

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

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

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|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED R 04/01/2015 |
| NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408 | | |
| (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} | <p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance 03/27/15, as alleged.</p> | {F 000} | | | |

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

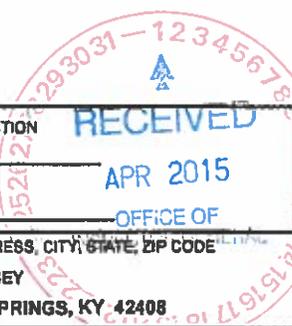
TITLE

(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.

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 02/27/2015 |
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|---|--|
| NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE | STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408 |
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|--------------------|---|---------------|--|----------------------|
| F 000 | INITIAL COMMENTS | F 000 | | |
| F 364 SS=E | <p>A Recertification Survey was conducted on 02/25/15 through 02/27/15 with deficiencies cited at the highest scope and severity of an "E".</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and procedure, and sampling of a test tray, it was determined the facility failed to ensure each resident receives and the facility provides food that was at proper temperatures.</p> <p>Review of the facility Census and Condition, dated 02/25/15, revealed the facility had a census of fifty-one (51) residents with only one (1) resident on tube feedings.</p> <p>The findings include: Review of the facility's policy and procedure titled, "Food Temperature Monitoring", dated 2005, revealed the dietary tray line food temperatures should be monitored prior to the beginning of the tray line service for appropriate temperature and ideally at the conclusion of the service. Any foods found to be out of the temperature range should be corrected or replaced prior to serving. The "Point of Service"</p> | F 364 | <p>Preparation and execution of this plan of Correction does not constitute an admission of 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 solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><u>F 364 (E) 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</u></p> <p><i>Corrective Actions for Residents Found to Have Been Affected</i></p> <p>Tray line temperatures monitored for correctness at next meal and every meal and any foods determined to be out of temperature range are being corrected prior to serving.</p> <p>All serving plates for hot food items are being warmed prior to the plating of hot food.</p> | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: Administrator DATE: 4-1-15

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 patient. (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 TRADEWATER POINTE | STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408 |
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| F 364 | <p>Continued From page 1</p> <p>(POS) temperatures should read greater than 120 degrees for meat, vegetable, and the starch (rice).</p> <p>During a Resident Group Meeting with five (5) of the facility residents, on 02/26/15 at 10:00 AM, revealed the resident stated the food they were served was sometimes lukewarm or cold when served in the dining room and/or in the residents' rooms.</p> <p>A test tray was obtained during a lunch meal, on 02/26/15 at 11:50 AM and temperatures were taken. The tray consisted of a beef meat patty, a vegetable, rice, and a carton of milk. The temperatures of the food on the tray at the POS revealed the beef meat patty was 117 degrees, the vegetable was at 123 degrees, the rice was at 148 degrees and the milk tested at 36 degrees. Per the facility policy the POS temperatures should read greater than 120 degrees for meat, vegetable, and the starch (rice). The beef meat patty did not meet the minimal requirements for POS temperature.</p> <p>Interview with the Dietary Manager, on 02/26/15 at 10:46 AM, revealed she would expect the food to be served at temperatures per the facility's policy and procedures and she thought the reason for the food not being at appropriate temperatures was because of a new staff member in the kitchen who may not have used the plate warmer prior to the tray line service which may have caused the food to cool faster.</p> <p>Interview with the Registered Dietitian (RD), on 02/26/15 at 1:34 PM, revealed she expected the food be served at a temperature suitable for the residents and within the facility's policy and</p> | F 364 | <p><i>Identification of Other Residents Having the Potential to be Affected</i></p> <p>All residents were determined to be at risk for foods with varying temperatures and palatability, however, no residents were determined to have any negative physical effects from the temperature changes.</p> <p><i>Measures or Systemic Changes put Into Place to Avoid Recurrence</i></p> <p>All Dietary staff were inserviced by the Registered Dietitian on 3-26-15 regarding warming plates prior to serving hot foods; and the monitoring of foods prior to service along with education provided on corrections of any temperatures determined to be out of range.</p> <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The Dietary Manager or the Head Cook will monitor and log the food temperatures at each meal for one month. If no issues, other dietary staff members will resume their regular temperature checks and log for each meal with periodic checks from the Dietary Manager and the Registered Dietitian with any needed corrections made immediately.</p> | |
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| NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408 | |
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| F 364 | Continued From page 2 procedures guidelines. | F 364 | | |
| F 371 SS=E | <p>Interview with the Administrator, on 02/27/15 at 12:35 PM, revealed he expected the food temperatures would meet the regulations as per the facility policy and to be served warm in the resident's rooms as well as in the dining room.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy and procedure, it was determined the facility failed to store food under sanitary conditions as evidenced by foods found with no dates and a roast in the freezer, dated 06/21/14, wrapped in foil with a hole exposing it to freezer burn.</p> <p>Review of the facility Census and Condition, dated 02/25/15, revealed the facility had a census of fifty-one (51) residents with only one (1) resident on tube feedings.</p> <p>The findings include:</p> | F 371 | <p>Findings will be presented in the monthly Quality Assurance/ Performance Improvement Committee meeting with members consisting of the Administrator, the Director of Nursing, The Quality Assurance Nurse, the Social Services Director and the MDS Coordinator, for recommendations.</p> <p><i>Date Corrected:</i></p> | 03/27/15 |

