

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

PRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/17/2013
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NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223
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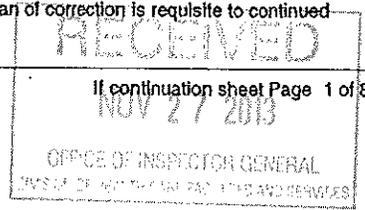
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F 000	INITIAL COMMENTS A standard health survey was conducted 10/15/13 through 10/17/13 and a Life Safety Code survey was conducted on 10/15/13 with highest scope and severity of a "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This plan of Correction is prepared and executed solely because it is required by Federal and State Law.	
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to store food in a sanitary manor by not labeling foods in the reach in refrigerator or freezer and storing meat opened and not labeled in the walk-in fridge. The facility failed to ensure equipment and floors were properly cleaned by three (3) containers holding flour, thickener and sugar to be soiled with dark marks and a sticky film. The floors were sticky and soiled in the kitchen, storage, and dirty dish room areas. The findings include:	F 371	F 371 It is the practice of this facility to store food and maintain equipment in a sanitary manner. I. The pork was dated and used timely. The bags of hamburger patties, chicken breast, fish, and chicken nuggets were disposed of. The cheese was dated. The bins containing flour, food thickener and sugar were cleaned. The kitchen floor was cleaned.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Admin* (X6) DATE *11/16/13*

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.

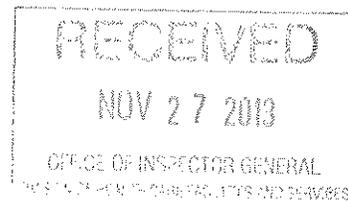
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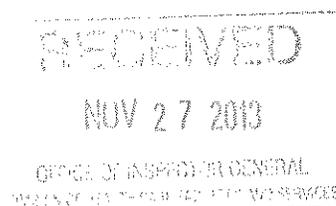
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F 371	<p>Continued From page 1</p> <p>1. Review of the facility's Food and Non-Food Storage Policy, dated 2006, revealed all foods were to be wrapped in moisture-proof materials. Foods that had been removed from their original containers were to be clearly marked with contents, dated and wrapped to exclude as much air as possible.</p> <p>Observation during the kitchen tour, on 10/15/13 at 8:10 AM, revealed a yellow substance in a pan, stored in the reach-in fridge, with no label or date. At 8:20 AM, a pot of pork was stored in the walk-in refrigerator left open with no label or date. At 8:30 AM, bags of opened hamburger patties, chicken breast, fish and chicken nuggets were stored in the freezer with no label or date.</p> <p>Interview with Dietary Cook/Aid, on 10/15/13 at 8:20 AM, revealed the pot of pork was cooked overnight and would be used that day. The Dietary Cook/Aid stated the pot of pork should have been sealed, labeled and dated and then stated they did not want to give the elderly outdated food because it could make them sick.</p> <p>Interview with the Dietary Cook/Aid, on 10/16/13 at 4:20 AM, revealed the yellow substance in the pan was cheese and should have been labelled and dated. She stated once an item was opened, the item should be labeled and dated.</p> <p>Interview with the Dietary Manager, on 10/16/13 at 4:04 PM, revealed food items should be stored with a label. The Dietary Manager stated they wanted to know the expiration date so they would know when to dispose of the food items. The Dietary Manager stated they did not want to cause contamination.</p>	F 371	<p>II. A sanitation inspection of the kitchen was conducted by the Department Director. Additionally, a sanitation inspection was conducted by the Registered Dietician and her supervisor on November 8, 2013.</p> <p>III. The Dining Services staff will be inserviced on the proper cleaning methods, cleaning schedules, and food storage/dating requirements and understanding validated by post test. A cleaning schedule for the kitchen floor has been developed and implemented. The cleaning schedule for the storage containers has been reviewed.</p>		



