

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

PRINTED: 10/31/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186368	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2011
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 SHEPHERD LANE BEDFORD, KY 40006	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>The annual health survey for recertification was conducted on 10/18-10/20/11. The facility was found to meet the minimum regulatory requirements with no deficiencies identified.</p> <p>A Life Safety Code survey was completed on 10/18/11 with deficiencies identified, and the highest s/s at an "F".</p>	F 000		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185358	(X2) MULTIPLE CONSTRUCTION OFFICE OF INSPECTOR GENERAL A. BUILDING: 01 - MAIN BUILDING B. WING: _____	(X3) DATE SURVEY COMPLETED 10/18/2011
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NAME OF PROVIDER OR SUPPLIER

SIGNATURE HEALTHCARE OF TRIMBLE COUNTY

STREET ADDRESS, CITY, STATE, ZIP CODE

50 SHEPHERD LANE
BEDFORD, KY 40006

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K 000

INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)
BUILDING: 01
PLAN APPROVAL: 1977
SURVEY UNDER: 2000 Existing
FACILITY TYPE: SNF/NF
TYPE OF STRUCTURE: One (1) story, Type V Unprotected
SMOKE COMPARTMENTS: Four (4) smoke compartments
FIRE ALARM: Complete fire alarm system with heat and smoke detectors
SPRINKLER SYSTEM: Complete automatic dry sprinkler system.
GENERATOR: Type II generator installed in 1978. Fuel source is Natural Gas with a Letter of Reliability.
A standard Life Safety Code survey was conducted on 10/18/11. Signature Health Care of Trimble County was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds and the census was forty seven (47) on the day of the survey.
The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from

Signature Healthcare of Trimble County does not believe and does not admit that any deficiencies existed, before, during, or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its responses, credible allegations of compliance as part of its ongoing efforts to provide quality of care to residents.

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

TITLE

(X6) DATE

Mark Witt

Administrator

11/10/11

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

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 80 SHEPHERD LANE BEDFORD, KY 40006	
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K 000	Continued From page 1 Fire)	K 000	K 027 Immediate Interventions: 10/19/11 Immediate education given to Plant Ops Dir. regarding NFPA 101-19.3.7.3 - section 8.3.2. specifying the correct fire rating resistance timeframes and materials required for these locations. Education given by corporate VP of Plant Ops, JD Ferrell. Identification of the residents with potential to be affected: 10/19/11 Plan constructed to correct attic door material per rating, proper materials ordered, installation of new fire doors to be completed by 11/18/11. Measures to prevent reoccurrence: Plant Ops Dir. to request quarterly updates on any NFPA code changes from Corporate office. Monitoring: Attic fire door inspection to be included in monthly safety committee checklist performed by Plant Ops Dir. - to be reported	10/19/11
K 027 SS=F	Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey. The findings include: Observation, on 10/18/11 at 2:45 PM, with the Plant Operation Director revealed three (3)	K 027		11/18/11

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ongoing in QA process for at least 3 months.
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K 027	Continued From page 2 unrated homemade smoke barrier access doors located in the attic. Interview, on 10/18/11 at 2:45 PM, with the Plant Operation Director revealed he was not aware the doors in the attic must be rated for use. Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 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	K 029		

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K 029	<p>Continued From page 3</p> <p>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</p> <p>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 one (1) of the four (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/18/11 at 11:00 AM, with the Plant Operation Director revealed a closet in the Administrators Office filled with a hazardous quantity of paper documents. The closet had a hollow core door, without a self closing device.</p> <p>Interviews, on 10/18/11 at 11:00 AM, with the Plant Operation Director and the Administrator revealed the Administrator had only been in the Administrators' position for two (2) months and the hazardous storage was in the closet when he started the job. The Administrator stated that he</p>	K 029	<p>K 029</p> <p>Immediate Interventions:</p> <p>10/19/11 Immediate education given to Plant Ops Dir. by corporate VP of Plant Ops, JD Ferrell regarding NFPA 101-8.3.4.1 & 19.3.5.4.</p> <p>10/19/11 Closet emptied and hazardous material removed to offsite storage.</p> <p>Identification of the residents with potential to be affected:</p> <p>10/19/11 Reviewed all other building closets for potential risk of hazardous storage. None were found.</p>	<p>10/19/11</p> <p>10/19/11</p> <p>(cont.) →</p>

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K 029 Continued From page 4
had not had time to go through the closet, and relocate the documents to a more suitable storage location.