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| F 371 | <p>Continued From page 3</p> <p>Review of the facility's policy and procedure, titled "Frozen Food Storage", (no date), revealed frozen food should be stored in a manner that ensures food safety, optimum nutrient and optimum aesthetic quality".</p> <p>Observation of the kitchen, on 02/25/15 at 6:18 AM, revealed snacks were in a refrigerator left over from the night shift with no dates on them. The snacks had stickers on them with the day of the week stamped on them; however, there was no date. The snacks consisted of milk, assorted juices, cottage cheese, and peaches.</p> <p>Further observation revealed a roast was in the freezer door with a date of 08/21/14, wrapped in aluminum foil with a hole in it exposing it to freezer burn, and what appeared to be a person's name written on it.</p> <p>Interview with Dietary Aide #1, on 02/26/15 at 11:55 AM, revealed the snacks should have had a date on the sticker indicating the date prepared and not just the day of the week because they were only allowed to keep snacks in the refrigerator for three (3) days. She stated the snacks would then have to be thrown away if not used within the three days.</p> <p>Interview with Dietary Aide #2, on 02/26/15 at 12:02 PM, revealed snacks could be kept for three (3) days and after that they should be thrown away. She revealed anytime a food was prepared there had to be a date on it even with the stickers that have the day of the week on them.</p> <p>Interview with the Dietary Manager, on 02/26/15</p> | F 371 | <p><i>Identification of Other Residents Having the Potential to be Affected</i></p> <p>Any resident potentially could be affected by foods that are not properly stored, labeled or dated. However, no resident has presented with negative effects from an improperly labeled, stored or undated food.</p> <p><i>Measures or Systemic Changes put into Place to Avoid Recurrence</i></p> <p>All cold food storage, refrigerators and freezers were checked on 2-25-15 by Dietary Staff members and the Dietary Manager for items without labels and/or dates or foods not stored in a manner that ensures food safety, optimum nutrient and optimum quality. Any item determined to be missing a label or a date or improperly stored were discarded.</p> <p>Inservice is scheduled March 26, 2015 for all Dietary Staff presented by the Registered Dietitian regarding the proper labeling, dating and storage of foods for resident consumption.</p> | |

