, the Valproic Acid level was 11 mcg/ml (subtherapeutic).</p> <p>Observations of Resident #1 on 11/26/12, at 6:45 PM and 7:00 PM, revealed the resident was in bed with eyes open, but did not respond to staff or the surveyor. Observations on 11/27/12, at 9:15 AM, 10:30 AM, 12:30 PM, 2:50 PM, and 4:00 PM, revealed staff turned and repositioned the resident at two-hour intervals. Observations revealed the resident would sometimes have his/her eyes open but was not responsive to staff in the room. Incontinence care was observed at 11:00 AM, and treatment to the resident's left heel was observed at 1:30 PM on 11/28/12. Although staff talked to the resident, the resident was not responsive to staff's conversation or treatment.</p> <p>An interview with State Registered Nurse Aide (SRNA) #2 at 2:00 PM on 11/28/12, revealed the SRNA had been employed at the facility for over two years and had not ever observed the resident having any seizure activity. The SRNA stated the resident at one time had non-purposeful movements of hands.</p> <p>An interview with Licensed Practical Nurse (LPN) #4 on 11/28/12, at 2:00 PM, revealed she had been employed at the facility for several years and was not aware of Resident #1 ever having any seizure activity.</p>	F 329		

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F 329	Continued From page 5 An interview with the Clinical Coordinator at 2:10 PM on 11/28/12, revealed she had not ever seen Resident #1 have seizures. The Clinic Coordinator further stated she was aware the drug levels for the Valproic Acid were subtherapeutic, and that the physician was aware as well. An interview with Resident #1's physician on 11/28/12 at 3:45 PM, revealed the physician had accepted Resident #1 as a patient five years ago and that the patient had a history of seizures related to Huntington's Disease. The physician further stated he was aware the drug levels for Resident #1 were subtherapeutic, but since the resident had not had any seizures he did not want to change the dosage. The physician also stated that he had not lowered the dosage or discontinued the Valproic Acid for fear the resident might have a seizure.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431		

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F 431	<p>Continued From page 6</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of Centers for Disease Control and Prevention (CDC) guidelines, and review of facility policies/procedures, it was determined the facility failed to ensure medication for resident use had not expired. Review of the CDC guidelines revealed if a multi-dose vial of medication had been opened or accessed, the vial should be dated and discarded within 28 days from the date the vial had been opened (unless the manufacturer specifies a different date). However, a multi-dose vial of pneumococcal vaccine dated as opened 10/01/12, was in the medication refrigerator available for use on 11/27/12.</p> <p>The findings include:</p>	F 431			

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F 431	Continued From page 7 Review of the facility policy/procedure, "Medication Storage in the Facility," dated as effective 03/01/07, revealed outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures were immediately removed from stock and disposed of according to procedures for medication disposal. Further review of the policy/procedure revealed medication storage conditions were to be monitored on a monthly basis. Review of the CDC guidelines for storage and handling of multi-dose vials of medications revealed if a multi-dose vial had been opened or accessed (e.g., needle-punctured) the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Observation of the medication refrigerator on the Derby Lane Hall on 11/27/12, at 2:50 PM, revealed a multi-dose vial of Pneumovax pneumococcal vaccine with an opened date of 10/01/12, available for resident use. Interview on 11/27/12, at 2:50 PM, with Licensed Practical Nurse (LPN) #1 revealed all multi-dose vials should be dated when opened and discarded after 30 days. According to LPN #1, facility staff members "try" to monitor the medication refrigerators on a monthly basis to ensure outdated medications were discarded.	F 431		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The	F 502		

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F 502	<p>Continued From page 8</p> <p>facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and review of the facility policy, it was determined the facility failed to ensure laboratory services were provided for one of twenty-four sampled residents (Resident #10). A review of the physician's orders revealed Resident #10 had an order for a Thyroid Stimulating Hormone (TSH) level, a T4 (thyroid test), and a Depakote level to be obtained every six months. A review of Resident #10's medical record revealed the TSH, T4, and Depakote levels were obtained in January 2012; however, review of the laboratory results revealed facility staff failed to ensure the TSH, T4, and Depakote levels were obtained for Resident #10 when due in July 2012.</p> <p>The findings include:</p> <p>Review of the facility policy, General Lab Procedure Steps (undated), revealed the Unit Supervisor would review the lab calendar daily to ensure all ordered labs have been obtained and results have been received back to the facility.</p> <p>Review of Resident #10's medical record revealed routine physician's orders dated November 2012 for a TSH, T4, and Depakote level to be drawn every six months. Review of the laboratory results for Resident #10 revealed a TSH, T4, and Depakote level were obtained on 01/05/12. There were no other laboratory results documented in the medical record. A review of</p>	F 502			

