

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/17/2013 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS | STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207 |
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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 |
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| F 000 | INITIAL COMMENTS A standard health survey was initiated on 01/15/13 and concluded on 01/17/13 with a Life Safety Code survey initiated and concluded on 01/15/13. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition. An abbreviated survey was initiated on 01/15/13 and concluded on 01/17/13 investigating KY19644. The Division of Health Care substantiated the allegation; however, no related deficiencies were cited. | F 000 | | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to make survey results, for the year 2012, available for examination by residents. The facility failed to post the results of eighteen(18) abbreviated surveys. | F 167 | F167 1. No residents were determined to be affected. 2. No residents were determined to be affected. 3. The survey results for 2012 will be added to the survey results book by 2/25/2013. | |

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

X [Signature]

TITLE

X INTERIM ED X

DATE

2/20/13

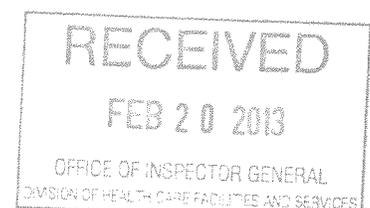
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

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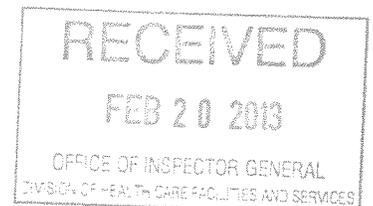
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| F 167 | Continued From page 1 The findings include: Observation of the survey results book, located on a table in the administrative hallway, on 01/15/13 at 3:00 PM, on 01/16/13 at 10:00 AM and on 01/17/13 at 11:00 AM, revealed survey results were missing for 2012. Interview with the Administrator, on 01/17/13 at 11:15 AM, revealed the survey results book contained the results of all surveys completed in 2012. He stated he thought the book was updated about a week ago. Review of the facility posting, revealed the results of surveys were not available in the survey book in the administrative hallway. | F 167 | 4. The Director of Operations will in-service the ED on keeping the survey results binder up to date by 2/25/2013. The Social Service Director will audit the survey results binder for results of the most recent surveys and readily accessible placement monthly for 6 months. The Social Service Director will bring audit results to the QAPI committee for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to follow their policy to ensure dietary staff used soap and water to sanitize hands and failed to | F 371 | 5. Date of compliance: 2/28/13 | |



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| F 371 | <p>Continued From page 2</p> <p>recognize that antimicrobial gels could not be used in a food service setting. A dietary staff member was observed to sanitize her hands with sanitizing gel nine (9) times when assisting on the tray line while it was in progress for the meal service on 01/16/13.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Handwashing, dated 2011, revealed hand sanitizing gel could be used in situations where there was no direct contact with food using bare hands; however, hands were to be washed with soap and water prior to handling, preparing, serving and distributing food and when touching clean utensils and dishes.</p> <p>Observation of the West Dining Room, on 01/16/13 at 12:00 PM, revealed a walled off area containing the steam table and a tray line. The Head Cook was observed assisting by placing drinks and desserts on resident trays. She was noted to reenter the kitchen several times to retrieve requested items for residents. During the tray line, she was observed to use an antimicrobial hand gel nine (9) times.</p> <p>Interview with the Head Cook, on 01/16/13 12:20 PM, revealed she was taught by the facility that using hand gel to sanitize hands was acceptable. She stated the gel killed germs.</p> <p>Interview with the Dietary Manager, on 01/16/13 at 12:25 PM, revealed all dietary staff were trained to wash their hands with soap and water, not hand gel. She stated that was the facility's policy to prevent food-borne illness.</p> | F 371 | <p>F 371 F</p> <ol style="list-style-type: none"> 1. No residents were determined to be affected. 2. All residents have the potential to be affected. 3. The Director of Clinical Education and Director of Dinning Services will re-educated dietary staff on the hand washing procedure to include how and when hand washing is to be used by 2/25/13. Staff competency will be determined by successful completion of post education test reviewed by the Director of Clinical Education. The dietary staff will be in-serviced upon hire and annually on hand washing to include how and when to wash hands. | |



