

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

PRINTED: 01/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185316</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRINCETON HEALTH &amp; REHAB CENTER, INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1333 WEST MAIN ST.</b> <b>PRINCETON, KY 42445</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 01/14/14 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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

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NAME OF PROVIDER OR SUPPLIER  PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445		
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F 000	INITIAL COMMENTS  A standard recertification survey was conducted on 12/10/13 through 12/12/13 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E."	F 000	DISCLAIMER: Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the 2567. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on interview, review of personnel files, and review of the facility's policy/procedure, it was determined the facility failed to implement written policies and procedures to ensure potential employees were screened for a history of mistreatment, neglect, abuse or misappropriation for one (1) of five (5) employees.  Findings include:  Review of the "Alleged Abuse, Potential Neglect, Exploitation Reporting, Investigation" policy/procedure, revised 07/26/12, revealed the facility would demonstrate reasonable efforts to determine whether a person being considered for employment had an abuse record.  Review of the "Applicants and New Hires" policy/procedure, revised 04/21/10, revealed before an employee could be entered into the	F 226	<u>483.13(c) Develop/Implement Abuse/Neglect, Etc. Policies</u> It is the practice of Princeton Health and Rehab Center to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  <u>Corrective Measures for Employee Identified in the deficiency:</u> State Registered Nurse Aide (SRNA) #2 was immediately removed from the schedule when the error was realized. SNRA #2's background check was requested on December 11, 2013. SRNA #2 was cleared for work duty on December 18, 2013.  <u>Others identified who may have been impacted by the deficient practice:</u> A 100% audit was completed by Human Resources, December 11, 2013 on all employee files to determine if the criminal background check was obtained. 100% of the current employees except SRNA #2's criminal background screens were obtained.  <u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> Administrator in-serviced the Scheduler and Human Resource Director on the process to pre-employment screenings on December 11, 2013 Process implemented to prevent re-occurrence: the Scheduler will notify Human Resources when a job offer has been made. Human Resources will request the Criminal Background Screen, Kentucky Abuse Registry, and preform	01/14/14	

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

TITLE

(X6) DATE

*[Signature]* NHA

NHA

1/9/14

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 226	Continued From page 1 computer system, placed on the schedule, or be paid, the facility must have a clear criminal background check.  Review of the personnel record for State Registered Nurse Aide (SRNA) #2, on 12/11/13, revealed a hire date of 11/13/13, with no criminal background check. Review of the facility's work schedule, dated November and December 2013, revealed SRNA #2 worked (12) days in November and has worked (7) days in December since her hire date.  Interview with Human Resources, on 12/11/13 at 3:45 PM, revealed she usually submits the criminal background check for a potential employee after negative drug screen results. She revealed SRNA #2 had a positive drug screen; therefore, it was sent to the laboratory for confirmation testing due to certain medications the employee was prescribed. SRNA #2 called the facility over two weeks later indicating she had a negative drug screen. She was instructed to report the next day for orientation; however, the "scheduler" was not aware a criminal background check had not been submitted.  Interview with the Administrator, on 12/12/13 at 11:15 AM, revealed criminal background checks should be obtained prior to employment at the facility. She revealed SRNA #2 failed the drug screen, disrupting the pre-employment process.	F 226	<u>cont'd.</u>  pre-employment drug screen. Prior to employee orientation, required screenings will be confirmed in each new hire's personnel file by the Human Resource Director.  <b>Monitoring Measures to Maintain On-going Compliance:</b> Human Resource Director will audit all new hire personnel files monthly. Results of the audit will be reported in the monthly Quality Assurance and Assessment Meeting for six months.		
F 241 SS=E	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	F 241	<b>483.15(a) Dignity and Respect of Individuality</b> It is the practice of Princeton Health and Rehab Center to 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.	01/14/14	