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F 502	<p>Continued From page 9</p> <p>the nurse's notes, dietary notes, and physician's progress notes revealed there was no evidence of a TSH, T4, or Depakote level drawn in July 2012 as ordered.</p> <p>Interview with the Unit Supervisor on 11/29/12, at 9:30 AM, and a review of the facility's laboratory calendar revealed a TSH, T4, and Depakote level had been written on the laboratory calendar for the laboratory tests to be obtained on 07/10/12; however, the Unit Supervisor was unable to provide any evidence the laboratory tests were drawn for Resident #10. The Unit Supervisor was unsure why the laboratory tests were not available and stated they could not be found.</p> <p>Interview with the Administrator and the Director of Nursing on 11/29/12, at 1:00 PM, revealed the results of the laboratory tests that had been ordered to be obtained in July 2012 for Resident #10 could not be located. The Administrator stated the laboratory calendar was marked indicating the labs had been drawn, and the physician's progress notes had been checked indicating the lab tests had been reviewed; however, the facility could not produce the results of the laboratory tests for Resident #10.</p>	F 502			

F246 REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES

1. Residents # 8 and # 17 did receive the mayonnaise packets for their chicken sandwiches. The menu spreadsheet was changed to reflect that mayonnaise packets should be included on the resident's trays per their diet order.
2. All menu spreadsheets have been reviewed by the Dietary Manager and the Dietician to ensure correct for all diets and specifically condiments including mayonnaise.
3. All dietary staff has been inserviced by the Dietary Manager and Dietician on November 29th, 2012 to follow and check the menu spreadsheets for all diets and specifically for condiments including mayonnaise. Also to notify the Dietary Manager immediately if they observe a mistake on the menu spreadsheet so the mistake can be corrected immediately before the meals are sent to the residents. The Dietary Manager and or Cook will review all menu spreadsheets for each day to ensure everything is correct for all diets before the meals are sent to the residents.
4. The Quality Improvement Committee designee (clinical coordinators) will monitor 5 resident trays from each unit weekly for 1 month then quarterly for 6 months to ensure all appropriate items are on the resident trays specifically condiments (per the menu spreadsheet). In addition the menu spread sheets will be monitored weekly for 1 month and then quarterly for 6 months to ensure accuracy of all items to be placed on the resident trays. Any irregularities found will be reported immediately to the Dietary Manager and the QI committee. The problem will be corrected immediately
5. 12-5-12

F329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

1. The drug regimen for resident #1 has been reviewed by the attending physician and reductions made accordingly and the appropriate diagnosis put in place specifically for the Valproic Acid 125 mg daily.
2. The Director of Nursing with the clinical coordinators have reviewed all psychotropic medications in use for each resident and has worked with each staff physician on reductions and discontinuations of each of these medications as resident appropriate. The consultant pharmacist has also completed a review of all resident drug regimens and new recommendations have been sent to all staff physicians, along with updated guidance on their review and completion of these.
3. Each staff physician and all nurses have been inserviced by the Director of Nursing and Administrator and received educational information as well as guidance regarding the black box warning and the requirements we need for them to meet regarding the use of psychotropic medications as well as all unnecessary medication use. Each physician has also received a listing of all their residents, their medications, and diagnosis for review and to make any changes with doses and or diagnosis. Clinical Coordinators will review all telephone/physician orders weekly to ensure appropriate guidelines are being used for all medications. Any problems found will be reported to physician for changes as needed. The consultant pharmacist will review all medications monthly to make recommendations to physicians as needed and these will be given to the Director of Nursing and the physicians. The Director of Nursing will ensure the physicians act on these recommendations in a timely manner (she will follow up on all recommendations the following day to ensure all have been addressed).
4. All nursing staff has been inserviced regarding FDA guidelines/black box warnings for the use of psychotropic medications as well as unnecessary medications in the elderly population, and their role in helping decrease the use of these medications. The staff physicians have all been met with regarding their residents and educated on psychotropic drug guidelines as well all unnecessary medications. All physicians have agreed that they will review all their residents medications closely on each visit and make any changes as needed. The QI committee designee (director of nursing or administrator) will review 3 charts on each unit weekly for 1 month and quarterly for 6 months to ensure resident drug regimens are being reviewed and appropriate guidelines are followed for residents. Any problems found will be reported immediately to Director of Nursing and Physician as well as QI committee and corrected as needed.
5. 12-5-12