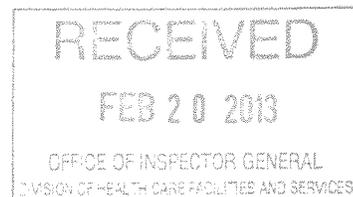
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| <p>F 371</p> <p>F 456 SS=F</p> | <p>Continued From page 3</p> <p>Interview with the Infection Control Nurse, on 01/17/13 at 10:00 AM, revealed dietary staff were not to use hand gels to sanitize their hands and were to use soap and water to prevent the spread of infection.</p> <p>483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</p> <p>The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the manufacturers' recommendations, it was determined the facility failed to have medical equipment plugged into acceptable electrical outlets on five (5) of five (5) resident halls.</p> <p>The findings include:</p> <p>Review of the manufacturers' recommendations for the Abbott/Enteral Pump, Invacare Aspirator, and Invacare Oxygen Concentrator revealed all of those types of medical equipment should be plugged into a grounded electrical outlet directly.</p> <p>Observations of resident equipment on 01/15/13 from 8:45 Am to 9:50 AM revealed the following:</p> <ol style="list-style-type: none"> Room 126 had an enteral feeding pump, an oxygen concentrator and a suction machine all plugged into the same electrical power strip. Room 109 had a mini-nebulizer plugged into | <p>F 371</p> <p>F 456</p> | <p>4. The Director of Dinning Services will audit 25% the dietary staff for hand washing compliance weekly for 30 days, bi-weekly for next 30 days and monthly for 4 months. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The Director of Dinning services will bring audit results to the QAPI committee for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits.</p> <p>5. Date of compliance: 2/28/13</p> | |



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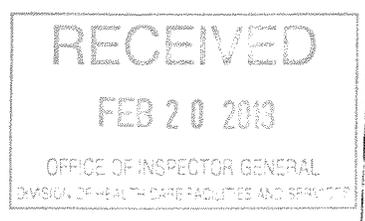
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| F 456 | <p>Continued From page 4 an electrical power strip.</p> <p>3. Room 202 had an oxygen concentrator, two (2) resident beds and an air mattress pump plugged into a multiplug electrical adaptor (ungrounded).</p> <p>4. Room 204 had a resident bed plugged into a multiplug electrical adaptor.</p> <p>5. Room 306 had a resident bed and an oxygen concentrator plugged into a multiplug electrical adaptor.</p> <p>6. Room 309 had a mini-nebulizer plugged into a multiplug electrical adaptor.</p> <p>7. Room 313 had a resident bed plugged into an electrical power strip.</p> <p>8. Room 406 had an oxygen concentrator plugged into a power strip and a mini-nebulizer and a resident bed plugged into an extension cord.</p> <p>9. Room 507 had two mini-nebulizers plugged into two (2) different power strips and an oxygen concentrator plugged into one (1) of those power strips.</p> <p>Interview with the Maintenance Director, on 01/15/13 at 2:00 PM, revealed he was aware medical equipment should be plugged into grounded electrical outlets, but the facility did not have enough outlets for all of the electrical equipment. He stated the staff and sometimes the families of the residents would plug equipment into the wrong type of electrical outlets</p> | F 456 | <p>1. The refrigerator located in the 500 hall was removed from the power strip on 1/18/13. In room 507 the mini nebulizer, oxygen concentrator, lift chair were removed from the power strip on 1/18/13. The mini nebulizer was removed from the 2nd power strip on 1/18/13. The refrigerator was removed from the 3rd power strip and the 3rd power strip was removed from the multi-plug adapter on 1/18/13. In room 504 the refrigerator was removed from the power strip on 1/18/13. In room 406 the oxygen concentrator was removed from the power strip on 1/18/13. The mini nebulizer and bed were removed from the extension cord on 1/18/13. In room 313 the bed was removed from the power strip on 1/18/13. In room 309 the mini nebulizer and refrigerator were removed from the multi-plug adapter on 1/18/13. In room</p> <p style="text-align: center;"><i>CONTINUED NEXT PAGE</i></p> | |
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F 456

306 the bed and oxygen concentrator were removed from the multi-plug adapter on 1/18/13. In room 305 the television was removed from the extension cord on 1/18/13. In the Social Services office the refrigerator and microwave were removed from the power strip on 1/18/13. In room 204 the bed was removed from the power strip on 1/18/13. In room 200 both beds (2), the oxygen contractor, and the air mattress pump were removed from the multi-plug adapter on 1/18/13. In the copy room, the power strip cord was removed from the wall it was passing through on 1/18/13. In the Administrator's office the refrigerator was removed from the power strip on 1/18/13. In the vending area, the vending machines were removed from the multi-plug adapter on 1/18/13. In the basement, the sump pump was removed from the extension cord on 1/18/13. In Central Supply, both power strips were removed on 1/18/13. In room 109 the mini nebulizer was removed from the power strip on 1/18/13. In room 108 the clock was removed from the extension cord on 1/18/13.

