

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

PRINTED: 09/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185395	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/02/2015
NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HOSPITAL DR. MADISONVILLE, KY 42431		
(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 on implementation of the acceptable POC, the facility was deemed to be in compliance 08/13/15.	{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 BAPTIST HEALTH TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HOSPITAL DR. MADISONVILLE, KY 42431		
(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	F 000			
F 371 SS=E	<p>483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and review of facility policy it was determined the facility failed to ensure food was distributed in a sanitary manner related to an ice scoop repeatedly placed back into the ice container instead of a scoop holder. Additionally, staff served meal trays to eleven (11) rooms moving the food cart from one hall to another with the ice container uncovered and with the doors on the cart completely open.</p> <p>The findings include:</p> <p>Review of facility policy titled, "Food & Nutrition", last reviewed 08/2013, revealed the purpose of the policy was to meet the nutritional needs of residents in a safe, sanitary and timely manner. Further review revealed staff should scoop ice for</p>	F 371	<p>On 07/29/15, immediate action was taken to address the storing, preparing, distribution and food service issues. The "Routine Meal Service" Policy was updated on 7/29/15 by Abby Humphrey, Director of Food and Nutrition. All patient care supervisors, catering associates and Registered Dieticians were educated by Abby Humphrey, Director of Food and Nutrition, on 7/29/15 of the policy changes and process change. All catering associates began closing the doors on meal delivery carts between each tray delivery on 7/29/15. The cart should only be opened when retrieving the next tray.</p> <p>Also changed on 7/29/15 was the process in which ice for beverage service is handled. There will no longer be a clean container of ice with an ice scoop to place ice into cups as beverages are served. All cups of ice will be prepared in the kitchen using a clean ice scoop that is stored in the ice scoop holder when not in use. The ice cups will be covered with a disposable lid and placed on trays</p> <p>All patients admitted to the unit have the potential to be affected. As a result of the education, change in process, and in-servicing of staff on 7/29/15, all patients on the unit are protected.</p>		



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

TITLE

(X6) DATE

[Handwritten Signature]

Administrator

9/4/15

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F 371	<p>Continued From page 1</p> <p>beverages as needed, placing the ice scoop back in holder and covering ice between rooms. In addition, the policy revealed staff should close cart door after removing each tray, unless all food items are completely covered.</p> <p>Observation of the noon meal service, revealed the meal tray cart arrived on the unit on 07/28/15 at 12:00 PM. Dietary Aide #1 removed plastic wrap from the ice container located on the top of the cart and began putting ice in prepoured glasses of beverages. The Dietary Aide moved through the different areas of the unit to different rooms and each time she put ice in a beverage she put the ice scoop back into the ice container instead of a scoop holder and did not recover the ice container. Additionally, she served food trays from the tray cart to residents on the different halls with the doors on the cart left open as she moved to the different halls.</p> <p>Interview with Dietary Aide #1, on 07/28/15 at 12:20 PM, revealed the ice container was supposed to have a scoop holder but did not. She stated she usually went from one (1) hall to another with the doors open on the food cart unless housekeeping came on the floor.</p> <p>Interview, on 07/29/15 at 9 50 AM with the Dietary Manager, revealed she expected the ice scoop to be placed into a scoop holder after each use and not placed into the ice. She stated she would not expect the door to the food cart to be closed when moving from one area of the unit to another as all food items were covered with lids or wrap.</p>	F 371	<p>Continued from page 1</p> <p>Listed below are the systemic changes put in place on 7/29/15 to prevent this from recurring:</p> <p>All catering associates, on 7/29/15, will begin closing the doors on meal delivery carts between each tray delivery. The cart should only be opened when retrieving the next tray.</p> <p>On 7/29/15, the process in which ice for beverage service is handled was also changed. There will no longer be a clean container of ice with an ice scoop to place ice into cups as beverages are served. All cups of ice will be prepared in the kitchen using a clean ice scoop that is stored in the ice scoop holder when not in use. The ice cups will be covered with a disposable lid and placed on trays for delivery. This will eliminate the mishandling of ice scoops between patients.</p> <p>All catering associates, supervisors and registered dieticians were notified on 7/29/15 by Abby Humphrey, Director of Food and Nutrition, of the process changes.</p> <p>The Routine Meal Service policy was updated 7/29/15, by Abby Humphrey, Director of Food and Nutrition, to reflect the changes of cart doors being closed between delivery of each tray and using individual cups of ice covered with disposable lids.</p> <p>Continued on next page</p>		

