

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

PRINTED: 05/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185387	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2013
NAME OF PROVIDER OR SUPPLIER T J SAMSON COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RACE ST GLASGOW, KY 42141	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 05/14/13 through 05/16/13. A Life Safety Code Survey was conducted on 05/15/13. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164	F 164 <u>5-16-13</u> Immediately after administering injection in the front of the surveyor, the nurse went to the supervisor and discussed her care provided including failure to close the door appropriately prior to the injection. Nursing Supervisor reinforced privacy responsibility and verified that nurse's routine practice was to close the patient door and also pull the privacy curtain when the resident is in a semi private room at any time the resident is at risk for exposure including injections. The nurse in question had transferred to this unit within the past year and completed orientation under the supervision of a preceptor who had also included patient rights as a part of routine care. Prior to this event, no other non-compliance with patient privacy had been identified to our knowledge through observation or patient / family complaint.	

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

TITLE

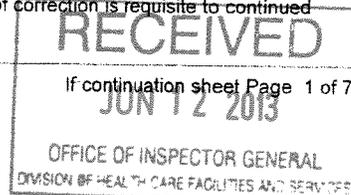
(X6) DATE

X Shendy Moore, MSN, LVNA

X Admin

X 6-11-13

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.

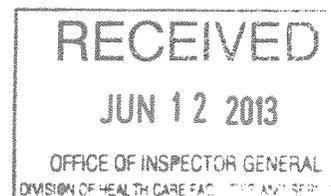


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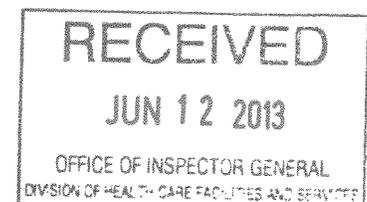
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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, Patient Rights and Responsibilities, it was determined the facility failed to provide privacy during administration of a subcutaneous (SQ) injection for one (1) of eight (8) sampled residents and one (1) unsampled residents (Unsampled Resident A). The staff left the door to the hallway open leaving the resident's abdomen visible for staff and visitors passing by during an injection. The findings include: Review of the facility's policy regarding Patients Rights and Responsibilities, revised on August 2007, revealed the patient had the right, within the law, to personal and informational privacy, as manifested by the following rights to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy. Observation during the medication pass, on 05/15/13 at 9:05 AM, revealed LPN #2 prepared a Lovenox injection (blood thinning medication) to be administered to Unsampled Resident A. LPN #2 raised the resident's gown, and exposed the abdomen prior to administering the injection. The outside door to the resident's room had been left open, allowing staff and visitors passing by to visualize the resident's exposed abdomen. The door was closed after surveyor intervention. In addition, during the preparation of the injection, the Occupational Therapist (OT) was in the room	F 164	6-4-13 During regularly scheduled monthly staff meeting, Nursing Coordinator and Case Manager presented education to staff members on role in ensuring resident privacy and the Patient Rights. All staff members were given the Patient Rights that are included in the resident admission packet and required to review current policy and document that they have read and understand their role in maintaining resident privacy and confidentiality. All employees completed requirement 6-10-13. A new quality indicator was initiated. RN supervisor will monitor LPNs during medication passes to ensure patient privacy is maintained. Compliance will be monitored monthly and reported to QA committee quarterly. Any identified non-compliance will be immediately addressed according to current HR policy of verbal, written, suspension and possible termination in escalating order.	6-11-13	



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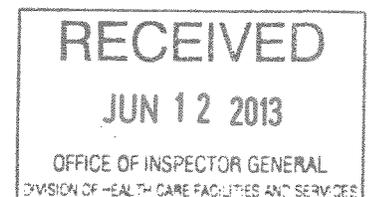
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F 164	Continued From page 2 talking with the resident, and was not asked to leave the room until the door was closed after surveyor intervention. Unsampled Resident A was observed during the procedure trying to pull her gown down to prevent exposing his/her abdomen. Interview with the resident, on 05/15/13 at 9:40 AM, revealed no evidence of distress regarding the incident, and stated he/she was all right. Interview with LPN #2, on 05/15/13 at 9:30 AM, revealed she should have closed the resident's door when she gave the injection. The LPN stated she wasn't thinking, because the therapist was in the room talking to the resident, and this had distracted her. The LPN stated the policy was to provide privacy at all times for residents. Interview with the Department Director, on 05/16/13 at 7:00 AM, revealed LPN #2 should have closed the door immediately, and provided privacy to the resident prior to giving the injection, and even though distracted by the therapist, should have known to do this. The Department Director stated that was the facility's policy.	F 164			
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.	F 167	F 167 5-16-13 Upon notification by surveyor of missing most recent survey results in Resident Information Welcome Binder, a copy was reprinted and replaced in binder. The report was also shown to both surveyors. Administrator will also place this completed POC in binder and check binder monthly to assess for need to print and replace missing report.		6-12-13



