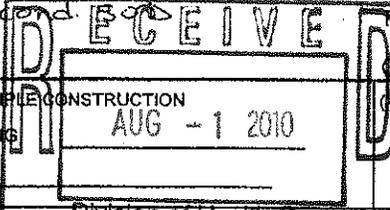


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second Book



PRINTED: 07/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/09/2010
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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP DIVISION of Health Care Southern Enforcement Branch 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423
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(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	<i>This plan of correction constitutes our written allegation of compliance for the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal Law.</i>	
F 160 SS=B	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to convey funds within thirty (30) days after the death of a resident for three (3) of nineteen (19) sampled residents. Residents' #17, #18, and #19, accounts were not closed and funds conveyed within thirty (30) days of the residents' deaths.</p> <p>The findings include:</p> <p>A review of the resident account for resident #17 revealed the resident was deceased on February 19, 2010, and according to facility documentation a check was not issued to close the resident's account until March 22, 2010.</p> <p>A review of the resident account for resident #18 revealed the resident was deceased on February 11, 2010, and according to facility documentation a check was not issued to close the resident's account until March 22, 2010.</p>	F 160	<p>F160</p> <p>The personal funds of residents' are maintained by the office manager. To ensure a resident's funds are conveyed within thirty (30) days of a death or discharge, the following will be implemented.</p> <p>1) Upon notification via the daily nursing census of a death or discharge, the office manager will determine if there is a personal funds account for that resident.</p> <p>2) If an account exists, the name of the resident will be put on the calendar at the Monday prior to the thirtieth day as a reminder to convey the funds, and the check will be issued before the thirtieth day.</p> <p>These steps will eliminate the possibility of failing to convey funds within thirty (30) days.</p> <p>Completion Date 07/02/10</p>	07/02/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark H. Sparks TITLE: president, admin owner (X6) DATE: 7-26-10

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423	
(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 160	Continued From page 1 A review of the resident account for resident #19 revealed the resident was deceased on February 10, 2010, and according to facility documentation a check was not issued to close the resident's account until May 21, 2010. An interview conducted with the facility Accountant on June 9, 2010, at 9:30 a.m., revealed the accountant was aware that funds had to be conveyed within 30 days of a resident being deceased. Further interview revealed the Accountant did not have a system to ensure that funds were conveyed as required and gave no reason as to why the residents' funds were not conveyed as required.	F 160	<u>Addendum</u> The personal funds account was audited after the survey to determine if there were any deceased residents with funds to be conveyed. Resident who expired on 5/23/10 had a check issued estate on 6/21/10. Resident who expired on 6/8/10 had a check issued on 7/6/10. Resident who was discharged on 6/10/10 was issued a check on 6/17/10. Resident who expired on 6/16/10 had check issued on 6/22/10. Completion date 7/2/10.	
F 241 SS=D	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 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote care for one (1) of nineteen (19) sampled residents in a manner that maintains or enhances the resident's dignity and respect. A Foley catheter bag utilized for resident #5 was observed to be uncovered and within view of the hallway. The findings include: Observations conducted for resident #5 on June 8, 2010, from 8:25 a.m. to 11:30 a.m., revealed the resident's Foley catheter bag was not covered	F 241	<u>F241</u> The urinary drainage bag of resident #5 was covered on June 9, 2010. Residents with urinary catheters were assessed for coverage of drainage bag and non were observed without a cover. Treatment records were noted to check for drainage bag cover every shift, care plans updated as well as nursing assistant information records.	06/29/10

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F 241	Continued From page 2 and was observed to be in a pan on a mat beside the resident's bed, in full view from the hallway. An interview conducted with resident #5 on June 8, 2010, at 5:00 p.m., revealed the resident preferred for the catheter bag to be covered and to not be seen by others. An interview conducted on June 8, 2010, at 11:30 a.m., with the Licensed Practical Nurse (LPN) responsible for resident #5's care revealed the LPN was not aware why the Foley catheter bag was not covered. An interview conducted with the Director of Nursing (DON) on June 9, 2010, at 1:15 p.m., revealed the facility did not have a written policy regarding the covering of catheter bags, however, the DON expected the catheter bags to be covered to enhance resident dignity.	F 241	An inservice with all nursing staff was completed on July, 1 2010, relating to the policy an procedure f urinary drainage bag cover. Monitoring for compliance will be daily for 2 weeks; montly for 3 weeks; then quarterly utalizing a quality assurance record by a member of the nusing staff as directed by the Director of Nursing.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to properly season the food for twenty (20) residents on a pureed diet. A palatability test revealed the pureed food (lima beans and noodles) was not seasoned.	F 364	F364 Inservice all cooks on taste testing. Cooks are encouraged to taste all prepared food item before serving to evaluate taste and palatability. Certified Dietary Manage and or Administrator to complete weekly taste test tray for Puree die for two months to evaluate taste and palatability of food items.	06/25/10

