

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

PRINTED: 05/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185029	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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F 000	INITIAL COMMENTS A standard health survey was initiated on 05/15/12 and concluded on 05/17/12 and a Life Safety Code survey was conducted on 05/15/12 with the highest scope and severity of "F." The facility had the opportunity to correct before remedies would be recommended for imposition. A complaint investigation was initiated on 05/15/12 for Complaint #KY18234. The Division of Healthcare substantiated the allegation as verified by the evidence with no related deficiencies cited.	F 000	The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the facility policy, it was determined the facility failed to ensure one (1) of twenty-three (23) sampled residents and one (1) Un-sampled Resident #A, was assessed by an interdisciplinary team to self-administer medications. The findings include: Record review of the facility policy titled "Self-Administration of Medications" undated revealed the policy gives each resident the opportunity to self-administer medication if the facility's interdisciplinary team (IDT) has	F 176	1) This facility does have and will continue to have policies in place related to the self-administration of medications. Unsampled Resident A was assessed on May 16, 2012. No changes to the resident's plan of care were indicated. Unsampled Resident A has had no adverse outcomes related to the self-administration of the reference inhaler. The	

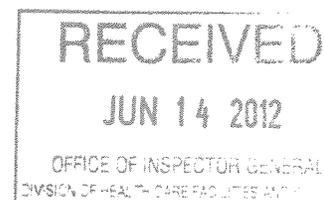
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE X <i>Raymond A. D...</i>	TITLE X <i>Executive Director</i>	(X6) DATE X <i>6/13/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution 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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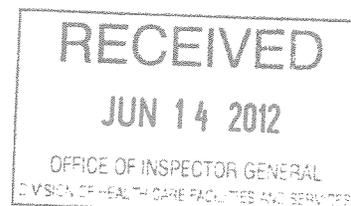
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F 176	<p>Continued From page 1</p> <p>determined that the practice would be safe for the resident. The IDT determines the resident's ability to self-administer medication by means of a skill assessment conducted on a quarterly basis. The results of the IDT assessment are recorded in the resident's medical record.</p> <p>Observation, on 05/16/12 at 7:50 AM of Un-sampled Resident #A revealed the prescribed medication Advair on the resident's bedside table during medication pass. Continued observation, on 5/17/12 at 10:55 AM, revealed Un-sampled Resident #A had Advair on his/her bedside table.</p> <p>Review of medical record for Un-sampled Resident #A revealed an assessment for self-administration of medications dated 03/29/06 was determined not applicable.</p> <p>Review of the medical record for Un-sampled Resident #A revealed a physician order dated 07/02/10 for Advair Diskus 250-50 micrograms (MCG) to inhale one (1) puff by mouth twice daily and may keep at bedside.</p> <p>The facility provided an assessment of medication for Un-sampled Resident #A for Advair Diskus dated 05/16/12 and signed by the Minimum Data Set (MDS) Coordinator.</p> <p>Review of the clinical record for Un-sampled Resident #A revealed the resident was admitted to the facility on 02/17/06 with diagnoses of Mild Dementia, Chronic Obstructive Pulmonary Disease, Hypertension, Depression, and Sleep Apnea. The facility completed a quarterly Minimum Data Set Assessment on 01/15/12</p>	F 176	<p>MDS reflects that Resident A understands and her vision is adequate to administer this medication. Resident A is independent with most ADL activity and has adequate manual dexterity.</p> <p>2) All residents were reviewed on 5/16/12 to ensure that any resident who was performing the self-administration of medications had an assessment of his/her ability to properly administer a medication(s). All assessments identified as needed with this review were completed on 5/16/12 (EXHIBIT #1). In addition, any resident that self-administers a medication will have a re-assessment completed on a quarterly basis with the interdisciplinary team conference (EXHIBIT #2).</p> <p>3) The policy and procedure on the self-administration of medication was reviewed</p>		