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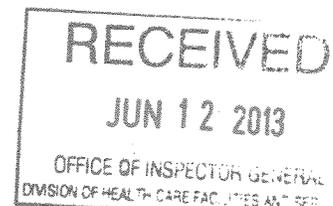
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F 167	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the survey result book, and review of the facility's policy, it was determined the facility failed to provide the most recent survey results for 2012 for all residents to review. The findings include: Review of the facility's Informational Welcome Booklet, not dated, which was provided to each resident upon admission to the facility, under section Examination of Survey Results, revealed the resident had 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. Observation of the survey book, located in the sitting room across from the nurse's station, on 05/14/13 at 2:00 PM, revealed no evidence the survey results from the previous survey in 2012 was in the book. Interview with the Department Director, on 05/16/13 at 8:00 AM, revealed she was not aware the survey statement of deficiencies with plan of correction had to be in the survey book. Interview with the Director of Quality Management, on 05/16/13 at 12:30 PM, revealed she had the survey results in her office; however, she did not know they had not been placed in the survey book.	F 167			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	F 371 5-14-13 Immediately following		



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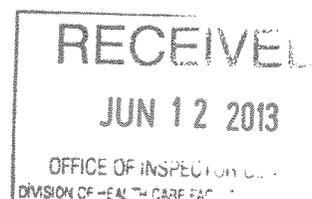
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F 371	<p>Continued From page 4</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the cleaning schedule, it was determined the facility failed to prepare and serve food under sanitary conditions. Observation revealed three (3) uncovered trash cans with food debris in the food prep area of the kitchen. The menu clerk was observed walking in the kitchen without a hair net to contain her long hair during tray line service. In addition, a metal rack in the dish room had heavy build-up of food spillage of red, brown, and black substances.</p> <p>The findings include: The facility provided a cleaning schedule for the metal rack that indicated all metal racks would be delimed weekly. The facility did not provide a policy for covering trash cans and covering of hair.</p> <p>Observation during tour of the kitchen, on 05/14/13 at 9:00 AM, revealed an uncovered trash can in the salad room with food debris inside. Continued tour of the kitchen revealed two</p>	F 371	<p>surveyor's review of Dietary Department, findings were addressed. The Certified Dietary Manager addressed the following two issues:</p> <ol style="list-style-type: none"> 1) Kitchen staff were inserviced <u>5/14/13</u> on covering trash cans when food production is not taking place to avoid cross-contamination or unsanitary conditions. Replacement lids were ordered for the trash cans. Plastic sheeting was used in the interim period to cover the cans until replacement lids arrived. Trash Can Lids were received <u>5-24-13</u> for each trash can. On a daily basis, the Supervisor is monitoring compliance by direct observation and providing immediate reinforcement of policy if non-compliance is observed according to current HR policy of verbal, written, suspension and possible termination. 2) The non-compliant staff member was informed of policy and informed of no tolerance for non-compliance immediately following the survey process. All kitchen staff members were inserviced <u>5/14/13</u> on hair net / hair covering use in kitchen area. Supervisor is monitoring compliance of hair 	