Reference: NFPA 101 (2000 Edition).

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 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

K 029

(cont.)

Measures to prevent reoccurrence:

Audit tool for monitoring of all, 100%, closets and contents will be used weekly by Plant Ops Dir. Any deficient storage practices to be rectified immediately.

Monitoring:

The weekly audit tool to be reported and monitored for at least 3 months during QA process.

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K 050	Continued From page 6 Interview, on 07/27/11 at 1:30 PM, with the Maintenance Staff, and the Administrator revealed they were unaware the fire drills were not being conducted as required.	K 050	Measures to prevent reoccurrence: Fire Drill occurrence log including drill times to be given monthly to ADON-QA officer for review to ensure compliance and to prevent reoccurrence. Monitoring: Fire Drill occurrence log to be reported on through QA process for at least 3 months.	
K 056 SS=F	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. 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 the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and	K 056	K 056 Immediate Interventions: 10/19/11 Immediate identification of safety risk. Education given to Plant Ops Dir. by corporate VP of Plant Ops, JD Ferrell regarding NFPA 13 and 25 - 19.3.5 Identification of the residents with potential to be affected: 10/19/11 Fire extinguishers located within acceptable distance of affected areas For use in case of fire occurrence in affected area until enhanced sprinkler system installed.	10/19/11 10/19/11

(cont.) →

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K 056 Continued From page 7
visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey.

The findings include:

Observation, on 10/18/11 at 11:05 AM, with the Plant Operation Director revealed three (3) porches located outside exit doors throughout the facility to extend out four (4) foot or greater, made of combustible materials, and were not sprinkler protected. The porches are located by the MDS Office, the Conference Room, and the Front Porch.

Interview, on 10/18/11 at 11:05 AM, with the Plant Operation Director revealed he was not aware the porches needed to be sprinkler protected.

Reference: NFPA 13 (1999 Edition) 5-13 8.1

Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.

K 056
(Cont.)

Measures to prevent reoccurrence:

Reviewed and assessed further structural fire sprinklers to ensure no other sprinkler areas are non-compliant. There were none found.

Additional Fire sprinkler system consulted and materials ordered per Century Fire Systems Co. Installation has been quoted by Century Fire to be completed by 11/28/11

The affected areas are designated No Smoking. The residents smoking area is located elsewhere under a sprinkled cover. Automobiles can not physically pull/park under the affected overhangs. No Smoking signs have been placed in the affected areas as of 11/10/11.

Monitoring:

Any/all future renovations, additions, or remodels will be ensured to meet the Fire Safety sprinkling requirements in accordance with NFPA 13 and 25 - 19.3.5.

11/28/11

11/10/11

K 062 SS=D
Reference: NFPA 13 (1999 Edition)
NFPA 101 LIFE SAFETY CODE STANDARD

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

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K 062	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey. The Findings Include: Observation, on 10/18/11 at 1:30 PM, with the Plant Operation Director revealed items being stored within 18 inches of a sprinkler head located in the Conference Room Closet. Interview, on 10/18/11 at 1:30 PM, with the Plant Operation Director revealed dietary used the closet to store extra items and he was not aware someone had placed items in the closet so close to the sprinkler head. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous	K 062	K 062 Immediate Interventions: 10/19/11 Immediate education given to Plant Ops Dir. by facility ADON-QA officer Shawna Mahoney, RN, BSN regarding requirements and guidelines of closet storage relating to distance from sprinkler heads. NFPA 13 & 25 19.7.6, 4.6.12, 9.7.5. Identification of the residents with potential to be affected: 10/19/11 Inspected and evaluated all closets in facility to check for non-compliance. There were none found. Measures to prevent reoccurrence: Audit tool in use for weekly checks by Plant Ops Dir. to ensure closet storage is in compliance. Any occurrences of non-compliance to be addressed and corrected immediately upon finding. 11/4/11 Education – Inservice given by Shawn Raisor, Plant Ops Dir., to all staff regarding proper closet storage in relation to fire sprinkler heads.	10/19/11 10/19/11 11/4/11 (cont.) →