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F 241	<p>Continued From page 2 full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity for one resident (A), not in the selected sample. Resident (A) revealed on more than one occasion, he/she had to wait at least ten (10) minutes for staff to answer the call light resulting in an incontinent episode. Additionally, the facility failed to respect each resident's personal space by walking in several rooms without knocking on the door during a medication pass.</p> <p>Findings include:</p> <p>Review of the Privacy, Dignity, and Confidentiality policy/procedure, undated, revealed the facility would respect and enhance the resident's quality of life by protecting the resident's right for privacy and dignity. The residents would be addressed and treated with dignity and respect.</p> <p>1. Record review revealed Resident (A) was admitted to the facility on 07/08/13 with diagnoses to include Guillain-Barre Syndrome with paralysis, Muscle Weakness, and General Osteoarthritis. Review of the quarterly Minimum Data Set, dated 10/14/13, revealed the facility identified the resident as cognitively intact and frequently incontinent of bladder, requiring extensive assistance with toilet use.</p> <p>Interview with Resident (A), on 12/10/13 at 3:00</p>	F 241	<p><u>Corrective Measures for residents identified in the deficiency:</u> Resident (A) has been asked to inform the Nurse/Unit Charge Manager (UCM) if he/she has any more incontinent episodes from delays in answering his/her call light. CMT #1 and 2 were re-educated on Resident's Rights, specifically of knocking prior to entering all resident rooms and waiting for permission to enter on December 11, 2013 by the UCM.</p> <p><u>Others identified who may have been impacted by the deficient practice:</u> In a 100% audit of all alert and oriented residents, there were no residents who stated they were having problems with their call lights being answered nor were there any who voiced concerns regarding staff entering their rooms prior to knocking or gaining permission. The audits were conducted by the Activities Director and the Licensed Social Worker and completed on January 2, 2014.</p> <p><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u> All CMTs are being re-educated on Resident's Rights, specifically of knocking prior to entering all resident rooms and waiting for permission to enter by Unit Charge Managers. Staff Development Coordinator (SDC)/ Unit Charge Manager (UCM) will document three episodes of observing CMTs prior to entering resident's rooms per week for two weeks. UCM/Designee will ask Resident (A) daily if he/she has had any problems with incontinent episodes due to the call light not being answered timely for two weeks. Monthly Medication checklists will be completed for CMTs and monthly Call Light checks.</p> <p><u>Monitoring Measures to Maintain On-going Compliance:</u> SDC/ UCM /Designee will report results of the medication &amp; call light checklists at the Monthly Quality Assurance and Assessment Meeting for six months.</p>	01/14/14	

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F 241	<p>Continued From page 3</p> <p>PM and 12/12/13 at 2:00 PM, revealed there have been times when he/she has to wait ten (10) minutes for staff to answer the call light, resulting in an incontinent episode. The resident revealed he/she required total care due to paralysis. He/she stated "there was nothing more embarrassing than having your diaper changed."</p> <p>Interview with the Director of Nursing (DON), on 12/12/13 at 2:20 PM, revealed she expected staff to answer call lights within 1-2 minutes. She revealed if staff was busy at the time, they should at least answer the light and reassure the resident they would be back as soon as possible.</p> <p>2. Observation of a medication pass, on 12/11/13 at 11:05 AM, 11:08 AM, and 11:10 AM, revealed Certified Medication Technician (CMT) #1 administered medication in three different resident rooms without knocking on the door prior to entry.</p> <p>Interview with CMT #1, on 12/11/13 at 2:50 PM, revealed she was supposed to knock on each resident's door prior to entering.</p> <p>Observation of a medication pass, on 12/11/13 at 2:30 PM, 2:35 PM, and 2:40 PM, revealed CMT #2 administered medication in three different resident rooms without knocking on the door prior to entry.</p> <p>Interview with CMT #2, on 12/11/13 at 2:45 PM, revealed she was supposed to knock on the resident's door prior to entry; however, she "forgot" to do it during the medication pass.</p> <p>Interview with the DON, on 12/12/13 at 2:20 PM, revealed staff should knock on the door and listen</p>	F 241		

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F 241  F 274 SS=D	Continued From page 4 for an answer, prior to entering a resident's room. <b>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</b>  A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the Resident Assessment Instrument (RAI) Version 3.0 Manual, it was determined the facility failed to identify a significant change in a resident's physical condition for one resident (#1) in the sample selection of nineteen (19) residents.  Findings include:  Review of the RAI Version 3.0 Manual, dated April 2012, revealed a significant change was a decline or improvement in a resident's status that: 1. Would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, and was not self-limiting.	F 241  F 274	<b>483.20(b)(2)(ii) : Comprehensive Assessment After a Significant Change.</b> It is the practice of Princeton Health and Rehab Center, Inc. to conduct a comprehensive assessment of a resident within 14 days after the facility determines or should have determined, that there has been a significant change in the resident's physical or mental condition.  <b>Corrective Measures for residents identified in the deficiency:</b> A corrected significant change was completed on Resident #1 as of December 20, 2013.  <b>Other residents identified who may have been impacted by the deficient practice:</b> 100% audit on the Significant Change Worksheets was completed for the past six months by the MDS Coordinator. Significant Change assessments had been completed on all residents that met the requirements of a significant change.  <b>Measures Implemented or Systems Altered to Prevent Re-occurrence:</b> MDS Coordinator educated the Interdisciplinary Care Plan members on January 3, 2014 regarding communicating changes in a resident's assessment. The disciplines will be required to turn in their assessment worksheets to the MDS Coordinator/MDS nurse during the seven day look back period.  <b>Monitoring Measures to Maintain On-going Compliance:</b> MDS Coordinator will report quantity of Significant Changes and medical record numbers of the residents a significant change was completed on each month to the Quality Assurance and Assessment committee meeting for the next six months.	01/14/14	