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| F 371 | <p>Continued From page 4</p> <p>at 10:46 AM, revealed anything that goes into the refrigerator or freezer had to have a date on it and the staff person who got the snacks ready was aware of the need to date the stickers regardless of them having the day of the week on them. She further revealed she had no idea who the roast in the freezer belonged to and it was thrown away immediately.</p> <p>Interview with the Administrator, on 02/27/15 at 12:35 PM, revealed he expected all food to be dated and for the staff to follow the policy and procedure regarding labeling and dating. He further revealed no food should be kept in the freezer that was not meant to be prepared by the facility's dietary staff for the residents.</p> | F 371 | <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>Cold food storage to include labels and dates will be monitored by the Dietary Manager and/or the Registered Dietitian weekly with any needed corrections completed immediately.</p> <p>Findings will be presented in the monthly Quality Assurance/Performance Improvement Committee meeting with members consisting of the Administrator, the Director of Nursing, Quality Assurance Nurse, the Social Services Director and the MDS Coordinator, for recommendations</p> <p><i>Date Corrected:</i></p> | 03/27/15 | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED R 03/26/2015 |
| NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408 | | |
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| {K 000} | INITIAL COMMENTS Based on implementation of the acceptable POC, the facility was deemed to be in compliance 03/26/15, as alleged. | {K 000} | | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | TITLE | | (X6) DATE |

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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: One (1) story, Type III (211)</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with (3) heat and (18) smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A recertification Life Safety Code survey was conducted on 02/25/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-one (51).</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* (X6) DATE *3-20-15*

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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| K 000 | Continued From page 1 | K 000 | <p>Preparation and execution of this plan of Correction does not constitute an admission of 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 solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><u>K 018 (D) NFPA 101 LIFE SAFETY CODE STANDARD</u></p> <p><i>Corrective Actions for Residents Found to Have Been Affected</i></p> <p>Room # 112 and Room # 118 located in 2 smoke compartments were corrected by the replacement of the door latches by the Maintenance Director.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i></p> <p>All residents potentially determined to be at risk, however no adverse effects have been noted.</p> | |
| K 018 SS=D | <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 1¾ 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 two (2) of three (3) smoke compartments, four (4) residents, staff and visitors. The facility has the capacity for sixty</p> | K 018 | | |

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| K 018 | <p>Continued From page 2</p> <p>(80) beds and at the time of the survey, the census was fifty-one (51).</p> <p>The findings include:</p> <p>Observation, on 02/25/15 at 10:45 AM, with the Maintenance Director revealed the corridor door to room #112 would not latch properly when tested.</p> <p>Interview, on 02/25/15 at 10:46 AM with the Maintenance Director, revealed he was unaware the door was not latching.</p> <p>Observation, on 02/25/15 at 10:48 AM, with the Maintenance Director revealed the corridor door to room #118 would not latch properly when tested.</p> <p>Interview, on 02/25/15 at 10:49 AM with the Maintenance Director, revealed he was unaware the door was not latching.</p> <p>The census of fifty-one (51) was verified by the Administrator on 02/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 02/25/15.</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</p> | K 018 | <p><i>Measures or Systemic Changes put into Place to Avoid Recurrence</i></p> <p>Maintenance Director rechecked all doors for proper closure by 3-20-15.</p> <p>Maintenance Director added door latching to the preventative maintenance program.</p> <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The Maintenance Director will check all resident doors for latching ability at least quarterly, make any needed corrections and report findings in the monthly Quality Assurance/ Performance Improvement Committee meeting with members consisting of the Administrator, the Director of Nursing, The Quality Assurance Nurse, the Social Services Director and the MDS Coordinator, for recommendations.</p> <p><i>Date Corrected:</i></p> | 03/26/15 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185133 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 02/25/2015 |
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| NAME OF PROVIDER OR SUPPLIER TRADEWATER POINTE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 W. RAMSEY DAWSON SPRINGS, KY 42408 | |
| (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 018 | Continued From page 3 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. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar 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 025 SS=D | 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 | K 025 | | |