2. A room to room search of residents' rooms, offices, storage rooms and basement was completed and all power strips and extension cords were removed.
3. ED in-serviced maintenance director, maintenance assistant, DON to this regulation on 2/05/13. Competency was determined by successful

verbalization reviewed by ED. The CSC in-serviced the DCE to this regulation on 2/06/13.

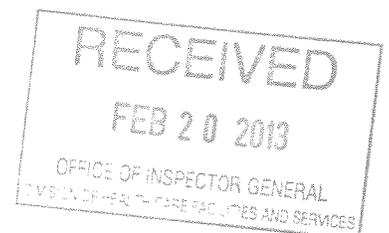
Competency was determined by successful verbalization reviewed by ED. The housekeeping/laundry supervisor and department heads were in-serviced to this regulation on 2/19/2013 by the ED.

Competency was determined by successful verbalization reviewed by ED. DCE will in-service nursing staff, dietary manager will in-service dietary staff, housekeeping/laundry supervisor will in-service their staff to this regulation. Staff competency will be determined by successful completion of post education test reviewed by the Director of Clinical Education. Maintenance will place at least one or more approved 2 to 4 receptacle for each resident's area by 2/27/13.

All offices will plug items directly into receptacle or remove items from center. Maintenance will do a monthly check of all resident's rooms for power strips, multi-plug outlets and extension cords for 6 months. A letter will be sent out to families making them aware and requesting them to not bring power strips into center by 2/20/13. Admission director will make residents and families aware upon admission during the admission process with the signing of admission paper work.

4. The Maintenance Director will bring audit findings to the QAPI committee for two quarterly meetings to validate that all resident's rooms have had the receptacles replaced; all offices, basement and storage area are free of power strips and extension cords for. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits

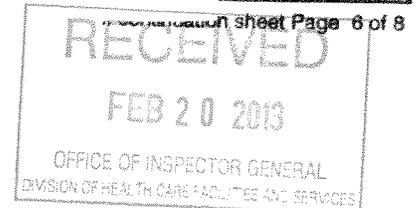
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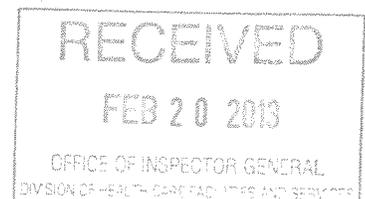
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| F 456 | Continued From page 5 and he felt he was continually trying to educate them not to use ungrounded power sources. Interview with the Administrator, on 01/17/13 at 4:30 PM, revealed he had been at the facility for only six (6) months and it had been difficult to solve numerous concerns. However, he did state the issue of medical equipment plugged into multiplug electrical adaptors and in power strips had been addressed just a month ago and he thought they were no longer in use. | F 456 | F 465 E 1. Room 201-2 paper signs taped to the walls and furniture were removed. Rooms 109, 120, 124, 126, 137, and 138 the taped signs were removed; the pharmacy medication storage bin was removed from the floor of the West medication room; the upholstered chairs in therapy, West and North dining rooms will be cleaned; the East ice cart will be replaced; rooms 105, 115, 301-2, 306-2 and 507-2 were de-cluttered; personal items boxed, briefs and Ensure were removed from the floor by 2/25/2013. 2. All residents have the potential to be affected. An audit will be completed by the Interdisciplinary team to identify housekeeping and maintenance services needed. Any repair needs or housekeeping needs identified will be completed by 2/25/2013. | |
| F 465 SS=E | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the facility was clean, the resident furniture was in good repair, linens were not frayed or stained, ice carts were repaired appropriately, resident rooms were not cluttered, walls and furniture were free of signs and tape residue and items were not stored on the floor for two (2) of two (2) units and one (1) of one (1) dining room and the therapy room. The findings include: Observation of the facility, on 01/15/13 at 3:30 PM, revealed Room 201-2 had thirteen (13) paper signs taped to the walls and the furniture. Many of the signs were soiled. Rooms 109, 120, | F 465 | | |