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F 274	<p>Continued From page 5</p> <p>2. Impacted more than one area of the resident's health status.</p> <p>3. Required interdisciplinary review and/or revision of the care plan.</p> <p>The nursing home may take up to fourteen (14) days to determine whether the criteria were met.</p> <p>Record review revealed Resident #1 was admitted to the facility on 12/13/10 with diagnoses to include Senile Dementia, Lower Leg Fracture, Osteoporosis, and Osteopenia. Review of the significant change Minimum Data Set (MDS), dated 06/05/13 revealed the facility identified the resident as moderately cognitively impaired and required supervision with eating. The resident's weight was 124 pounds and had no pressure sores. Review of the quarterly MDS, dated 10/29/13, revealed the facility now identified the resident as severely impaired and required extensive assistance with eating. The resident's weight was 106 pounds with a Stage II pressure sore on the left heel. Further record review revealed the resident was ordered "comfort measures" as of 09/11/13; however, the facility did not identify a significant change in condition for the resident.</p> <p>Interview with the MDS Coordinator, on 12/12/13 at 1:45 PM, revealed they use a "worksheet" to write down information for each resident and compare them each time we do an MDS assessment. She revealed a significant change in condition assessment should be completed if a resident has declined or improved in two separate areas. She revealed Resident #1 declined in cognition, eating, and weight with the development of a pressure sore. She indicated it was her responsibility to ensure a significant change for the resident was completed within 14</p>	F 274		



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F 441	<p>Continued From page 7 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate handwashing during incontinent care for one resident (#1), in the sample selection of nineteen (19) residents, and during a medication pass. Additionally, the facility failed to ensure appropriate infection control practices were followed for one resident (#12), related to a foley catheter.</p> <p>Findings include:</p> <p>Review of the Handwashing policy/procedure, dated 01/27/11, revealed the goal was to clean the hands and prevent the spread of infection. Hand washing should be done before and after caring for each resident and whenever hands were obviously soiled.</p> <p>1. Observation of care, on 12/10/13 at 2:55 PM, revealed State Registered Nurse Aide (SRNA) #1 donned gloves and provided incontinent care for Resident #1. Afterwards, she adjusted the resident's gown, placed a wedge under the resident's feet, and removed the resident's clean clothing from a hanger while wearing the same soiled gloves.</p>	F 441	<p>validate residents are being provided care and services using hand hygiene and glove use according to the standard precautions while performing incontinent care, medication passes, and placement of catheter bag and tubing.</p> <p><b>Monitoring Measures to Maintain On-going Compliance:</b> Infection Control audits will be completed by the Unit Charge Managers/ Staff Development Coordinator each week to validate residents are being provided care and services using hand hygiene and glove use according to the standard precautions while performing incontinent care, medication passes, and placement of catheter bag and tubing. Findings will be reported to the monthly Quality Assurance and Assessment committee for review and recommendations for 6 months.</p>	01/14/14

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F 441	Continued From page 8  Interview with SRNA #1, on 12/11/13 at 2:52 PM, revealed she should have removed the soiled gloves and washed her hands immediately after incontinent care.  Interview with the Director of Nursing (DON), on 12/12/13 at 2:20 PM, revealed she expected staff to complete incontinent care, then remove gloves and wash hands prior to the continuation of care.  2. Observation of a medication pass, on 12/11/13 at 11:05 AM and 11:08 AM, revealed Certified Medication Technician (CMT) #1 administered medications to three residents; however, did not sanitize her hands until after administration of the third resident.  Interview with CMT #2, on 12/11/13, revealed she typically washed her hands after every two or three residents; however, she should wash or sanitize her hands after each resident.  Interview with the DON, on 12/12/13 at 2:20 PM, revealed staff should wash their hands before and after medication administration for each resident.  Review of the Infection Prevention and Control policy, dated 5/22/12, revealed the goal was to provide a safe, sanitary, and comfortable environment. . The facility will identify any resident with a potential for infection and provide appropriate nursing intervention.  3. Observation of Resident #12, on 12/10/13 at 10:55 AM, revealed he/she was lying in bed with a foley catheter in place. His/her foley catheter bag was not in a dignity bag and the catheter	F 441			