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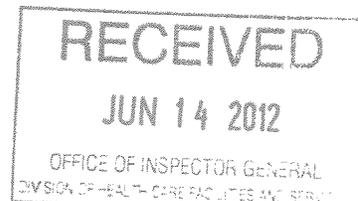
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F 176	<p>Continued From page 2</p> <p>which indicated the resident's cognition was thirteen (13). Further review of the comprehensive care plan did not address the resident's desire to self administer medications.</p> <p>Interview with Certified Medication Technician CMT #1 on 05/17/12 at 11:55 AM revealed she was not aware of the self administration assessment tool utilized by facility staff to determine the resident's ability to self administer medication, and was not provided a report for Un-sampled Resident #A's bedside medications. CMT #1 stated she received no training in orientation on how to evaluate facility residents for self administration of bedside medications.</p> <p>Interview with Register Nurse Unit Manager 1st floor, on 05/17/12 at 11:15 AM, revealed the facility policy was to assess residents upon admission and quarterly for self-administration of medications. The nurse stated she was not able to find an assessment for Un-sampled Resident #A for the use of Advair at the bedside prior to 05/16/12. She further stated the resident should have been assessed to self-administer Advair and revealed if the resident did not take Advair correctly or missed doses it could effect his/her respiratory status.</p> <p>Interview with MDS Coordinator, on 05/17/12 at 2:15 PM, revealed she was not able to find an assessment for self-administration of medication for Un-sampled Resident #A and had not attended any care plan meeting to discuss the need for the bedside administration of Advair. The MDS Coordinator confirmed the original date of the Advair at bedside order was 07/02/10. She further stated the risk for not completing the</p>	F 176	<p>and revised (EXHIBIT #3). Additionally, the pharmacy will implement monitoring monthly of medical charts to identify any resident that is shown to be self-administering medications. The pharmacy will report this information to the Director of Nursing (DON) for follow-up. Lastly, all nurses and CMTs were educated on May 31, 2012 by the Staff Development Coordinator on the required assessments and monitoring for the self-administration of medications. MAR will be written to reflect monitoring and verification of medication scheduled to be self-administered by resident (EXHIBIT #4).</p> <p>4) An indicator for the assessment of residents self-administering medications before initiation or quarterly will be added to the facility's Quality Assurance (QA) program. The indicator</p>



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F 176	Continued From page 3 self administration tool included the resident not being able to take the medication correctly, what the medication was for, and what problems the resident should report back to the nurse. Interview with the Director of Nursing (DON), on 05/17/12 at 4:00 PM, in the conference room, revealed the facility has an assessment tool to identify residents that want to self administer medication. She further stated the facility assessment for self-administration of medication for Un-sampled Resident #A was not done, it was missed, and she planned on addressing it.	F 176	will be collected by the Unit Managers. The DON will provide a report to the QA Committee monthly for 12 months. Compliance Date: July 1, 2012		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and review of the facility's policy on Falls Prevention, it was determined the facility failed to provide care and services to meet professional standards of care for one (1) of the twenty-three (23) sampled residents (Resident #10). The facility failed to ensure a personal safety alarm was placed on Resident #10, as care planned and ordered by the physician, to prevent falls. The findings include: Review of the facility's policy Falls Prevention, not dated, revealed it was the policy of the facility through assessment and intervention to provide	F 281	1) This facility has policies and systems in place for the prevention of falls. Resident #10 had an order for the wheelchair and bed alarms. The order was on the nurse's TAR, resident's care plan, and the C.N.A. assignment sheet. Resident #10's alarm was placed as ordered on her wheelchair. Resident #10 had no falls or adverse outcomes related to the falls monitor placement.		