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| F 465 | <p>Continued From page 6</p> <p>124, 126, 137 and 138 had paper signs taped to the walls. In addition a pharmacy medication storage bin was observed stored on the floor of the bathroom off the West medication room.</p> <p>Continued observation revealed fourteen (14) of fourteen (14) upholstered chairs in the West dining room were stained with white areas and blackish areas. Nine (9) of (9) upholstered chairs in the North dining room were stained with white and blackish areas. Four (4) of six (6) upholstered chairs in therapy were stained with white and blackish areas.</p> <p>Observation of the facility, on 01/17/13 at 11:00 AM, revealed the East ice cart handle was broken in two (2) areas and had been repaired by wrapping white medical tape around the breaks. The tape was soiled, black and sticky.</p> <p>Continued observation revealed Rooms 105, 115, 301-2, 306-2 and 507-2 were cluttered and resident personal items, in boxes and containers, were stored on the floor. Boxes of briefs and Ensure (liquid food supplement) were stored on the floors.</p> <p>Interview with the Housekeeping Manager, on 01/16/13 at 3:10 PM, revealed torn and stained linen were pulled from circulation and not placed back in the linen rooms. She stated she was not sure how the stained linen ended up back in the linen room. She stated she was responsible to ensure resident linens were in good condition. She stated there was no policy on linen. She stated that there was no policy regarding paper signs.</p> | F 465 | <p>3. The Director of Clinical Education will re-educate the staff on reporting housekeeping and maintenance needs by 2/25/2013. Staff competency will be determined by successful completion of post education test reviewed by the Director of Clinical Education. The housekeeping manager will add cleaning the upholstered chairs to the cleaning checklist for job routines. The housekeeping staff will be re-educated by the housekeeping manager on cleaning checklist for job routines to include upholstered chairs by 2/25/2013. Staff competency will be determined by successful verbalization of adding upholstered chairs to cleaning checklist for job routines.</p> | |



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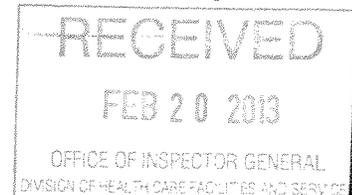
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| F 465 | Continued From page 7 Interview with the Housekeeping Manager, on 01/17/13 at 10:00 AM, revealed upholstered chairs were cleaned on a monthly basis. She stated rooms that were cluttered with resident belongings were cleaned monthly so every thing could be moved off the floor if the resident was willing. She indicated that otherwise the open floor space was cleaned daily and nothing was moved. She stated the chairs were soiled and needed cleaning. She stated she was responsible to ensure rooms were clean and she did supervise staff. | F 465 | 4. The interdisciplinary team will audit the center for housekeeping and maintenance services needed daily for five days, weekly for 30 days, and bi-weekly for next 30 days and monthly for 4 months. Any issues with lack of compliance will be addressed by employee re-education and/or discipline or revision of this plan to reach compliance. The Executive Director will bring audit results to the QAPI committee for two quarterly meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits. 5. Date of compliance: 2/28/13 | |
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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 |
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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: 1965</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type (111)</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/15/13. Golden Living Center St. Matthews was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> | K 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE **X INTERIM ED** (X8) DATE **X 2/20/13**

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

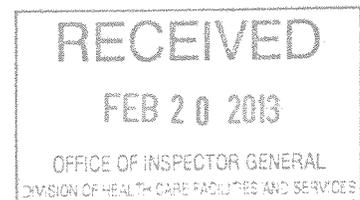
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 01/15/2013 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ST MATTHEWS | STREET ADDRESS, CITY, STATE, ZIP CODE 227 BROWNS LANE LOUISVILLE, KY 40207 |
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| K 000 | Continued From page 1 | K 000 | K018 | |
| K 018 SS=D | <p>Deficiencies were cited with the highest deficiency 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 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 NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six</p> | K 018 | <ol style="list-style-type: none"> Corridor doors to room 128, 130, 132 and 134 have been repaired to latch on 1/22/13. An audit of all resident rooms' doors for latching was completed and all found to not latch were repaired. Maintenance Director and maintenance assistant were in-serviced by ED on this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED. The Director of Education was in-serviced on this regulation by the CSC on 2/06/13. Competency was determined by successful verbalization reviewed by CSC. The DCE in-serviced nursing, housekeeping/laundry and department head staff of this regulations and the system to report if any resident's room doors do not latch by 2/25/13. Staff competency will be determined by successful completion of post education test reviewed by the Director of Clinical Education. | |