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F 441	<p>Continued From page 9</p> <p>tubing was lying on the floor. Further observation, on 12/10/13 at 2:43 PM, revealed the resident's foley catheter bag remained on the floor and was not in a dignity bag.</p> <p>Interview with SRNA #3, on 12/10/13 at 2:45 PM, revealed she observed the foley catheter bag and the catheter tubing on the floor. She stated, at that time, she did not correct the situation and revealed she should have gotten the bag and tubing off the floor.</p> <p>Interview with Unit Manager #8, on 12/10/13 at 3:20 PM, revealed the catheter bag and tubing should not be touching the floor.</p> <p>Interview with the DON, on 12/12/13 at 11:18 AM, revealed staff should never allow the foley catheter bag or tubing to touch the floor and the catheter bag should be in a dignity bag.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  PRINCETON HEALTH & REHAB CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445
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{K 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 01/14/14 as alleged.	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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

PRINTED: 12/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185316	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  12/11/2013
NAME OF PROVIDER OR SUPPLIER  PRINCETON HEALTH & REHAB CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1333 WEST MAIN ST. PRINCETON, KY 42445	
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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: 1972.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1972, upgraded in 2011 with 38 smoke detectors and 5 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1972 and upgraded in 2011.</p> <p>GENERATOR: Type II generator installed in 2011. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/11/13. Princeton Health and Rehab Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for One-Hundred Four (104) beds with a census of Ninety-One (91) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>DISCLAIMER: Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the 2567. The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

*[Signature]* NHA 1/7/14

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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 062 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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 record review and interview, it was determined the facility failed to have quarterly inspections performed of the fire sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for One-Hundred Four (104) beds with a census of Ninety-One (91) on the day of the survey. The facility failed to ensure a second quarter sprinkler inspection was conducted during 2013.</p> <p>The findings include:</p> <p>Sprinkler report review, on 12/11/13 at 1:20 PM with the Maintenance Supervisor, revealed the facility did not have documentation for a second quarter inspection of the fire sprinkler system. Components located in the fire sprinkler system must be inspected monthly and quarterly accordingly to NFPA requirements and the records for the inspection made available for the</p>	K 062	<p><b><u>NFPA 101 Life Safety Code Standard:</u></b> It is the practice of Princeton Health and Rehab Center, Inc. to meet the Life Safety Codes as stated in the NFPA 101 Life Safety Code Standard.</p> <p><b><u>Corrective Measures for those identified in the deficiency:</u></b> Plant Services was not notified of the failure to inspect our fire alarm system within each quarter by the contracted company. The Company missed the second quarter inspection by a few days. Plant Services will keep a calendar to ensure that inspections are completed quarterly according to the requirements.</p> <p><b><u>Others identified who may have been impacted by the deficient practice:</u></b> No others were impacted by the failure to inspect the fire alarm system within the time period.</p> <p><b><u>Measures Implemented or Systems Altered to Prevent Re-occurrence:</u></b> Plant Services will contact the Contracted Company with a date for the Company to complete the quarterly inspection. Plant Services will follow up the week before the scheduled date to confirm the inspection date. Plant Services will accompany the inspection technicians to confirm the inspection is completed.</p> <p><b><u>Monitoring Measures to Maintain On-going Compliance:</u></b> Plant Services will report results of the quarterly inspections at the Quarterly Quality Assurance and Assessment committee for 12 months.</p>	01/14/14

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K 062	Continued From page 2 authority having jurisdiction.  Interview, on 12/11/13 at 1:20 PM with the Maintenance Supervisor, revealed he was unaware the sprinkler system had not been inspected in the second quarter of 2013. Further interview revealed the sprinkler company had an employee that was telling them he was completing the inspections but not actually doing the inspections. He revealed he never checked behind the sprinkler company because there had never been a problem with them before.  Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1	K 062		

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K 062	Continued From page 3 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10  Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves	K 062		

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K 062	Continued From page 4 Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7	K 062			

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K 062	Continued From page 5 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062			