F431 DRUG RECORDS, LABEL/STORE DRUGS&BIOLOGICALS

1. The expired multi-dose vial of pneumococcal vaccine has been removed and discarded.
2. All medication/treatment rooms and carts have been checked by clinical coordinators for any expired drugs/biologicals/supplies.
3. All nurses have been inserviced by Director of Nursing on November 30th,2012 on proper storage, assembly, use, dating, and checking expiration dates on all drugs/biologicals/supplies in the medicine/treatment rooms and carts. Third shift nurses will be responsible for checking all expiration dates on all medications/supplies/multi-dose vials. The clinical coordinators will complete weekly checks and the Pharmacist Consultant will complete monthly checks on medicine/treatment rooms and carts to ensure no expired drugs/biologicals/supplies are kept. Reports will be given to Director of Nursing and Administrator.
4. The Quality Improvement Committee designee(clinical coordinators) will monitor for expired drugs/biologicals/supplies on a weekly basis for 1 month and quarterly for 6 months. In addition to the monthly audit by the pharmacist consultant. Any irregularities will be corrected immediately and reported to the Director of Nursing and Quality Improvement Committee for further follow up.
5. 12-5-12

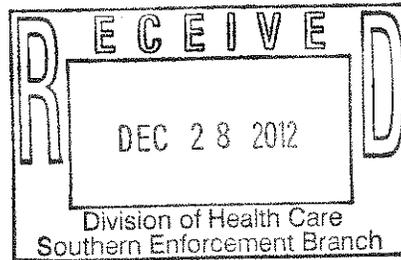
F502 Administration

1. The physician was notified of the missing labs on resident # 10. A new order was obtained for resident # 10 for the TSH,T4, and Depakote level to be obtained. The lab calendar was re-checked to ensure this standing order lab was on the calendar and in the standing order lab book.
2. All labs were reviewed by clinical coordinators on all residents to ensure all lab orders were completed and the results were in the chart. All calendars and lab books were checked to ensure all resident lab standing orders were placed on both the calendar and in the lab standing order books on each unit.
3. All nurses were inserviced on the lab process/system including to check the lab calendar and lab book daily to ensure all labs had been obtained as ordered as well as follow up and check to ensure that all labs from previous day had results with physician notification and were placed in the resident's chart. The clinical coordinators have also been inserviced to check the lab calendar and lab book daily on all units to ensure all labs are obtained and that results are back with physician notification as well as placed back in the chart. Clinical coordinators receive all lab requisitions that are completed by the nurses on the floor and they take these requisitions to all units and compare them to lab calendars and the lab books on all units to ensure that all labs have been drawn and that all results have come in on labs that have been drawn. They also ensure there is physician notification and that the labs are placed in the resident's chart.
4. The QI committee designee (clinical coordinators) will review 3 charts weekly on each unit for 1 month and then quarterly for 6 months to ensure all lab orders are being obtained as ordered and results are received back in a timely manner with MD/RP notification and placed on the resident's chart. Any irregularities found will reported immediately to Director of Nursing and Physician. The problem will be corrected as needed.
5. 12-5-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185148	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/28/2012
NAME OF PROVIDER OR SUPPLIER WILLIAMSBURG HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 287 N ELEVENTH ST WILLIAMSBURG, KY 40769	
(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
K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1989 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type III (000) SMOKE COMPARTMENTS: Eight COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET AND DRY SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 11/28/12, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 025 SS=F	NFPA 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	K 025	See Attached POC	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Michelle Garbow* TITLE: Administrator (X6) DATE: 12/26/12