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PREFIX
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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

F371

F371

Continued from Page 2

The Food & Nutrition Director, Nutrition Supervisor, or relief leader will monitor the staff performance with the above changes. Beginning 8/4/15, daily random monitoring of cart doors being closed and ice being clean and covered will occur. They will monitor daily for one month, 3 times weekly for one month, and once weekly for 10 months. The monitoring form will identify the date, who is monitoring, a yes or no section for doors closed and ice scooped and scoop stored appropriately and ice cup covered as well as corrective action if needed. All monitoring will be completed on a random basis at random meal periods.

The results of the audit will be reported at the quarterly Quality Assessment and Improvement Committee meeting by the Director of Food & Nutrition or a Nutrition Supervisor. This data will be used to guide further process improvement and will be part of the quality assessment process.

08/13/15

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NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HOSPITAL DR. MADISONVILLE, KY 42431		
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{K 000}	INITIAL COMMENTS Based on implementation of the acceptable POC, the deficiencies were corrected on 08/01/15, as alleged.	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X8) DATE

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NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 HOSPITAL DR. MADISONVILLE, KY 42431
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1971.</p> <p>SURVEY UNDER. 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: Six (6) story, Type II (222).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1971, upgraded in 2003 with 300 smoke detectors and 12 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1971.</p> <p>GENERATOR: Type I generator installed in 1979. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 07/28/15. The facility was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for twenty (20) beds with a census of eleven (11) on the day of the survey.</p> <p>The findings that follow demonstrate non-compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X5) DATE: *8/21/15*

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 BAPTIST HEALTH TRANSITIONAL CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 HOSPITAL DR. MADISONVILLE, KY 42431
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<p>K 000</p> <p>K 018 SS=D</p>	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest scope and severity identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, two (2) residents, staff and visitors. The facility has the capacity for twenty</p>	<p>K 000</p> <p>K 018</p>	<p>On the day of the survey doors on rooms 602 and 604 failed to close fully due to recently being painted. On July 29, 2015 the excess paint was removed from the door jams and the doors were checked for proper operation. All other patient room doors were checked at this time and closed appropriately.</p> <p>All patients admitted to the unit have the potential to be affected.</p> <p>Listed below are the systemic changes to be put into place to prevent this from recurring:</p> <p>A preventative maintenance (PM) schedule will be entered into our computer system and it will generate a work order each week. A maintenance technician will check each of the patient room doors to assure each door latches appropriately. Any found not to latch will be adjusted at that time. The results of the checks will be reviewed by the Supervising Engineer or the Director of Support Services. These checks will continue for at least one year.</p> <p>The results of these checks will be reported at the quarterly CQI meeting by the Supervising Engineer or the Director of Support Services. The results will be used to improve practice.</p>	<p>08/01/15</p>
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NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 980 HOSPITAL DR. MADISONVILLE, KY 42431	
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K 018	<p>Continued From page 2</p> <p>(20) beds and at the time of the survey, the census was eleven (11).</p> <p>The findings include:</p> <p>Observation, on 07/28/15 at 4 01 PM, with the Supervising Engineer revealed the corridor door to resident room #602 and 604 would not latch when tested.</p> <p>Interview, on 07/28/15 at 4 02 PM, with the Supervising Engineer revealed he was unaware the doors would not latch.</p> <p>The census of eleven (11) was verified by the Administrator on 07/28/15. The findings were acknowledged by the Administrator and verified by the Supervising Engineer at the exit interview on 07/28/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar</p>	K 018		

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K 018	Continued From page 3 auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018			
K 027 SS=D	Reference: CMS: S&C-07-18 NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1½-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027	On the day of the survey the west side cross corridor smoke doors failed to close completely due to recently being painted. This was resolved on July 29, 2015 by removing the excess paint from the door jam. All other smoke doors were tested that day and worked appropriately. All patients admitted to the unit have the potential to be affected. Listed below are the systemic changes to be put into place to prevent this from recurring: A preventative maintenance (PM) schedule will be entered into our		