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| K 018 | <p>Continued From page 2</p> <p>(96) on the day of the survey. The facility failed to ensure doors to resident rooms would latch when closed.</p> <p>The findings include:</p> <p>Observations, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed the corridor doors to rooms #128, 130, 132, and 134 would not latch properly when tested.</p> <p>Interview, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director confirmed the observation of the doors not latching.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the administrator revealed he was not aware the doors would not latch properly.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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 1 3/4-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> | K 018 | <p>Maintenance Director or assistant will do monthly audit that all resident's doors latch for 6 months. Any issues will be repaired or replaced immediately.</p> <p>4. The Maintenance Director will bring audit results to the QAPI committee for two quarterly QAPI meetings. QAPI committee consists of Administrator, Director of Nursing, Medical Director, Maintenance Director, Housekeeping laundry Supervisor, Social Services, Dietary Director. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits</p> <p>5. Date of compliance: 2/28/13</p> | |

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| K 018 | Continued From page 3 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=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 | K 025 | | |

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K 025 Continued From page 4

This STANDARD is not met as evidenced by: Based on observations 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 NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility has one hundred twenty five (125) certified beds with a census of ninety six (96) on the day of the survey.

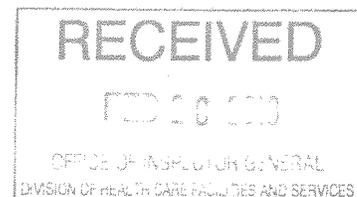
The findings include:

Observations, on 01/15/13 between 9:00 AM and 10:00 AM, with the Maintenance Director revealed the smoke barriers, extending above the ceiling had penetrations of pipes and wires. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The locations are as follows:

- 1) The smoke partition located by room #111 had been sealed with quick foam.
- 2) The smoke partition located by room #115 had unsealed wires, and penetrations sealed with quick foam.
- 3) The fire walls on each side of the laundry area were both sealed with quick foam.
- 4) The smoke partition located by room #207 was sealed with quick foam, and had a 12" by 12" hole with wires passing through the smoke partition.
- 5) The smoke partition located by room #300 was sealed with quick foam.
- 6) The smoke partition located by room #400,

K 0: K025

1. The quick form by room 111 smoke partition was replaced with fire rated caulk by 2/15/13. The quick form by room 115 smoke partition was replaced with fire rated caulk and the unsealed wires were sealed with fire rated caulk by 2/15/13. The fire walls on each side of laundry had the quick form replaced with fire rated caulk by 2/15/13. The quick form by room 207 smoke partition was replaced with fire rated caulk and the 12 by 12 hole with wires passing through was sealed with fire rated caulk by 2/15/13. The smoke partition located by room 300 had quick form replaced by fir rated caulk, the smoke partition located by room 400 had quick form replaced by fire rated caulk and the 12 by 12 unsealed penetration was sealed with fire rated caulk by 2/15/13. The smoke partition located in the 500 hall was made accessible on 2/20/13.



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K 025 Continued From page 5
was sealed with quick foam, and had a 12" by 12" unsealed penetration.
7) The smoke partition located in the 500 Hall was not accessible to be surveyed.

Interview, on 01/15/13 between 9:00 AM and 10:00 AM, with the Maintenance Director revealed he was not aware of the penetrations or the use of quick foam in the smoke barriers.

Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was aware of the requirements for smoke barriers but not aware of the penetrations or use of quick foam in the smoke barrier.

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 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

K 025

2. All residents have the potential to be affected. A smoke barrier audit was completed for the use of quick form, holes or unsealed wires. All areas of concern were sealed with fire rated caulk by 2/15/13.
3. ED in-serviced maintenance director and assistant to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED. Maintenance director is to follow up after any type of entrance into the attic or work is completed in the attic to check for any damage to the smoke barriers seal. Immediate repair will be completed with fire rated caulk. ED will validate monthly with the maintenance director this was completed for 6 months.
4. QAPI committee will review with ED and maintenance director that all smoke barriers are sealed with fire rated caulk after any entrance into attic for compliance for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits
5. Date of compliance 2/28/13