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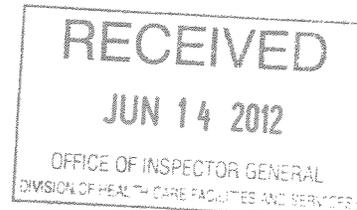
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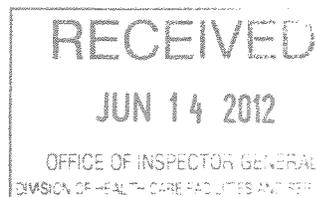
F 281	<p>Continued From page 4</p> <p>supervision and assistance to residents in an effort to avoid falls and minimize injury that may result from a resident falling. Residents identified as being at risk for falls will have a falls care plan initiated based on individual risk factors.</p> <p>Review of the clinical record revealed the facility admitted Resident #10 on 05/09/09 with the following diagnosis: Dementia with behavior disturbance, anxiety and depression. Review of the Minimum Data Set (MDS), dated 11/27/11, revealed the resident had impaired mobility and had experienced a fall, thus triggering for falls on the Care Area Assessment. Review of the resident's comprehensive plan of care revealed an intervention to have a sound alarm to bed and chair, and to ensure alarm was connected. Review of the Physician's orders, dated 05/01/12, revealed orders to have a sound alarm to the bed and the wheelchair. Review of the Certified Nursing Assistant (CNA) care plan, updated 05/09/12, revealed Resident #10 was to have a sound alarm to the wheelchair.</p> <p>Observations on 05/15/12 at 11:00 AM, 11:20 AM, 11:55 AM, 12:40 PM, 2:30 PM, 3:00 PM and on 05/16/12 at 8:30 AM, 9:55 AM, 10:30 AM, 11:30 AM, 12:45 PM revealed Resident #10 was sitting up in the wheelchair with no sound alarm in place.</p> <p>Interview with CNA #2, on 05/16/12 at 3:25 PM, revealed she did refer to the CNA care plan and knew the residents well. When asked about the location of the Resident's chair alarm, the CNA's revealed she thought the resident had one on their chair and did not know the location of the alarm.</p>	F 281	<p>2) A review of all residents with any type of adaptive/safety equipment was completed on June 2, 2012 (EXHIBIT #5). Any issues noted on the audit were resolved immediately.</p> <p>3) The policy related to care plans was updated to include the implementation of care plan interventions (EXHIBIT #6). In addition, any staff member involved with the failure to attach the falls monitor were counseled and educated by the Director of Nursing on the compliance with physician orders and his/her C.N.A. assignment sheets. Lastly, education to all nursing staff related to falls and adaptive equipment was completed on June 9, 2012 by the Staff Development Coord. (EXHIBIT # 7).</p>	
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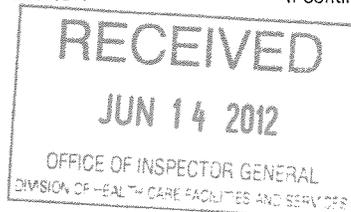
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F 281	Continued From page 5 Observation of CNA #2 and Licensed Practical Nurse (LPN) #2, on 05/16/12 at 3:27 PM, revealed a search of Resident #10's wheelchair concluding no alarm was present. Observation of CNA #2 and LPN #2's search of the resident's room revealed a sound alarm attached to the bedrail. LPN #2 removed the alarm and attached it to the resident. Review of Resident #10's May medication administration sheet (MAR) revealed LPN #2 signed that the alarm was in place on 05/15/12 and LPN #3 signed the alarm was in place on 05/16/12. Interview with LPN #2, on 05/16/12 at 3:35 PM, revealed she thought the resident was to only have a bed alarm and not a chair alarm. After Reviewing the comprehensive care plan the LPN revealed the CNA must have forgotten to place the alarm. The LPN revealed Resident #10 did occasionally attempt to get out of the wheelchair unassisted and the alarm was needed to alert the staff and prevent the resident from falling. The LPN revealed both the CNA's and the nurses should be monitoring to ensure the alarms were in place as ordered and care planned. The LPN revealed she did sign the MAR that the alarm was in place, but did not look to see it was in place. Interview with CNA #3, on 05/17/12 at 1:45 PM, revealed she thought the resident was on a pad alarm that stayed in the wheelchair and did not realize until it was brought to her attention that the resident was to use the sound alarm that was on the resident's bed. The CNA revealed the resident tends to lean over in the wheelchair to	F 281	4) An indicator for "Verification of adaptive and falls equipment in use per care plan" will be collected using a 25% sample monthly of all residents will be added to the facility's QA program. This indicator will be collected by the Unit Managers. (EXHIBIT #8). The DON will provide a report to the QA Committee monthly for 12 months. Compliance Date: July 1, 2012		