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K 027	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in a smoke barrier, would resist the passage of smoke in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for twenty (20) beds and the census was eleven (11) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/28/15 at 4 26 PM, with the Supervising Engineer revealed the doors located in the smoke barrier wall by Room #634 would not close completely when tested.</p> <p>Interview, on 07/28/15 at 4:27 PM, with the Supervising Engineer revealed the doors were painted recently and he was not aware they were not closing completely.</p> <p>The census of eleven (11) was verified by the Administrator on 07/28/15. The findings were acknowledged by the Administrator and verified by the Supervising Engineer at the exit interview on 07/28/15.</p> <p>Reference NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Actual NFPA Standard.</p>	K 027	<p>Continued from page 4</p> <p>computer system and it will generate a work order for checking all smoke and fire doors weekly. A maintenance technician will check each of the doors to assure each door closes appropriately. Any found not to be closing fully will be adjusted at that time. The results of the checks will be reviewed by the Supervising Engineer or the Director of Support Services. These checks will continue weekly for at least one year.</p> <p>The results of these checks will be reported at the quarterly CQI meeting by the Supervising Engineer or the Director of Support Services. The results will be used to improve practice.</p>	8/1/15

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K 027	<p>Continued From page 5</p> <p>Reference: NFPA 101 (2000 edition), 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.</p>	K 027		
K 061 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was</p>	K 061	<p>The post indicator valves were checked manually by a maintenance technician on the date of the survey to make sure they were open and locked with a pad lock.</p> <p>All patients admitted to the unit have the potential to be affected.</p> <p>Listed below are the systemic changes to be put into place to prevent this from recurring:</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185395	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2015
NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH TRANSITIONAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 HOSPITAL DR. MADISONVILLE, KY 42431		
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K 061	<p>Continued From page 6</p> <p>determined the facility failed to provide electronic supervision (tamper switches) for a water supply control valve installed on the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for twenty (20) beds and at the time of the survey, the census was eleven (11).</p> <p>The findings include:</p> <p>Observation, on 07/28/15 at 3:47 PM, with the Supervising Engineer revealed four (4) out of five (5) Post Indicator Valves (PIV) for the Sprinkler System were not electronically connected to the Fire Alarm. The valves did have a pad lock installed on the handle; however, they were not electronically supervised.</p> <p>Interview on 07/28/15 at 3:48 PM, with the Supervising Engineer revealed he was not aware that electronic supervision of the PIV was required.</p> <p>The census of eleven (11) was verified by the Administrator on 07/28/15. The findings were acknowledged by the Administrator and verified by the Supervising Engineer at the exit interview on 07/28/15.</p> <p>Actual NFPA Standard:</p> <p>Reference NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements, 19.3.5.1 Where required by 19.1.6, health care facilities</p>	K 061	<p>Continued from page 6</p> <p>The post indicator valves will be checked manually by a maintenance technician weekly to assure they are open and locked.</p> <p>The 4 post indicator valves will be wired to alarm system and monitored.</p> <p>The alarm will go off at the PBX in the hospital which is staffed 24/7 and Johnson Controls. Maintenance will respond to the alarm.</p> <p>The 4 post indicator valves will be installed prior to 9/12/15.</p> <p>The post indicator valves will be monitored by Johnson Controls.</p> <p>The post indicator valves will continue to be checked weekly by a maintenance technician.</p> <p>The results of these checks will be reported at the quarterly CQI meeting by the Supervising Engineer or the Director of Support Services. The results will be used to improve practice.</p>	8/1/15	