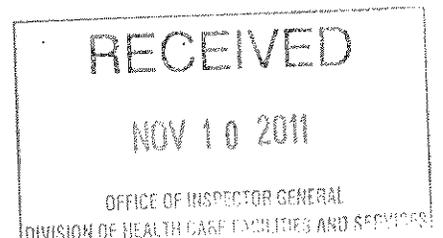
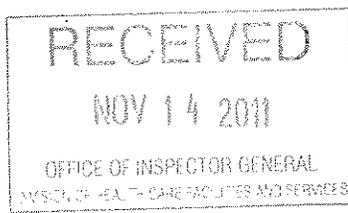
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K 062	Continued From page 9 obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. Reference: NFPA 13(1999 edition) 6-1.1.5 Sprinkler piping or hangers shall not be used to support nonsystem components. Reference: NFPA 25 (1999 Edition). 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062 <i>(cont.)</i>	Monitoring: Audit tool findings to be tracked and reported on during QA process for at least 3 months.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 072	K 072 Immediate Interventions: 10/19/11 Immediate education of all on-duty staff and removed from halls all equipment causing this non-compliance. Alternate storage for equipment designated as East Hall storage closet and West Hall storage closet. Further education given to oncoming staff shift.	10/19/11 <i>(cont.)</i> →



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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY	STREET ADDRESS, CITY, STATE, ZIP CODE 60 SHEPHERD LANE BEDFORD, KY 40006
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K 072

Continued From page 10
determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey.

The findings include:

Observation, on 10/18/11 at 11:29 AM, with the Plant Operation Director revealed linen carts, and lifts, were being stored in the East, and West Halls. The lifts were plugged into the wall receptacles of the corridor for charging.

Interview, on 10/18/11 at 11:29 AM, with the Plant Operation Director revealed the facility routinely stored linen carts and lifts in the corridor.

Reference: NFPA 101 (2000 Edition)
Means of Egress Reliability 7.1.10.1
Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.

K 130
SS=D

NFPA 101 MISCELLANEOUS
OTHER LSC DEFICIENCY NOT ON 2786

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This

K 072

Cont.

Identification of the residents with potential to be affected:

All hallways in building were inspected for non-compliant equipment being present. There was none.

Measures to prevent recurrence:

Ongoing weekly audit tool conducted by Plant Ops Dir. to ensure hallways free and clear of any egress obstruction by equipment. Any occurrences of non-compliance to be immediately rectified by Plant Ops Dir.

11/4/11 Inservice-Education given by, Shawn Raisor, Plant Ops Dir. to all staff on reminder of clear hallways and procedures for proper storage of facility equipment.

Monitoring:

Audit tool results to be reported during QA process for at least 3 months.

11/4/11

K 130

K 130

Immediate Interventions:

10/19/11 Plant Ops Dir. Removed all interior latches on all identified (4) doors.

10/19/11

(cont.)