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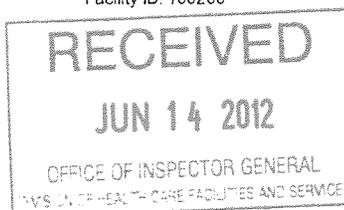
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F 281	<p>Continued From page 6</p> <p>pick things up off the floor or attempts to get out of the chair unassisted. The CNA revealed not having the alarm in place on the wheelchair created a safety issue. The CNA revealed she was aware the alarm was listed on the CNA care plan.</p> <p>Interview with LPN #3, on 05/17/12 at 1:50 PM, revealed she usually checked to make sure the resident's alarm was in place every day. However, the LPN revealed she did not actually visualize the alarm before she signed the MAR on 05/16/12.</p> <p>Interview with LPN #4, on 05/17/12 at 1:55 PM, revealed she usually rounds to ensure the resident's sound alarm was in place, but stated she did not realize it was on the wheelchair. The LPN revealed safety alarms were care planned to help ensure the residents were safe. The LPN revealed the purpose of the care plan was to ensure the residents need were met, to ensure the facility was meeting the residents needs, and to reevaluate their needs.</p> <p>Interview with the Neighborhood Unit Manager (UM), on 05/17/12 at 2:10 PM, revealed alarms were placed on the MAR and CNA assignment sheets. The UM revealed there was no official type of monitoring system in place to ensure sound alarms were placed as careplanned. The UM revealed she did look at the MAR to see if it was being signed by the nursing staff. The UM revealed she felt this was sufficient monitoring.</p> <p>Interview with Director of Nursing (DON), on 05/17/12 at 3:35 PM, revealed the resident should have an alarm in place when not in direct</p>	F 281			



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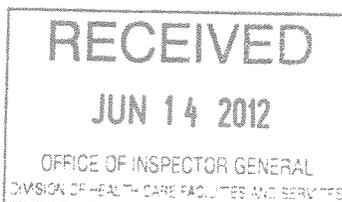
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F 281	Continued From page 7 supervision of the nursing staff. The DON revealed the CNA's did not do what they were supposed to do and it was a simple compliance issue. The DON revealed nursing staff should be following the care plan. The DON revealed care plans were monitored monthly.	F 281		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	1) This facility had and will continue to have policies and procedures on infection control practices. Resident #6 and #7 were assessed on June 12, 2012 by the Unit Manager to assure no signs or systems of infection. There were no signs or systems from Resident #6 and #7 related to the spread of infection. The facility has monitored and will continue to monitor the nosocomial infection rate on a monthly basis. 2) The nurse noted to have used a deficient practice was observed doing skin assessments on May 30, 2012. As a result, no other residents were identified to have been affected.	



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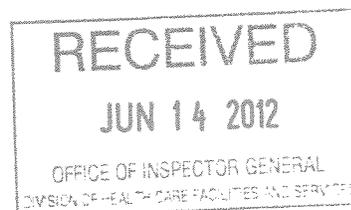
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F 441	Continued From page 8 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy on Hand Washing, it was determined the facility failed to ensure proper hand hygiene during skin assessments for two (2) of twenty-three (23) sampled residents. The findings include: Review of the facility's policy entitled Hand Washing, not dated, revealed the Staff should wash hands as necessary to prevent the spread of infection or germs. The appropriate times to wash hands are before and after caring for resident. Observation on 05/16/12 at 9:30 AM, with the Assistant Director of Nursing (ADON), in Resident #6's room, during a skin assessment, revealed the ADON touched the privacy curtain and proceeded with the skin assessment without washing her hands or applying gloves. The ADON opened the resident's brief, touched the resident's buttocks and inner thighs, and proceeded to touch the resident's upper arms, neck, and head area, without washing her hands or applying gloves.	F 441	3) Education on infection control was provided to all nursing staff on May 31, 2012 by the Staff Development Coordinator (EXHIBIT #9). In addition, a 25% sample of nursing staff were monitored by the DON and Staff Development Coordinator on May 31 and June 11, 2012 while doing care to ensure proper infection control practice. Lastly, the nurse identified in the survey report was counseled and re-educated by the DON on May 23, 2012 on compliance with infection control standards. 4) An indicator for "Verification of proper hand washing and use of gloves during care" will be collected by monthly observation of a 25% sample of nursing staff to the facility's QA program. This indicator will be collected by the Staff	