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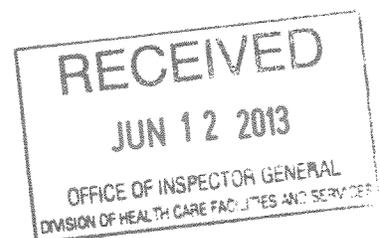
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F 371	Continued From page 5 additional trash cans without lids in the food prep areas. Interview with the Dietary Manager, who was present during the observation at 9:00 AM, revealed the trash cans should be covered when not in use. Observation of the dish room, on 05/14/13 at 9:30 AM, revealed a metal rack (four shelves) empty, sitting against the wall across from the dishwasher. The metal rack were observed to have a heavy build-up of food spillage of red, black, and brown substances. Review of the cleaning schedule for the kitchen, revealed the metal racks were to be delimed weekly. There were no other cleaning schedules for the metal racks. Interview with the Dietary Manager, on 05/14/13 at 11:30 AM, revealed the metal racks were supposed to be washed down daily. She stated it appeared the metal rack in the dish room had not been cleaned for awhile. There were no particular kitchen staff assigned to clean the metal racks. Observation during the tray line service for lunch, on 05/14/13 at 11:00 AM, revealed the menu clerk walked through the kitchen without her long hair contained by a hair net or ball cap. The kitchen staff was preparing food trays to be delivered to the residents. Other dietary staff were preparing additional food for the meal. Interview with the menu clerk, on 05/14/13 at 11:10 AM, revealed she had walked through the kitchen to give a dietary staff a phone message and	F 371	covering by direct observation daily and will immediately address non-compliance according to current HR policy of verbal, written, suspension and possible termination in escalating order. The Executive Chef addressed the following identified issue: 1) Porters were inserviced on <u>4-25-13</u> on delime process. At time of survey, racks were visibly soiled and checklist indicated cleaning had not been completed as required. Non-compliance was immediately addressed and reminded of required cleaning discussed during 4-25-13 inservice. Dish racks were delimed <u>5-14-13</u> and will be completed on a weekly basis to prevent build up on racks and prevent cross-contamination during wash process. Supervisor will monitor compliance of cleaning daily and weekly deliming by direct observation and review of documentation on daily log including inspection of dish room and will provide immediate reinforcement of policy when non-compliance is observed according to current HR policy of verbal, written, suspension and possible termination.		



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F 371	Continued From page 6 forgot to put a hair net on. She stated she knew she should have put on a hair covering before entering the food area. She revealed she normally does not work in the kitchen but in an office beside the kitchen, printing menus for the residents.	F 371	Three additional quality indicators have been initiated in Dietary Department: 1) Maintaining closed lids on trash cans when food production is not taking place. 2) Monitoring staff to ensure hair is properly covered in food prep, production and serving areas by all staff members. 3) Dish Room is appropriately cleaned on a daily a daily basis including deliming of dish racks on a weekly basis. The Executive Chef will monitor compliance on all the additional indicators and report outcomes quarterly to Performance Improvement Committee (PIC).	5/25/2013	



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1971</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Type I (443)</p> <p>SMOKE COMPARTMENTS: One (1) smoke compartment</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 generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/15/13. TJ Sampson Community Hospital was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for sixteen (16) beds with a census of eleven (11) 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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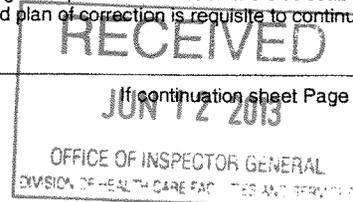
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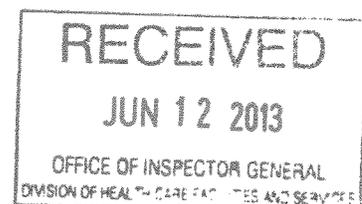
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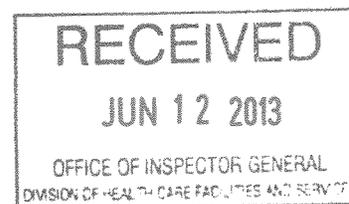
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K 038 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of one (1) smoke compartments, residents, staff, and visitors. The facility is certified for sixteen (16) beds with a census of eleven (11) on the day of the survey. The facility failed to ensure the means of egress were free of obstructions and impediments.</p> <p>The findings include:</p> <p>Observation, on 05/15/13 at 3:37 PM, with the Plant Engineer revealed a twelve inch or greater step outside the exit door from the South Stairwell.</p> <p>Interview, on 05/15/13 at 3:37 PM, with the Plant Engineer revealed he was not aware the sidewalk had fallen and created too large of a step.</p>	K 038	<p>K 038</p> <p><u>5/15/13</u> After surveyor completed assessment, Director of Maintenance assessed acute care areas for risk of evacuation via same exit, it was identified that third floor south and west wings would also use the same stairwell as an egress route. No other exits were identified as a risk other than the one identified by the surveyor.</p> <p><u>5-29-13</u> A work order was submitted to Maintenance Department, "OIG findings on SNU," to add a concrete step on sidewalk threshold to allow access from doorway to sidewalk. Maintenance contacted and obtained a verbal contract on <u>5/29/13</u> with Alliance Corporation to install landing.</p> <p><u>6/3/13</u> Landing installed and completed with Director of Maintenance approval. Current process is to do a Hazardous Survey of facility twice a year to assess for compliance and risks for life safety threats. Any identified issue is followed up with a work order request and reported through the facility Life Safety Committee monthly. The following month the committee assesses completeness of work orders and</p>	