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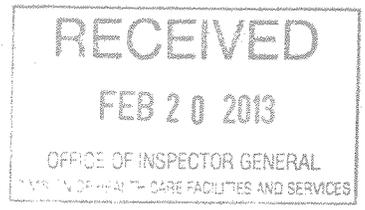
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| K 025 | Continued From page 6 between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where 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 029 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey. The | K 029 | K029 1. Self closing device was placed on room 507, 400 hall soiled linen room, laundry soiled linen room, laundry clean linen room, the north wing janitor room and the mechanical room next to room 136 by 2/25/13. 2. An audit was completed of all doors in barriers for self closing | |

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| K 029 | <p>Continued From page 7 facility failed to provide self-closing devices for doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed rooms containing a hazardous amount of combustibles did not have self-closing device to keep the door closed. The rooms were identified as:</p> <ol style="list-style-type: none"> 1) Room #507 which had an excessive amount of stuffed animals that had not been treated with a flame retardant. 2) The 400 Hall soiled linen room. 3) Soiled linen room located in the Laundry. 4) Clean linen room located in the Laundry. 5) The North Wing "T" Hall Janitor Room. 6) Mechanical Room located next to room #136. <p>Interview, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed they were not aware the doors to these rooms were required to be self-closing.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was not aware the doors to these rooms were required to be self-closing.</p> | K 029 | <p>device. Any doors found to not have self closing device had one placed.</p> <ol style="list-style-type: none"> 3. ED in serviced Maintenance director, maintenance assistant and laundry/housekeeping staff to this regulation on 2/05/2013. Competency was determined by successful verbalization reviewed by ED. Maintenance director or assistant will monitor monthly all smoke barrier doors for self closing devices for 6 months. Any issues will be replaced or repaired. 4. The Maintenance Director will bring audit findings to the QAPI committee. The QAPI committee will review audit of doors self closing device for compliance for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of compliance: 2/28/13 | |

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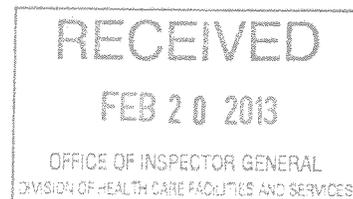
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| K 029 | <p>Continued From page 8</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of</p> | K 029 | | |

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| K 029 | Continued From page 9 combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD | K 029 | | | |
| K 038 SS=D | Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had proper signage. The findings include: | K 038 | 1. Appropriate signage was placed on the exits located at the front and rear entrances by 2/20/13. 2. An audit of all entrances and exits doors to centers was completed to validate appropriate signage was on door relaying to delayed egress. Any areas of concern were immediately corrected. 3. ED in-serviced Maintenance director, maintenance assistant on 2/05/13 to this regulation. Competency was determined by successful verbalization reviewed by ED. Maintenance Director or | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185192 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____ | (X3) DATE SURVEY COMPLETED 01/15/2013 |
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| K 038 | Continued From page 10 Observation, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed the exits located at the Front and Rear entrances did not have signage that indicated the doors were equipped with delayed egress. Interview, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed he was unaware the doors did not have proper signage. Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was unaware the doors did not have proper signage. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through | K 038 | maintenance assistant will do a monthly audit to validate delayed egress signage is in place for 6 months. 4. The Maintenance Director will bring audit findings to the QAPI committee. The QAPI committee will review delayed egress audit for compliance for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of compliance: 2/28/13 | |

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| K 038 | <p>Continued From page 11 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device,</p> |
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| K 038 | |
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| K 038 | <p>Continued From page 12</p> <p>there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.</p> <p>7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress.</p> | K 038 | | |

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K 038 Continued From page 13
(b) They are installed across an opening that is at least 6 ft (1.8 m) in width.
(c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.

K 045 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey.

The findings include:
Observation, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed exterior exits with only one light bulb outside to light the egress path. The exits with only one light are located next to room #101, and 200.