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F 364	<p>Continued From page 3</p> <p>The findings include:</p> <p>Observation of the evening meal at 6:10 p.m. on June 7, 2010, revealed resident #6 was in the dining room (accompanied by his/her spouse) when the food tray was served to the resident. The spouse was preparing to feed the resident when the surveyor observed the spouse taste the pureed food and make the remark that the food was not salted. The spouse proceeded to add salt to the pureed food. Further observation revealed that there was only one small pack of salt on the resident's tray.</p> <p>An interview was conducted with the spouse at 6:15 p.m. on June 7, 2010. The spouse stated that resident #6's food is never seasoned because some of the other residents cannot have seasonings such as salt.</p> <p>At 6:20 p.m. on June 7, 2010, a pureed diet test tray was requested by the surveyor. A palatability test was conducted with three surveyors accompanied by the Dietary Manager. The palatability test revealed no seasoning (salt) could be tasted in the lima beans. The pureed noodles had a pasty/sticky taste.</p> <p>An interview was conducted with the Dietary Manager at the time of the palatability test. The Dietary Manager said the food could have used some salt/seasoning.</p> <p>A resident group interview was conducted at 2:30 p.m. on June 7, 2010, with eight residents. The residents stated the food tasted bland. The resident council president stated that the Dietary Manager (DM) had been notified about the food being bland and tasteless, and the DM explained</p>	F 364	RD to complete monthly taste test tray for Puree diet for two months to taste palatability of food items.		

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F 364	Continued From page 4 to the resident the food could not be cooked with seasoning, because some residents were not allowed seasoning on their diet restrictions. A review of the Liberalized Geriatric Diet Manuel and the menu spreadsheets revealed that all of the residents' foods (regardless of the consistency) were supposed to be salted/seasoned during the cooking process.	F 364			

Policy

Covered Urinary Drainage Bags

Purpose:

To promote dignity and ensure privacy, urinary drainage bags are to be covered at all times.

The treatment administration record will be noted: urinary drainage bag in place. Check every shift for placement.

Treatment or charge nurse to initial that the drainage bag is properly covered.

Drainage bag covers are available in the supply area on each unit.

Effective 6/28/10

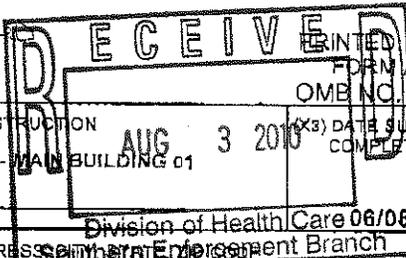
RECORD OF DRAINAGE BAG COVERS FOR POLICY COMPLIANCE

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1 = noncompliant

0=compliant

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED 08/02/2010
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED AUG 3 2010
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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER	STREET ADDRESS 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423
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K 000	INITIAL COMMENTS	K 000		
K 012 SS=D	<p>A life safety code survey was initiated and concluded on June 8, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the outside canopies at the facility were of noncombustible or limited combustible construction or sprinkler protected as required.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on June 8, 2010, at 11:35 a.m., with the Director of Maintenance, a combustible canopy, approximately 10 feet by 8 feet, located at the side of the facility was noted not to be sprinkler protected. Combustible canopies exceeding four feet in width must be sprinkler protected. The Director of Maintenance was not aware of this requirement. During the survey a combustible canopy, approximately 7 feet by 4 feet, at the back employee entrance was also noted not to be sprinkler protected.</p>	K 012	<p><i>K 012</i></p> <p>Facility will remove canopy that is approximately 10 feet by 8 feet, and 7 feet by 4 feet.</p> <p>Completion date is August 3, 2010.</p>	8-3-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mark K. Sparks* TITLE: *president/owner* (X8) DATE: *8-3-10*

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.

Received Time Aug. 3, 2010 11:37AM No. 1799

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185284	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(Xa) DATE SURVEY COMPLETED 06/08/2010
NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423	
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K 012	Continued From page 1 Reference: NFPA 13 (1999 Edition). 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire/smoke barrier walls with at least a one-half hour fire resistance rating as required. Unsealed penetrations were noted above four (4) sets of fire/smoke barrier doors and two (2) fire/smoke barrier walls in the attic area. The facility also failed to utilize proper access doors in the fire/smoke wall assemblies. This condition affected five (5) of six (6) smoke compartments, staff, and all of the residents. The facility has the capacity for 90 beds and a resident census of 83 on the day of survey.	K 025	K025 Maintenance will adjust fire doors to ensue proper closure to meet code. Fire and Sprinkler company will inspect and monitor quarterly there after to ensure compliance. Maintenance will cover fire/smoke penetrations with approved sealant an will remove access doors in the attic. Will replace with approved materials to seal fire and smoke barriers.	07/21/10