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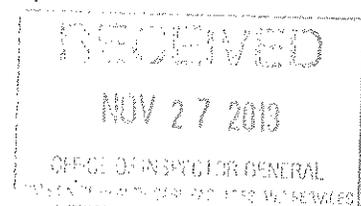
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F 371	<p>Continued From page 2</p> <p>2. Review of the Environmental Sanitation/Infection Control Policy, dated 2006, revealed all food service employees were trained in proper cleaning schedules and routines. Record review of the Recommended Cleaning Frequency, revealed storage containers would be cleaned after each use and floors would be cleaned daily.</p> <p>Observation of the kitchen during tour, on 10/15/13 at 8:20 AM, revealed the bin containers storing flour, food thickener and sugar had brown scuffs around the containers. The top of the containers were sticky with a white filmy substance.</p> <p>Interview with the Dietary Cook/Aid, on 10/16/13 at 4:20 PM, revealed the bins got wiped down once or twice a week. The inside and outside of the bin were cleaned once or twice a month. The Dietary Cook/Aid stated she knew there was a cleaning schedule and each dietary position had something different to clean.</p> <p>Interview with the Assistant Dietary Director, on 10/16/13 at 4:04 PM, revealed the bins were cleaned daily and once a month.</p> <p>Interview with the Dietary Manager, on 10/16/13 at 4:04 PM, revealed the bins did not look clean, nor were they clean.</p> <p>Observation of the kitchen floors, on 10/15/13 at 8:30 AM, revealed the storage area had a brown, sticky substance with white debris on the floor. The dirty dish area floor area had a brown film and was noted to be sticky.</p> <p>Observation of the kitchen floors, on 10/16/13 at</p>	F 371	<p>IV. The Director of Dining Services will monitor sanitation via an audit to be completed 3 times a week for 4 weeks then weekly for 4 weeks then bi-weekly for 4 weeks. Thereafter the audit will be conducted on a monthly basis. All audit findings will be reported to the Quality Assurance Committee during the quarterly meeting and changes will be made to the schedule as recommended by the committee.</p> <p>V. Completion Date November 15, 2013</p>	



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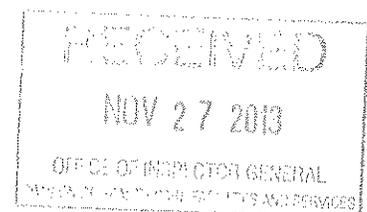
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F 371	<p>Continued From page 3</p> <p>4:04 PM, revealed the kitchen floors had a brown substance and was sticky to walk on.</p> <p>Interview with the Dietary Cook/Aid, on 10/16/13 at 4:20 PM, revealed the Dishwasher was responsible for cleaning the kitchen floors and the PM Assistant was responsible for cleaning the dirty dish room floors. The Dietary Cook/Aid stated she thought the floors looked dirty and thought the kitchen area needed new floors.</p> <p>Interview with the Assistant Dietary Director, on 10/16/13 at 4:04 PM, revealed the floors needed to be deep cleaned and Maintenance was not responsible for deep cleaning the kitchen. The kitchen staff was not responsible to deep clean either. The Assistant Director stated she was responsible to pick up the slack where the Dietary Manager could not. The Assistant Director stated it was her responsibility to monitor dally. The Assistant Director stated she noticed after meals the floors were feeling a little more sticky and greasy from the deep fryers. The Assistant Director stated she became aware after lunch that the floors were not cleaned and they had a new Dishwasher who did not get a chance to clean the floors. The Assistant Director stated she knew the floors were getting cleaned at night.</p> <p>Interview with the Environmental Services Director, on 10/17/13 at 10:53 AM, revealed he cleaned the dirty dish room floors about every four (4) months. The Environmental Director stated he had a schedule, but the previous Administrator took the schedule. The Environmental Director stated he was out sick for twelve (12) weeks and guessed no one was available to pick up the slack. The Environmental Director stated he had been back since</p>	F 371			



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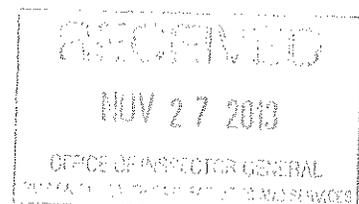
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F 371	Continued From page 4 September and had not cleaned the floors. He stated he did not ever clean the main kitchen floors. The Environmental Director stated no one in housekeeping cleans those floors, it was the dietary staff responsibility to clean the kitchen floors.	F 371		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hallways were free of clutter on two (2) of two (2) nursing units. The facility staff stored medication carts and treatment carts in the hallways on both nursing units. In addition, the staff stored wheelchairs, ger-chairs, mechanical lifts, weight scales, overbed tables and walkers in the hallway when not in use.	F 465	F 465 It is the practice of this facility to maintain the hallways free of clutter. I. The medication carts, wheelchairs and lifts, over bed tables, scale and geri chairs have been moved to areas leaving the hallways clear. II. The Director of Nursing and administrator inspected the building to determine any other items stored in the hallways.	