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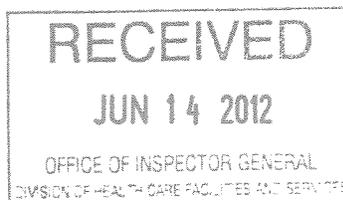
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F 441	<p>Continued From page 9</p> <p>Observation on 05/16/12 at 9:40 AM, with the Assistant Director of Nursing (ADON), in Resident #7's room, during a skin assessment, revealed the ADON touched the privacy curtain and proceeded with the skin assessment without washing her hands or applying gloves. The ADON opened the resident's brief, touched the resident's buttocks and inner thighs and proceeded to touch the resident's upper arms, neck, and head area without washing hands or applying gloves.</p> <p>Interview with the the Registered Nurse (RN) First Unit Manager on 05/17/12 at 11:30 AM revealed, she was trained to always wash hands and wear gloves when touching a resident's skin and a resident's brief. The Unit Manager said she would always remove gloves and wash her hands after touching a resident's brief, buttocks, or inner thighs, and then reapply gloves before proceeding with a skin assessment.</p> <p>On 7/17/12 at 2:20 PM, interview with CNA #4, revealed she was trained to always wash her hands and apply gloves whenever having contact with a resident. CNA #4 revealed she would always wear gloves when touching a resident's brief, inner thighs, or buttocks.</p> <p>During interview, on 5/17/12 at 3:10 PM, the ADON stated Resident #6 and #7's briefs were clean, that is why he/she opened them without wearing gloves.</p> <p>Interview with the Director of Nursing (DON), on 05/17/12 at 3:30 PM, revealed the facility's policy on hand hygiene was to wash hands before and after resident contact. Staff performing skin</p>	F 441	<p>Development Coordinator (EXHIBIT #10). The DON will provide a report to the QA Committee monthly for 12 months.</p> <p>Compliance Date: July 1, 2012</p>	



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F 441	Continued From page 10 assessments should wash their hands and apply gloves after touching privacy curtains before proceeding with skin assessments. Any area where urine could have been, gloves should be worn. The buttocks, inner thighs, and a resident's brief, are areas where urine could have been. The nurse should have removed the soiled gloves, washed her hands, and reapplied clean gloves, before proceeding with the skin assessment. Not doing this could have spread disease or bacteria.	F 441			



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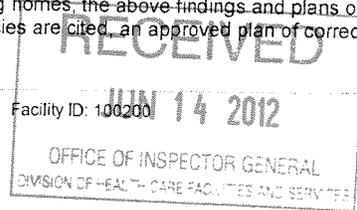
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 920 SOUTH FOURTH STREET LOUISVILLE, KY 40203
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1984</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories with a full basement, Type II unprotected.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments on each floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, wet sprinkler system.</p> <p>GENERATOR: Type II, 155 KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/15/12. Christian Health Center was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest</p>	K 000	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and/or executed solely because of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Raymond A. D...* TITLE: Executive Director (X6) DATE: 6/13/12

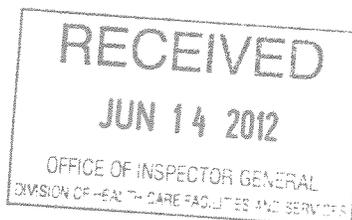
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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		
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</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 NFPA standards. The deficiency had the potential to affect three (3) of five (5) second floor smoke compartments, approximately sixty (60) residents, staff and visitors. The facility is licensed for one-hundred and twenty-two (122) beds and the census was one-hundred and fourteen (114) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 05/15/12 between 3:00 PM and 3:30 PM, with the Maintenance Director revealed three (3) of the four (4) fire resistant, rated smoke barriers located in the second floor, had been</p>	K 025	<ol style="list-style-type: none"> 1) The penetrations noted in the survey report were fixed on 5/16/12. 2) An audit of all facility smoke barrier walls will be completed by the Maintenance Director. Any identified penetrations will be fixed by the Maintenance Director. 3) The Maintenance Director will be responsible for auditing the smoke barrier walls on a monthly basis to ensure no penetrations exist. 4) An indicator for "Verification of no smoke barrier wall penetrations" will be added to the facility's QA program. The Maintenance Director will collect this indicator's data and provide a report to the QA Committee monthly for 12 months. <p>Compliance Date: July 1, 2012</p>	



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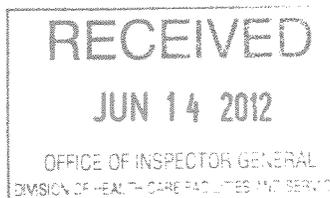
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K 025	<p>Continued From page 2</p> <p>penetrated by newly installed data lines above the ceilings. The spaces around the penetrations were not filled with a material rated equal to the smoke barrier and could not resist the passage of smoke. The two (2) barriers in the B Wing and one (1) of the two (2) barriers in the A Wing (near Rooms 217/218) where the locations were identified. The barrier in the B Wing (near Rooms 235/236) also had a penetration that had previously been sealed with a non-rated sealant which violates the integrity of the fire resistant rating.</p> <p>Interviews, on 05/15/12 between 3:00 PM and 3:30 PM, with the Maintenance Director revealed he was unaware of the penetrations in the smoke barriers and acknowledged the penetrations were a result of the newly installed data lines. It was his understanding that the Contractor installing the new data lines was required to properly seal the penetrations as part of their scope of work.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 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. <p>(b) Where the penetrating item uses a sleeve to</p>	K 025		
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K 025 Continued From page 3
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 046 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.