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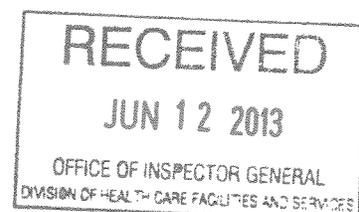
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K 038	Continued From page 2 Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. Reference NFPA 101 (2000 edition) 19.2.2.3 Stairs. Stairs complying with 7.2.2 shall be permitted	K 038	addresses any unresolved issues. The process will be updated to include exterior egress access and be included in current quality assurance reporting process.	6-4-13



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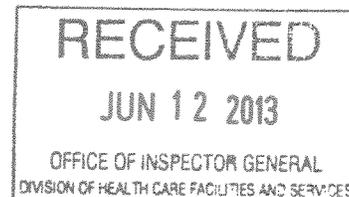
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185387	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2013
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K 038	Continued From page 3 7.2.2 Stairs. 7.2.2.1 General. Stairs used as a component in the means of egress shall conform to the general requirements of Section 7.1 and to the special requirements of this subsection. Exception No. 1: This requirement shall not apply to aisle stairs as provided in Chapters 12 and 13. Exception No. 2: This requirement shall not apply to existing noncomplying stairs where approved by the authority having jurisdiction. 7.2.2.2 Dimensional Criteria. 7.2.2.2.1 Standard Stairs. Stairs shall be in accordance with the following: (a) New stairs shall be in accordance with Table 7.2.2.2.1(a). Exception: This requirement shall not apply to industrial equipment access areas as otherwise provided in Chapter 40. Table 7.2.2.2.1(a) New Stairs Minimum width clear of all obstructions, except projections not more than 3 1/2 in. (8.9 cm) at or below handrail height on each side 44 in. (112 cm); 36 in. (91 cm) where total occupant load of all stories served by stairways is fewer than 50 Maximum height of risers 7 in. (17.8 cm) Minimum height of risers 4 in. (10.2 cm) Minimum tread depth 11 in. (27.9 cm) Minimum headroom 6 ft 8 in. (203 cm) Maximum height between landings 12 ft (3.7 m) Landing(See 7.2.1.3 and 7.2.1.4.4.) (b) * Existing stairs shall be permitted to remain in use, provided that they meet the requirements for existing stairs shown in Table 7.2.2.2.1(b).	K 038			



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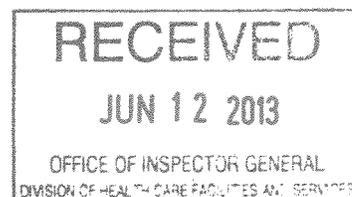
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K 038	Continued From page 4 Where approved by the authority having jurisdiction, existing stairs shall be permitted to be rebuilt in accordance with the dimensional criteria of Table 7.2.2.1(b) and in accordance with other Code requirements in 7.2.2 for stairs. Table 7.2.2.1(b) Existing Stairs Feature Class A Class B Minimum width clear of all obstructions, except projections not more than 31/2 in. (8.9 cm) at or below handrail height on each side 44 in. (112 cm) 44 in. (112 cm) 36 in. (91 cm) where total occupant load of all stories served by stairways is fewer than 50 Maximum height of risers 7 1/2 in. (19.1 cm) 8 in. (20.3 cm) Minimum tread depth 10 in. (25.4 cm) 9 in. (22.9 cm) Minimum headroom 6 ft 8 in. (203 cm) 6 ft 8 in. (203 cm) Maximum height between landings 12 ft (3.7 m) 12 ft (3.7 m) Landing (See 7.2.1.3 and 7.2.1.4.4.) Exception: This requirement shall not apply to industrial equipment access areas as otherwise provided in Chapter 40.	K 038		
K 045 SS=F	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	K 045	K 045 5/15/13 After surveyor completed assessment, Director of Maintenance assessed acute care areas for risk of evacuation via same exit, it was identified that third floor south and west wings would also use the same stairwell as an egress route. Director of	