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| K 025 | <p>Continued From page 4</p> <p>separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of three (3) smoke compartments, forty (40) residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty-one (51).</p> <p>The findings include:</p> <p>Observation, on 02/25/15 at 8:50 AM, with the Maintenance Director revealed unrated masking tape used to seal a penetration in the smoke barrier extending above the ceiling located above the cross corridor doors by Room #116.</p> <p>Interview, on 02/25/15 at 8:51 AM, with the Maintenance Director revealed he was not aware the unrated masking tape had been used to seal the penetration in the smoke barrier.</p> <p>The census of fifty-one (51) was verified by the Administrator on 02/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview</p> | K 025 | <p><u>K 025 (D) LIFE SAFETY CODE STANDARD</u></p> <p><i>Corrective Actions for Residents Found to Have Been Affected</i></p> <p>The smoke barrier above Room #116 was repaired and masking tape replaced with sheet rock and joint compound by the Maintenance Director.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i></p> <p>All residents potentially determined to be at risk, however no adverse effects have been noted.</p> <p><i>Measures or Systemic Changes put into Place to Avoid Recurrence</i></p> <p>All smoke barriers checked by the Maintenance Director on 3-2-15.</p> <p>Maintenance Director added periodic checks of the smoke barriers to the preventative maintenance program.</p> | |

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| K 025 | Continued From page 5 on 02/25/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. Reference: NFPA 101 (2000 Edition) 19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 1 3/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3 2.2. Reference: NFPA 101 (2000 Edition) 8 3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through | K 025 | <i>Plans to Monitor Performance for Sustained Solutions</i> The Maintenance Director will check all smoke barriers at least quarterly or after contractor work that might require penetration of a smoke barrier, make any needed corrections, and report findings in the Quality Assurance/ Performance Improvement Committee meeting with members consisting of the Administrator, the Director of Nursing, The Quality Assurance Nurse, the Social Services Director and the MDS Coordinator, for recommendations. <i>Date Corrected:</i> | 03/26/15 |

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| K 025 | Continued From page 6 floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. | K 025 | | |
| K 147 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with 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 | K 147 | | |

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| K 147 | <p>Continued From page 7</p> <p>capacity for sixty (60) beds and at the time of the survey, the census was fifty-one (51).</p> <p>The findings include:</p> <p>1. Observation, on 02/25/15 at 9:50 AM, with the Maintenance Director revealed a power strip was plugged into another power strip located in the MDS Office.</p> <p>Interview, on 02/25/15 at 9:51 AM, with the Maintenance Director revealed he was aware of the requirements for the proper use of power strips; however, he was not aware the power strips had been misused.</p> <p>2. Observation, on 02/25/15 at 11:00 AM, with the Maintenance Director revealed a power strip was plugged into another power strip located in the Director of Nursing Office.</p> <p>Interview, on 02/25/15 at 11:01 AM, with the Maintenance Director revealed he was aware of the requirements for the proper use of power strips; however, he was not aware the power strips had been misused.</p> <p>3. Observation, on 02/25/15 at 11:03 AM, with the Maintenance Director revealed a power strip was plugged into another power strip located in the Social Services Office.</p> <p>Interview, on 02/25/15 at 11:04 AM, with the Maintenance Director revealed he was aware of the requirements for the proper use of power strips; however, he was not aware the power strips had been misused.</p> <p>The census of fifty-one (51) was verified by the</p> | K 147 | <p>K 147 (E) LIFE SAFETY CODE STANDARD</p> <p><i>Corrective Actions for Residents Found to Have Been Affected</i></p> <p>Segment 1: One power strip removed from MDS office</p> <p>Segment 2: One power strip removed from Nursing Director's office</p> <p>Segment 3: One power strip removed from Social Services office</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i></p> <p>All residents were determined to be at risk, however no adverse effects have been noted.</p> <p><i>Measures or Systemic Changes put into Place to Avoid Recurrence</i></p> <p>A check of all offices and resident rooms for power strip use was completed on 3-20-15 by the Maintenance</p> | |

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| K 147 | <p>Continued From page 8</p> <p>Administrator on 02/25/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 02/25/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> | K 147 | <p>Director and Environmental Services staff. The Maintenance Director added periodic checks of power strips to the preventative maintenance program.</p> <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p>The Maintenance Director will check all offices and resident rooms at least quarterly for power strips in use, make any needed corrections, and report findings in the Quality Assurance/ Performance Improvement Committee meeting with members consisting of the Administrator, the Director of Nursing, The Quality Assurance Nurse, the Social Services Director and the MDS Coordinator, for recommendations.</p> <p><i>Date Corrected:</i></p> | 03/26/15 |

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