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 025	<p>Continued From page 1</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain access doors and walls in the fire/smoke wall assembly in the attic area. This deficient practice affected seven of eight smoke compartments, staff, and approximately 100 residents. The facility has the capacity for 125 beds with a census of 116 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 11/28/12, at 11:15 AM, with the Director of Maintenance (DOM), two access doors located in the fire/smoke barrier walls in the attic area of the 200 Wing were observed to have wiring through the doorways. This situation left gaps around the doors and the doors could not be made smoke tight as required. The 100 Wing had the same situation with two access doors with one door not being able to close because of a large electrical cable running through it. These access doors are required to be maintained for the specific purpose to help prevent fire/smoke from spreading to other areas of the building in a fire situation. Non-fire rated expansion foam was also observed</p>	K 025		

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K 025	Continued From page 2 to be used to fill holes in the fire/smoke barrier walls. An interview with the DOM on 11/28/12, at 11:15 AM, revealed he was aware the fire/smoke barrier walls had to be maintained but was not aware the access doors had to be maintained. The DOM was not aware that unrated expansion foam should not be used to fill holes in the fire/smoke barrier walls. Reference: NFPA 101 (2000 Edition). 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: (a) The space between the penetrating item and the smoke barrier shall 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. (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 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. (c) Where designs take transmission of vibration 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 025		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062 SS=E	<p>Continued From page 3</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that sprinkler heads were maintained as required. This deficient practice affected five of eight smoke compartments, staff, and approximately fifty residents. The facility has the capacity for 125 beds with a census of 116 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 11/28/12, at 10:20 AM, with the Director of Maintenance (DOM), mismatched temperature rated sprinkler heads were observed in the 100 Wing men's and women's shower rooms and resident room 106. This condition may affect the way the sprinkler system reacts in a fire situation.</p> <p>In addition, during the survey the men's and women's shower room and resident room 200 in the 200 Wing of the facility were observed to have mismatched sprinkler heads.</p> <p>An interview with the DOM on 11/28/12, at 10:20 AM, revealed he was not aware sprinkler heads should have the same rating per compartment.</p> <p>Reference: NFPA 13 (1999 Edition).</p>	K 062			

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K 062	Continued From page 4 5-3.1.5.2 When existing light hazard systems are converted to use quick-response or residential sprinklers, all sprinklers in a compartmented space shall be changed.	K 062			

K025 NFPA 101 life safety code standard

1. All affected access doors and walls in the fire/smoke wall in the attic area of the 200 and 100 wings have been checked and repaired (gaps around the doors repaired and electrical wiring/cables fixed appropriately to not affect the access doors and walls). The non-fire rated expansion foam was removed from the fire/smoke barrier walls.
2. All access doors and walls in the fire/smoke walls have been checked by the maintenance director to ensure they have good access and are maintained. All fire/smoke barrier walls have been checked to ensure there is no further non-fire rated expansion foam used to fill any holes.
3. Maintenance Director has been inserviced on the life safety code standard that involves the smoke barriers, access doors, and fire/smoke walls and how they should be maintained at all times. Maintenance Director will check smoke barriers, access doors, and fire/smoke walls weekly to ensure they are maintained, accessible, and everything is fire-rated as needed per the life safety code standard.
4. The corporate building manager will make rounds weekly for 1 month and quarterly for 6 months to ensure the smoke barriers, access doors, and fire/smoke walls are accessible, maintained, and fire-rated as needed per the life safety code standard. Any irregularities found will be reported to Administrator and Maintenance Director immediately and corrected as needed.
5. 12-7-12

K062 NFPA 101 life safety code standard

1. The sprinkler heads in the 100 and 200 wing men's and women's shower room as well as room 106 and 200 have been replaced with new sprinkler heads that have the same rating.
2. All sprinkler heads in the facility have been checked by the maintenance director to ensure all are appropriate and have the same rating.
3. The maintenance director has been inserviced on the automatic sprinkler systems and the appropriate ratings to be used as well as how they are to be inspected and tested per the life safety code standard.
4. The corporate building manager will inspect the sprinkler system weekly for 1 month and quarterly for 6 months to ensure all automatic sprinkler systems are rated appropriately and working as required per the life safety code standard. Any irregularities found will be reported to the Administrator and Maintenance Director immediately and corrected as needed.
5. 12-5-12