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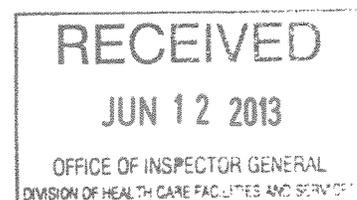
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K 045	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of one (1) smoke compartments, residents, staff and visitors. The facility is certified for sixteen (16) beds with a census of eleven (11) on the day of the survey. The facility failed to provide required illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observation, on 05/15/13 between 10:30 AM and 5:00 PM, with the Plant Engineer revealed the exits located in South Stairwell and by the Case Management Office did not have a light installed outside to provide the required illumination for exit discharge. The exits were equipped with a light fixture with only one bulb installed.</p> <p>Interview, on 05/15/13 between 10:30 AM and 5:00 PM, with the Plant Engineer revealed he was not aware the exits did not have the required illumination for egress lighting.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>18.2.7 Discharge from Exits.</p> <p>Discharge from exits shall be arranged in accordance with Section 7.7.</p>	K 045	<p>Maintenance identified no other exit light concerns during his walk through assessment that day. During daily rounds, Security assesses lighting and reports any outages to maintenance department in the form of a work order. Work order completion rate is currently monitored in the QA of the Maintenance Department.</p> <p><u>5-29-13</u> A work order submitted to Maintenance Department, "OIG findings on SNU," requesting an additional exterior lighting be added to both stairwells located at each end of the hallway: Case Management and South Exits. <u>5-30-13</u> Maintenance Department completed lighting installation as requested to both exterior fire exits.</p> <p>In addition, Security Safe does daily rounds to visually identify concerns. Current process includes a Hazardous Survey by Safety Officer and others of facility twice a year to assess for compliance and risks for life safety threats. Any identified issue is followed up with a work order request and reported through the facility Life Safety Committee monthly. The following month the committee assesses</p>	



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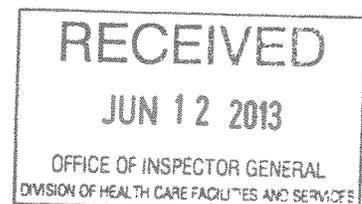
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K 045	Continued From page 6 18.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8. 7.7 DISCHARGE FROM EXITS 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23. 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1) through (3) are met: (1) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (2) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the	K 045	completeness of work orders and addresses any unresolved issues. The process was updated <u>6/10/13</u> to include exterior egress access, including lighting and be included in current quality assurance report process.	6/11/13



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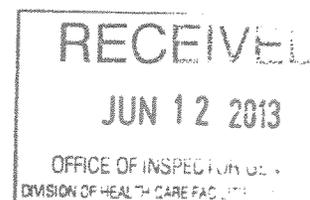
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K 045	Continued From page 7 portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1). Exception: The requirement of 7.7.2(2) shall not apply where the discharge area is a vestibule or foyer meeting all of the following: (a) The depth from the exterior of the building shall not be more than 10 ft (3 m) and the length shall not be more than 30 ft (9.1 m). (b) The foyer shall be separated from the remainder of the level of discharge by construction providing protection not less than the equivalent of wired glass in steel frames. (c) The foyer shall serve only as means of egress and shall include an exit directly to the outside. (3) The entire area on the level of discharge shall be separated from areas below by construction having a fire resistance rating not less than that required for the exit enclosure. Exception No. 1: Levels below the level of discharge shall be permitted to be open to the level of discharge in an atrium in accordance with 8.2.5.6. Exception No. 2: One hundred percent of the exits shall be permitted to discharge through areas on the level of exit discharge as provided in Chapters 22 and 23. Exception No. 3: In existing buildings, the 50 percent limit on egress capacity shall not apply if the 50 percent limit on the required number of exits is met. 7.7.3 The exit discharge shall be arranged and marked	K 045		