K 038

K 045

K045

1. The exits with only one light next to room 101 and 200 hall another light added on 2/12/13.
2. An audit was completed of all exits to ensure they were equipped with lighting in accordance with NFPA standards. Any concerns were replaced or repaired.
3. ED in-serviced maintenance director and assistant to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED. Maintenance director will do a monthly audit of exits to assure egress has lighting per regulation for 6 months.
4. The Maintenance Director will bring audit findings to the QAPI committee. The QAPI committee will review the monthly audits of egress lighting

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| K 045 | <p>Continued From page 14</p> <p>Interview, on 01/15/13 between 9:00 AM and 4:30 PM, with the Maintenance Director revealed he was not aware the exits did not have the required illumination for egress lighting.</p> <p>Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was not aware of the requirements for egress lighting.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods</p> | K 045 | <p>for compliance for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits</p> <p>5. Date of compliance: 2/28/13</p> | |

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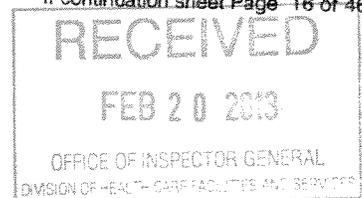
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| K 045 | <p>Continued From page 15</p> <p>of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3*</p> <p>The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels.</p> <p>7.8.1.4*</p> <p>Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p> | K 045 | | |
| K 047 SS=D | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1</p> | K 047 | | |



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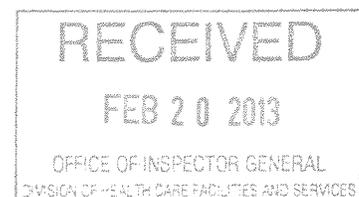
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| K 047 | Continued From page 16 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage. The findings include: Observation, on 01/15/13 at 2:19 PM, with the Maintenance Director revealed the exit doors located in the Kitchen did not have an exit sign above the door making the path of egress clearly recognizable. Interview, on 01/15/13 at 2:19 PM, with the Maintenance Director revealed he was not aware the exits did not have proper signage. Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was not aware the exits did not have proper signage. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, | K 047 | K047 1. The exit door located in kitchen had an exit sign placed on 2/12/13. 2. An audit was completed on all exit doors for appropriate signage identifying the exit. Any areas of concern were replaced or repaired. 3. ED in-serviced maintenance director and assistant to this regulation on 2/05/13. Competency was determined by successful verbalization reviewed by ED. Maintenance Director or maintenance assistant will do a monthly audit of all exit doors for appropriate exit signs for 6 months. 4. The Maintenance Director will bring audit findings to the QAPI committee. The QAPI committee will review exit sign audit for compliance for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of compliance: 2/28/13 | |
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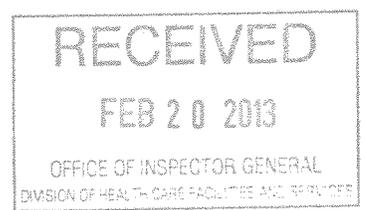
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| K 047 | Continued From page 17 shall be marked by an approved sign readily visible from any direction of exit access. | K 047 | | |
| K 050 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on Interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty five (125) beds with a census of ninety six (96) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times. The findings include: Fire Drill review, on 01/15/13 at 10:35 AM, with the Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on | K 050 | K050 1. No residents were determined to be affected. 2. All residents have the potential to be affected. ED in-serviced maintenance director, maintenance assistant, DON on 2/05/2013 to this regulation. Competency was determined by successful verbalization reviewed by ED. The CSC in-serviced the DCE to this regulation on 2/06/13. Competency was determined by successful verbalization reviewed by CSC. 3. Maintenance Director will do quarterly fire drills on each shift and at different times starting in February 2013. ED will audit drills for unexpected times, varying conditions on each shift by reviewing sign in log and staff interview of at least two employees who participated in the drill quarterly for two quarters. 4. The ED will bring audit results to the QAPI committee for two quarterly QAPI meetings. The QAPI committee will determine if further action needs to be taken and determine the continued time schedule for further audits 5. Date of compliance 2/28/13 | |



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K 050 Continued From page 18 first, second, and third shifts.

Interview, on 01/15/13 at 10:35 AM, with the Maintenance Director revealed he was not aware the fire drills were not being conducted as required.

Interview, on 01/15/13 at 4:40 PM, with the Administrator revealed he was not aware of the requirements for conducting fire drills.

Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.

K 056 SS=D
NFPA 101 LIFE SAFETY CODE STANDARD

If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure complete

K 050

K056

K 056

1. The porch roof located at the rear exit will have sprinkler installed by 2/25/13. The company that installed the new sprinkler heads in kitchen will come in to replace the newest with heads of the same response time by 2/25/13. The light in the administrator office and the 200 hall clean linen room were removed by 2/20/13.
2. An audit was done of all roof areas that extend 48 inches have sprinkler protection. An audit of the centers sprinkler heads was completed to make sure that those in same compartment were of same response time. An audit of the center's sprinkler heads