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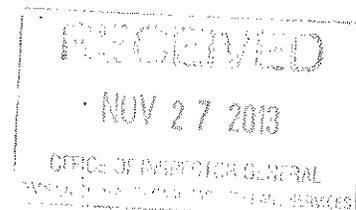
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F 465	Continued From page 5 The findings include: The facility did not provide a policy on storage of medical equipment. Observation, on 10/15/13 at 10:15 AM, revealed a weight scale sitting out in the hallway by room twenty (20). Observation, on 10/15/13 at 2:42 PM, revealed eight (8) wheelchairs were stored outside of residents' rooms, from rooms seventeen (17) to thirty (30). A mechanical lift was stored outside of room twenty-one (21). Four (4) wheelchairs and a walker were stored in the hallway from rooms one (1) to room sixteen (16). Observation, on 10/15/13 at 3:05 PM, revealed six (6) wheelchairs were stored in the hallway from rooms seventeen (17) to thirty (30). Observation, on 10/16/13 at 9:06 AM, revealed a wheelchair was stored outside of room eighteen (18) and room twenty-one (21). A mechanical lift was stored in the hallway between room twenty-one (21) and twenty-two (22). Continued observation revealed an overbed table outside of room two (2) and outside of room three (3) was a Geri-chair, a wheelchair, and a walker. A wheelchair was stored outside of room seven (7) and a walker was stored outside of room eight (8). Observation, on 10/16/13 at 10:13 AM, revealed the mechanical lift remained stored between rooms twenty-one (21) and twenty-two (22). In addition, five (5) wheelchairs and a Geri-chair remained outside of residents' rooms	F 465	III. A plan was developed on November 11, 2013, detailing where the medication carts and treatment carts will be stored when not in use. On East Unit the sunroom has been rearranged. The furniture has been relocated to cluster around the television. The medication and treatment carts are to be stored along the left wall. The wheelchairs are to be stored in the resident room, may be collapsed and placed in closet or bathroom. If the chair is too large, or not collapsible, it will be stored in the appointed storage room on the hall. The Computer carts are to be stored behind the nurse's station or directly beside the nurse's station when not in use. The scale will be stored in the therapy gym. The lifts will be stored behind the nurse's station when not in use. Over bed tables	



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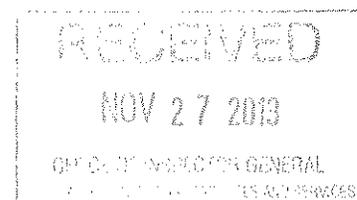
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F 465	Continued From page 6 Observation, on 10/16/13 at 10:42 AM, revealed six (6) wheelchairs and a mechanical lift stored outside of resident rooms, from rooms one (1) to thirty (30). All were stored on one side of the hallway while a medication cart was stored on the opposite side of the hallway. Observation, on 10/17/13 at 11:25 AM, found a Geri-chair, wheelchair, and a walker remained outside of room three (3). The treatment cart was stored outside of room five (5) and the medication cart was stored outside of room six (6). Observation, on 10/17/13 at 11:15 AM, revealed from rooms one (1) to thirty (30) were four (4) wheelchairs and six (6) medication/treatment carts stored in the hallway. Observation on the rehabilitation unit revealed a medication cart and treatment cart stored on both hallways. Interview with Licensed Practical Nurse #3, on 10/17/13 at 11:15 AM, revealed the facility did not have any place to store medication carts, treatment carts and wheelchairs. She stated they use to store the medication carts and treatment cart where the activities office was. She stated it was not a safe environment. Interview with a family member of Resident #18, on 10/17/13 at 1:30 PM, revealed the hallways get congested with the food carts and medication carts and people can't get through. Interview with LPN #1 and #2, on 10/17/13 at 2:15 PM, revealed there was no place to store carts or wheelchairs and it was not a safe environment. They both denied any complaints from residents about items stored in the hallways.	F 465	will be maintained in the resident room for their use. On West Unit the medication and treatment carts will be stored in the medication room. The wheelchairs are to be stored in the resident room, may be collapsed and placed in closet or bathroom. The computer carts are to be stored behind the nurse's station or directly beside the nurse's station. The lifts will be stored in the designated shower room when not in use. Nursing and Environmental Services staff members were inserviced on November 15, 2013 by the Director of Staff Development regarding the plans and learning validated by a post test.		