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K 061	<p>Continued From page 7</p> <p>shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>19.3.5.2*</p> <p>Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria:</p> <p>(1) It shall be in accordance with Section 9.7.</p> <p>(2) It shall be electrically connected to the fire alarm system.</p> <p>(3) It shall be fully supervised.</p> <p>Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>Reference: NFPA 101 (2000 Edition) 9.7.2.1*. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to,</p>	K 061		
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K 061	Continued From page 8 monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.	K 061			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for twenty (20) beds and at the time of the survey, the census was eleven (11). The findings include: Sprinkler testing record review, on 07/28/15 at 3 39 PM, with the Supervising Engineer revealed the facility failed to conduct the quarterly sprinkler inspection in the fourth (4th) quarter of 2014. Two (2) inspections were conducted in the first (1st) quarter of 2015.	K 062	The sprinkler inspection was found to be 6 days late for the quarterly inspection for the 4 th quarter of 2014. A call was made to Ohio Valley Sprinklers on the day of the survey. They advised that their schedule for us would be monitored much closer so we get all inspections done in the correct quarter. Two inspections were done in the first quarter of 2015. The Supervising Engineer or the Direct of Support Services will now monitor to assure the contracted service is completed within the appropriate quarter. All patients admitted to the unit have the potential to be affected. Listed below are the systemic changes to be put into place to prevent this from recurring: A preventative maintenance (PM) schedule will be entered into our computer system and it will generate a work order to remind the Supervising Engineer or the Director of Support Services to call the vendor and schedule the quarterly maintenance well in advance of the inspection due date. The Supervising Engineer or the Director of Support Services will make sure the		

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K 062	<p>Continued From page 9</p> <p>Interview, on 07/28/15 at 3:40 PM, with the Supervising Engineer revealed he relied on his Sprinkler Company to ensure the system was inspected properly and quarterly as required.</p> <p>The census of eleven (11) was verified by the Administrator on 07/28/15. The findings were acknowledged by the Administrator and verified by the Supervising Engineer at the exit interview on 07/28/15.</p> <p>Actual NFPA Standard:</p> <p>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.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="0"> <tr> <td>Item</td> <td>Activity</td> <td>Frequency</td> <td>Reference</td> </tr> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> <tr> <td>Gauges (wet pipe systems)</td> <td>Inspection</td> <td>Monthly</td> <td>2-2.4.1</td> </tr> <tr> <td>Hydraulic nameplate</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.7</td> </tr> <tr> <td>Buildings</td> <td>Inspection</td> <td>Annually</td> <td>(prior to freezing</td> </tr> </table>	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	Hydraulic nameplate	Inspection	Quarterly	2-2.7	Buildings	Inspection	Annually	(prior to freezing	K 062	<p>Continued from page 9</p> <p>inspections are done in the correct quarter. This will continue indefinitely to assure compliance.</p> <p>The results of these quarterly inspections checks will be reported at the quarterly CQI meeting by the Supervising Engineer or the Director of Support Services. The results will be used to improve practice.</p>	8/01/15	
Item	Activity	Frequency	Reference																														
Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2																														
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K 062	Continued From page 10 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 Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2	K 062			

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K 062	Continued From page 11 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 Control Valves Position Test Annually 9-3.4.1	K 062			

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K 062	<p>Continued From page 12</p> <p>Operation Test Annually 9-3 4.1</p> <p>Supervisory Test Semiannually 9-3 4.3</p> <p>Praction/Deluge Valves</p> <p>Priming water Test Quarterly 9-4 3 2.1</p> <p>Low air pressure alarms Test Quarterly 9-4 3 2.10</p> <p>Full flow Test Annually 9-4.3.2.2</p> <p>Dry Pipe Valves/Quick-Opening Devices</p> <p>Priming water Test Quarterly 9-4 4 2.1</p> <p>Low air pressure alarm Test Quarterly 9-4 4 2 6</p> <p>Quick-opening devices Test Quarterly 9-4 4 2 4</p> <p>Trip test Test Annually 9-4.4.2.2</p> <p>Full flow trip test Test 3 years 9-4 4 2 2.1</p> <p>Pressure Reducing and Relief Valves</p> <p>Sprinkler systems Test 5 years 9-5.1 2</p> <p>Circulation relief Test Annually 9-5.5.1.2</p> <p>Pressure relief valves Test Annually 9-5 5 2 2</p> <p>Hose connections Test 5 years 9-5 2 2</p> <p>Hose racks Test 5 years 9-5.3.2</p> <p>Backflow Prevention Assemblies Test Annually 9-5.2</p> <p>Control Valves Maintenance Annually 9-3.5</p> <p>Praction/Deluge Valves Maintenance Annually 9-4.3.3.2</p> <p>Dry Pipe Valves/Quick-Opening Devices</p> <p>Maintenance Annually 9-4.4.3.2</p>	K 062		
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