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K 130	Continued From page 11 deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds, with a census of forty seven (47) on the day of the survey. The findings include: Observation, on 10/18/11 at 10:55 AM, with the Plant Operation Director revealed an unapproved lock (slide bolt type) was installed on the egress side of two (2) public restroom doors located in the East Hall near the nurses' station. Interview, on 10/18/11 at 10:55 AM, with the Plant Operation Director revealed they were aware of the locks, but not aware they could not be used. Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130 (cont.)	Identification of the residents with potential to be affected: 10/19/11 Plant Ops Dir. then further evaluated all other doors to identify possibility of any other interior latches present, and for potential deficiencies in meeting this regulation. There were none. Measures to prevent reoccurrence: 10/19/11 Educated all staff and placed signs with information regarding change in door latches. 11/4/11 Inservice-Education for all staff given by Shawn Raisor, Plant Ops. Dir., on status of latches and plan to correct deficiency. Education on use of new installed door locks along with locations of emergency key. Monitoring: 10/19/11 Plant Ops Dir. began ongoing weekly monitoring with audit tool of all doors to ensure compliance. Report of audit tool findings to be made in QA meetings for at least 3 months.	10/19/11 10/19/11 11/4/11 10/19/11
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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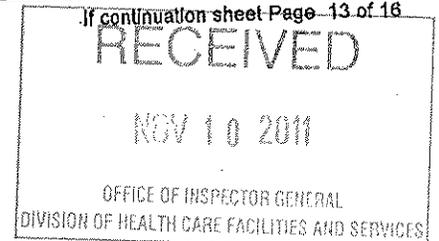
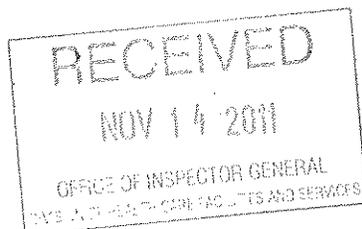
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K 144	<p>Continued From page 12</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation, on 10/18/11 at 11:10 AM, with the Plant Operation Director revealed the annunciation panel for the emergency generator located at the nurses' station was not functional.</p> <p>Interview, on 10/18/11 at 11:10 AM, with the Plant Operation Director revealed he was not aware the annunciation panel did not function.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator</p>	K 144	<p>K 144</p> <p>Immediate Interventions:</p> <p>10/19/11 Immediate education of Plant Ops Dir. given by corporate VP of Plant Ops, JD Ferrell, on requirements and importance of proper panel function related to generator.</p> <p>Identification of the residents with potential to be affected:</p> <p>10/19/11 Education given to Plant Ops Dir. by corporate VP of Plant Ops, JD Ferrell, on proper testing procedures to ensure panel is correctly working.</p> <p>Measures to prevent recurrence:</p> <p>10/24/11 Repair of defective part in Annunciator panel, performed by Plant Ops Dir.</p> <p>Plant Ops Dir. to use audit tool on weekly tests on annunciator panel.</p> <p>Monitoring:</p> <p>Results of audit tool findings to be reported in QA process for at least 3 months.</p>	<p>10/19/11</p> <p>10/19/11</p> <p>10/24/11</p>
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K 144	Continued From page 13 alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of forty seven (47) on the day of the survey. The findings include:	K 147	K 147 Immediate Interventions: 10/18/11 Immediate removal of all high-voltage-draw and medical equipment from any power strips, performed by Plant Ops Dir. All plugs placed in appropriate mounted wall outlets. 10/19/11 Plant Ops Dir. educated by corporate VP of Plant Ops, JD Ferrell, and facility ADON-QA officer, Shawna Mahoney, RN, BSN, regarding identification of high-voltage-draw equipment and medical equipment.	10/18/11 10/19/11

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K 147	<p>Continued From page 14</p> <p>Observation, on 10/18/11 between 10:30 AM and 4:00 PM, with the Plant Operation Director revealed:</p> <ol style="list-style-type: none"> 1) A nebulizer plugged into a power strip located in room #106, and 129. 2) A refrigerator and a microwave plugged into a power strip located in the Staff Development Office. 3) A resident bed plugged into a power strip located in room #124. 4) A power strip plugged into another power strip in a mechanical closet located in the Social Services Office. 5) A refrigerator plugged into a power strip located in the dietary storage. 6) A juice machine pump and a microwave plugged into a power strip located in the Kitchen. 7) A refrigerator plugged into a power strip located in the Central Supply Room. <p>Interview, on 10/18/11 between 10:30 AM and 4:00 PM, with the Plant Operation Director revealed he was not aware medical equipment and high electrical draw items could not be plugged into power strips.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number</p>	K 147	<p>Identification of the residents with potential to be affected:</p> <p>10/19/11 entire building checked for high-voltage-draw and/or medical equipment being plugged into power strips. There were no other occurrences found. On-duty staff informed by Plant Ops Dir. about proper guidelines of power strip use. Verbally passed on to subsequent shift.</p> <p>Measures to prevent reoccurrence:</p> <p>11/4/11 formal inservice-education given to all staff by Shawn Raisor, Plant Ops. Dir., on guidelines for use of power strips within facility.</p> <p>Weekly audit tool to be used while inspecting all rooms for improper use of power strips, performed by Plant Ops Dir. Any non-compliant occurrences to be corrected immediately.</p> <p>Monitoring:</p> <p>Weekly audit tool findings to be reported and monitored thru QA process for at least 3 months.</p>	10/19/11 11/4/11

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K 147	Continued From page 15 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.	K 147		