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F 465	Continued From page 7 Interview with Maintenance #6, on 10/17/13 at 2:33 PM, revealed he had asked management if they could turn a resident's room into a storage area and he was told no. Interview with the Director of Nursing, on 10/17/13 at 3:15 PM, revealed she had been at the facility about three (3) months and she had not been told of any complaints about hallways being cluttered with equipment. She stated it could be a hazard and you would have to push things around to get people in and out. Interview with the Administrator was not completed as she was out of the country as 10/16/13.	F 465	IV. The facility leadership team will monitor hallway clutter during their daily routine rounds throughout the building, address any issues noted immediately and submit documentation to the administrator weekly to. The Director of Nursing will include monitoring on her quality assurance rounds five days a week, document completion and submit to the administrator weekly. Additionally, DON will report findings to the Quality Assurance Committee on a quarterly basis. V. Completion Date November 15, 2013 <i>11-16-13</i> <i>per Lisa Davis</i> <i>by PB 12-4-13</i>		



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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: 1970</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story and a partial basement, Type III (200) Construction.</p> <p>SMOKE COMPARTMENTS: Five (5).</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Automatic (dry) sprinkler system, hydraulically designed.</p> <p>GENERATOR: Type II, 50 KW generator installed in 2010. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/15/13. Meadowview Health and Rehabilitation Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et. seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest</p>	K 000	<p>The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This plan of Correction is prepared and executed solely because it is required by Federal and State Law.</p> <p>K 029</p> <p>It is the practice of this facility to comply with safety requirements.</p> <p>1. A self-closing door hinge has been installed on the Administrative Suite storage door and the Dry Storage door in the kitchen area. Both hinges were installed on October 24, 2013 by the Director of Environmental Services.</p>	

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

TITLE

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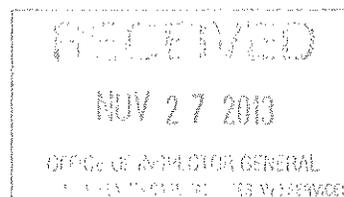
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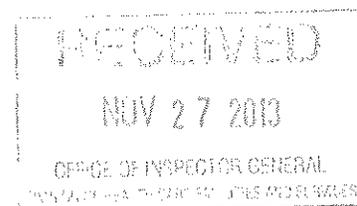
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K 000 K 029 SS=D	Continued From page 1 deficiency identified at "E" level. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility has ninety-five (95) certified beds and the census was ninety (90) on the day of the survey. The findings include: Observation, on 10/15/13 at 9:04 AM, with the Director of Environmental Services revealed the door to the Storage Room located in the Administrative Suite, did not have a self-closing device installed on the door. Further observation, on 10/15/13 at 9:58 AM, with the Director of	K 000 K 029	II. The Director of Environmental Services completed an inspection on October 16, 2013 of all doors that would require a self-closing device. No other issues were noted. III. All doors will be inspected monthly per the preventative maintenance program. The Assistant Director of Maintenance will complete the monthly inspection and the Director of Environment Services will follow with an inspection of random doors to validate the inspection results monthly. IV. The Director of Environmental Services will report the inspection reports to the Quality Assurance Committee, on a quarterly basis and any recommendations from the committee will be acted on. V. Completion Date November 11, 2013	