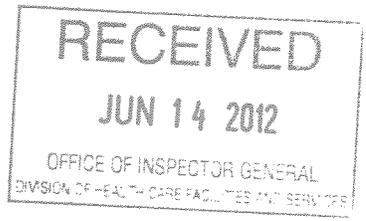
K 046

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of the five (5) basement smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and twenty-two (122) beds and the census was one-hundred and fourteen (114) on the day of the survey.

The findings include:

Observations, on 05/15/12 between 11:17 AM and 12:15 PM, with the Maintenance Director revealed two (2) emergency lights with battery powered backup did not function when tested. One (1) emergency light was located within the

- 1) The battery-powered emergency lights noted in the survey report were replaced on 5/18/12.
- 2) There are no other battery-powered emergency lights in addition to those noted in the survey report within the facility.
- 3) The Maintenance Director will be responsible for auditing both battery-powered emergency lights on a monthly basis to ensure that each light is in proper working condition.



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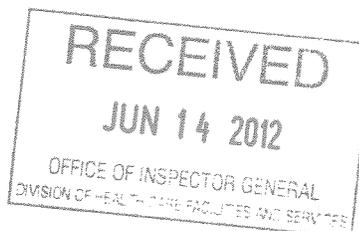
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K 046	Continued From page 4 Toilet Room outside of Physical Therapy and the other was within the Boiler Room, both located in the Basement. Interviews, on 05/15/12 between 11:17 AM and 12:15 PM, with the Maintenance Director revealed he was unaware the lights were not functioning properly. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	K 046	4) An indicator for "Verification of proper working condition of battery-powered emergency lights" will be added to the facility's QA program. The Maintenance Director will collect this indicator's data and provide a report to the QA Committee monthly for 12 months. Compliance Date: July 1, 2012	
K 147 SS=D	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 NFPA	K 147	1) The outlet noted in the survey report was changed to a Ground Fault Interrupter (GFI) outlet on May 16, 2012.	



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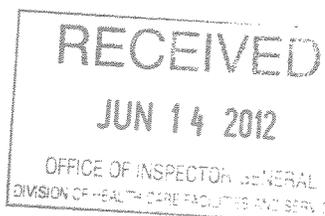
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K 147	<p>Continued From page 5 standards. The deficiency had the potential to affect one (1) of five (5) second floor smoke compartments, approximately twenty-five (25) residents, staff, and visitors. The facility is licensed for one-hundred and twenty-two (122) beds and the census was one-hundred and fourteen (114) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 05/15/12 at 7:57 AM, with the Maintenance Director revealed medical equipment (a Hydrocollator) located in the second floor Physical Therapy Room, was plugged into a standard electrical outlet, instead of a Ground Fault Circuit Interrupter (GFCI) outlet required in wet areas.</p> <p>Interview, on 05/15/12 at 7:57 AM, with the Maintenance Director revealed he was not aware of the requirement for the Hydrocollator (containing water) to be protected by plugging it into a (GFCI) outlet.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>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>2) An audit of the facility to identify any other electrical outlets that need converted to a GFI outlet was completed on May 16, 2012. Two other electrical outlets were identified for GFI conversion. The identified electrical outlets were converted by the Maintenance Director on June 13, 2012.</p> <p>3) The Maintenance Director was educated on GFCI electrical wiring and medical equipment requirements by the Administrator on June 12, 2012. The Maintenance Director will be responsible for auditing facility equipment containing water monthly to ensure continued connection to a GFI electrical outlet.</p> <p>4) An indicator for "Verification of facility equipment containing water connected to GFI electrical outlet" will be added to the facility's QA program. The</p>	
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			<p>Maintenance Director will collect this indicator's data and provide a report to the QA Committee monthly for 12 months.</p> <p>Compliance Date: July 1, 2012</p>	
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