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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 428 DANVILLE, KY 40423		
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K 025	<p>Continued From page 2</p> <p>The findings include:</p> <p>During the Life Safety Code survey on June 8, 2010, at 12:30 p.m., with the Director of Maintenance, unsealed penetrations of sprinkler piping, electrical conduit, and wiring were noted in the wall above the cross-corridor fire/smoke barrier doors in the middle of the B Hall coridor. Penetrations of fire/smoke barrier walls must be filled with a suitable material to prevent the passage of fire/smoke in a fire situation. A makeshift access door was also noted in the fire/smoke barrier wall. Access doors are required to be of an approved design and rating to help prevent fire/smoke from spreading to other areas of the building. The Director of Maintenance stated electrical and sprinkler work had been performed last fall and the Maintenance Director was aware the penetrations should have been properly sealed. The Director of Maintenance was not aware the access doors should have been of an approved design. During the survey other unsealed penetrations were also noted above three sets of cross-corridor doors in the A and B Halls and two fire/smoke barrier walls in the laundry area. An unapproved access door was also noted above the cross-corridor doors in the middle of the A Hall.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <p>1. Be filled with a material capable of maintaining</p>	K 025			

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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423	
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K 025	<p>Continued From page 3</p> <p>the smoke resistance of the smoke barrier, or</p> <p>2. Be protected by an approved device designed for the specific purpose.</p> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <p>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</p> <p>2. Be protected by an approved device designed for the specific purpose.</p> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <p>1. Be made on either side of the smoke barrier, or</p> <p>2. Be made by an approved device designed for the specific purpose.</p> <p>8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following.</p> <p>(a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.</p> <p>Reference: NFPA 80 (1999 Edition).</p> <p>11-1.2 Components. An access door shall be an integral unit including the door, frame, hinges, latch, and closing device (where required) bearing a label that reads " Frame and Fire Door Assembly. " Exception: A vertical access door shall be permitted to have hinges that are not part of the labeled assembly, provided the hinges conform to</p>	K 025		

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K 025	Continued From page 4 Table 2-4.3.1. 11-1.2.1 Access doors shall be self-closing. 11-1.2.2 Access doors shall be self-latching. Exception: A horizontal access door that does not open downward and that remains in place when an upward force of 1 psf (48 N/m ²) is applied over the entire exposed surface of the door shall not be required to be self-latching. 11-1.2.3 Self-closing access doors that are intended to be used to allow a person to enter the concealed space behind the door completely shall be operable from the inside without the use of a key or tool. 11-1.2.4 Access doors shall be installed in accordance with their listing. 11-2 Types of Doors. 11-2.1 Horizontal Access Doors. 11-2.1.1 Door assemblies used in fire-rated floors or floor-ceiling or roof-ceiling assemblies shall be tested in the horizontal position in accordance with the procedures described in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, and shall be labeled as horizontal access doors. 11-2.1.2 A horizontal access door shall bear a label that includes the additional wording " For Horizontal Installation. " 11-2.1.3 A horizontal access door shall be used in a fire-rated floor or floor-ceiling or roof-ceiling assembly only where it has been tested and listed for use as a component of the assembly.	K 025			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2010
NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 5 11-2.1.4 Horizontal access doors shall not be required to be subject to the hose stream test. 11-2.2 Vertical Access Doors. 11-2.2.1 Vertical access doors shall have a fire protection rating of 3/4 hour, 1 hour, or 1 1/2 hours. (See Appendix F.)	K 025		
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 an interview and record review, the facility failed to maintain their sprinkler system by NFPA standards. This condition affected six (6) of six (6) smoke compartments, staff, and all of the residents. The facility has the capacity for 90 beds and a resident census of 83 on the day of survey. The findings include: During the Life Safety Code tour on June 8, 2010, at 2:15 p.m., with the Director of Maintenance, a review of the facility's quarterly sprinkler system reports revealed no record for partial and full sprinkler trip tests. These tests ensure the sprinkler system is working correctly. The Director of Maintenance stated the Fire Marshal's office stated these tests were no longer required. Reference: NFPA 25 (1998 Edition).	K 062	K062 Met with sprinkler and fire alarm company; requested that sprinkler system was to have trip test every year to be done in August per code. Maintenance supervisor will have fire an sprinkler alarm company to state in contract annual trip per code and proper documentation of trip to ensue compliance. Expected Completion August 1, 2010.	06/14/10

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K 069	<p>Continued From page 7</p> <p>suppression system was maintained according to NFPA standards.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on June 8, 2010, at 2:00 p.m., with the Director of Maintenance, a record review revealed no documentation that the facility's kitchen range hood system was being inspected semi-annually as required. Documentation revealed the range hood was being cleaned semi-annually. An interview revealed the Director of Maintenance revealed he thought the cleaning procedure met the inspection requirement.</p> <p>Reference: NFPA 96 (1998 Edition).</p> <p>8-3.1*</p> <p>Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Table 8-3.1.</p> <p>Table 8-3.1 Exhaust System Inspection Schedule Systems serving moderate-volume cooking Semiannually Operations.</p> <p>8-3.1.1</p> <p>Upon inspection, if found to be contaminated with deposits from grease-laden vapors, the entire exhaust system shall be cleaned by a properly</p>	K 069			

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K 069	Continued From page 8 trained, qualified, and certified company or person(s) acceptable to the authority having jurisdiction in accordance with Section 8-3. B-3.1.2 When a vent cleaning service is used, a certificate showing date of inspection or cleaning shall be maintained on the premises. After cleaning is completed, the vent cleaning contractor shall place or display within the kitchen area a label indicating the date cleaned and the name of the servicing company. It shall also indicate areas not cleaned.	K 089		