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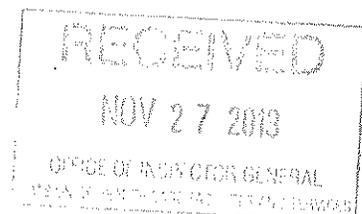
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/15/2013
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K 029	<p>Continued From page 2</p> <p>Environmental Services revealed the door to the Dry Storage Room located in the Kitchen, did not have a self-closing device installed on the door.</p> <p>Interviews, 10/15/13 at 9:04 AM and 9:58 AM, with the Director of Environmental Services revealed he was not aware of the requirements for the doors to the Administrative Storage Room and the Kitchen Dry Storage Room to be equipped with self-closing devices. The Storage Room in the Administrative Suite had been converted from an Office to Storage since the 2012 survey and the lack of a self-closing device on the Kitchen Dry Storage Room was a repeat tag from the 2012 survey.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4: Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops 	K 029		



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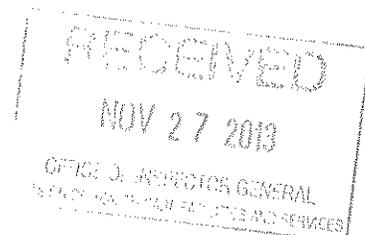
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K 029	Continued From page 3 (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 045 SS=D	illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has ninety-five (95) certified beds and the census was ninety (90) on the day of the survey. The facility failed to provide the required level of illumination outside an exit for discharge.	K 045	K 045 I. The exterior egress lighting fixture was changed to provide a fixture with 2 bulbs on November 11, 2013 by the Director of Environmental Services. II. The Director of Environmental Services completed an inspection on October 16, 2013 of all egress areas to validate lighting complied with regulation. No other issues were noted.	



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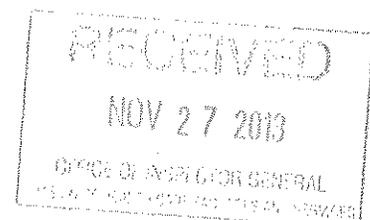
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K 045	<p>Continued From page 4</p> <p>The findings include:</p> <p>Observation, on 10/15/13 at 10:35 AM, with the Director of Environmental Services revealed the exit from the East Sun Room, did not have exterior egress lighting to provide the required level of illumination at the exit discharge. The exit was equipped with a light fixture with only one bulb.</p> <p>Interview, on 10/15/13 at 10:35 PM, with the Director of Environmental Services revealed he was not aware of the requirement for exterior light fixtures required for egress to have two (2) bulbs.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>19.2.8 Illumination of Means of Egress.</p> <p>Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS</p> <p>7.8.1 General.</p> <p>7.8.1.1*</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2</p> <p>Illumination of means of egress shall be continuous during the time that the conditions of</p>	K 045	<p>III. An inspection of all exterior egress lighting has been added to the quarterly inspection list to be completed by the Director of Environmental Services.</p> <p>IV. All inspections results will be submitted by the Director of Environmental Services to the Quality Assurance Committee on a quarterly basis and any recommendations from the committee will be acted on.</p> <p>V. Completion Date November 11, 2013</p>	



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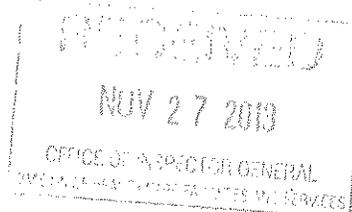
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K 045	Continued From page 5 occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045			
K 062 SS=D	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,	K 062			



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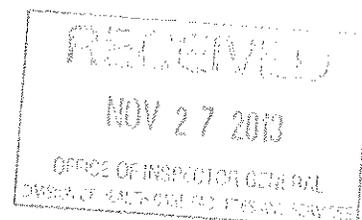
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K 062	Continued From page 6 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has ninety-five (95) certified beds and the census was ninety (90) on the day of the survey. The facility failed to ensure sprinkler head spray patterns were not obstructed. The findings include: Observations, on 10/15/13 between 9:06 AM and 9:16 AM, with the Director of Environmental Services revealed the sprinkler heads within the Storage Room located in the Administrative Suite and within the Mechanical Room located in the Main lobby, had its spray patterns obstructed by surface mounted fluorescent light fixtures. The light fixtures were positioned less than four (4) inches from the sprinkler heads and extended further down from the ceiling than the sprinkler head diffusers did. Interviews; on 10/15/13 between 9:06 AM and 9:16 AM, with the Director of Environmental Services revealed he was unaware the positioning of the surface mounted light fixtures would obstruct the spray patterns of the sprinkler heads upon activation of the automatic sprinkler system.	K 062	K 062 It is the practice of this facility to maintain clear spray patterns for all sprinkler heads. I. The lights in the Administrative Suite Storage Room and the Mechanical Room were relocated on October 21, 2013 by the Director of Environmental Services to ensure adequate spacing and are now in compliance with spray pattern regulation. II. The Director of Environmental Services completed an inspection on October 16, 2013 of the entire building. No other problems were noted. III. The Director of Environmental Services will inspect any areas where new lighting is installed to validate the appropriate placement to remain in compliance with sprinkler spray patter regulations.		



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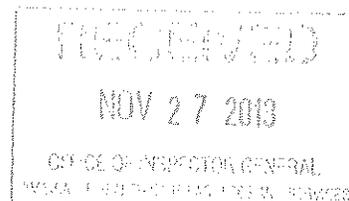
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K 062	Continued From page 7 Reference: NFA 101 (2000 Edition) 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition. NFA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing Shall comply with 5-5.5.2. Table 5-6.5.1.2. Positioning of sprinklers to avoid obstructions to discharge requires at least one foot clearance between sprinkler heads and obstructions to spray patterns that are level with or taller than the sprinkler head. NFA 25 (1998 Edition) 2-2.1.1. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.1.2*. Unacceptable obstructions to spray patterns shall be corrected.	K 062	IV. The Director of Environmental Services will report any future inspections where new light fixtures were installed to the Quality Assurance Committee and act of any recommendations from the committee. V. Completion Date October 24, 2013	
K 066	NFA 101 LIFE SAFETY CODE STANDARD	K 066		



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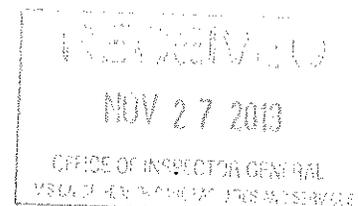
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K 066 SS=E	Continued From page 8 Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the two (2) designated outdoor smoking areas, one (1) for residents and one (1) for staff, were properly equipped for safe smoking. In accordance with NFPA standards. The deficiency had the potential to affect residents, staff and visitors. The facility has ninety-five (95) certified beds and the census was ninety (90) on the day of the survey.	K 066	K066 It is the practice of this facility to properly equip smoking areas with safety equipment. I. The resident smoking area was equipped with a fire blanket. The staff smoking area was equipped with an approved metal self closing container and a fire extinguisher. The items were installed by the Director of Environmental Services on November 1, 2013. II. The Director of Environmental Services completed an inspection of the smoking areas on October 16, 2013 and no other problems were noted.	



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K 066	<p>Continued From page 9</p> <p>The findings include:</p> <p>Observations, on 10/15/13 between 9:11 AM and 9:47 AM, with the Director of Environmental Services revealed the designated, outdoor smoking area for residents did not have a fire blanket readily available for usage. The designated outdoor smoking area for the staff did not have an approved metal container with a self-closing lid to empty ashtrays into and a fire extinguisher available for usage.</p> <p>Interviews, on 10/15/13 between 9:11 AM and 9:47 AM, with the Director of Environmental Services revealed he was not aware of the requirements for the designated, outdoor smoking for residents to be equipped with a fire blanket and for the designated smoking area for staff to be equipped with an approved metal container with a self-closing lid to empty ash trays and a fire extinguisher available for usage,</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited</p>	K 066	<p>III. The Director of Environmental Services will conduct a monthly inspection of the smoking areas to validate the required equipment remains in place.</p> <p>IV. The Director of Environmental Services will report the results of the monthly inspections to the Quality Assurance Committee quarterly and act on any recommendations from the committee.</p> <p>V. Completion Date November 4, 2013</p>	



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K 066	Continued From page 10 and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066		