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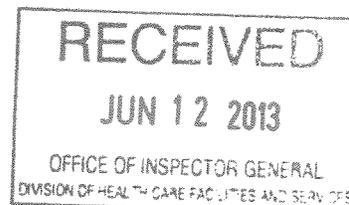
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K 045	Continued From page 8 to make clear the direction of egress to a public way. Stairs shall be arranged so as to make clear the direction of egress to a public way. Stairs that continue more than one-half story beyond the level of exit discharge shall be interrupted at the level of exit discharge by partitions, doors, or other effective means. 7.7.4 Doors, stairs, ramps, corridors, exit passageways, bridges, balconies, escalators, moving walks, and other components of an exit discharge shall comply with the detailed requirements of this chapter for such components. 7.7.5 Signs. (See 7.2.2.5.4 and 7.2.2.5.5.) 7.7.6 Where approved by the authority having jurisdiction, exits shall be permitted to discharge to roofs or other sections of the building or an adjoining building where the following criteria are met: (1) The roof construction has a fire resistance rating not less than that required for the exit enclosure. (2) There is a continuous and safe means of egress from the roof. 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	K 045		



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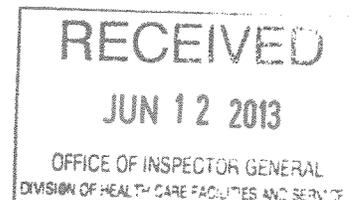
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K 045	Continued From page 9 of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous 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 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. 7.8.1.3* 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. 7.8.1.4* 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	K 045		



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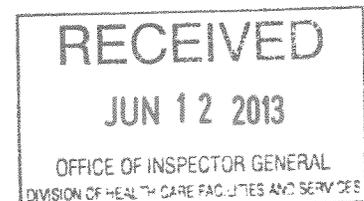
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K 045	Continued From page 10 ft-candle (2 lux) in any designated area. Reference: NFPA 101 (2000 Edition) 19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.	K 045		
K 056 SS=F	NFPA 101 LIFE 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 one (1) of one (1) smoke compartments, residents, staff and visitors. The facility is certified for sixteen (16) certified beds with a census of eleven (11) on the day of the survey. The facility failed to ensure the facility had complete sprinkler coverage installed	K 056	K 056 <u>5/15/13</u> At the time of survey, Life Safety Surveyor reviewed the NFPA 101 components of the sprinkler system requirements, specifically NFPA 72, Supervisory Signal requirement for sprinkler systems and monitored for integrity and NFPA 13, clearance requirement of 12 inches for all sprinkles to prevent flow obstruction as a method to educate Maintenance Director of these requirement. <u>5-29-13</u> A work order was submitted to Maintenance Department, "OIG findings on SNU," to correct the following non-compliance: 1) <u>Electronic supervision of PIV-</u> Secure fire alarm PIV located at helipad to prevent tampering. <u>5/31/13</u> Director of Maintenance further investigated PIV vault and identified electronic supervision by the fire alarm system to be in place. The system is set up to flag in the Maintenance Department if a tamper	



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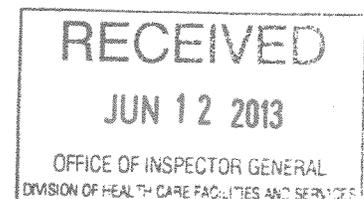
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K 056	<p>Continued From page 11 to meet NFPA standards.</p> <p>The findings include:</p> <p>Observation, on 5/15/13 at 1:53 PM, with the Facility Engineer revealed Post Indicator Valve (PIV) located outside by the Helipad was not electronically supervised by the Fire Alarm System.</p> <p>Interview, on 5/15/13 at 1:53 PM, with the Facility Engineer revealed he was not aware the PIV valve was not electronically supervised</p> <p>Observation, on 5/15/13 at 3:47 PM, with the Facility Engineer revealed light fixtures installed within twelve (12) inches of a sprinkler head located in the Directors Office, Clean Utility Room by the Nurses' Station, and the resident laundry room.</p> <p>Interview, on 5/15/13 at 3:47 PM, with the Facility Engineer revealed he was not aware of the requirement.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>9.7.2.1* Supervisory Signals. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the</p>	K 056	<p>occurs and also alarm at the switch board. The Switchboard operator notifies Maintenance immediately in the event the alarm is flagged. Maintenance Director of designee investigates and corrects the issue. The system was assessed to be in compliance and operational. Maintenance Director oversees report to ensure compliance is maintained.</p> <p>2) <u>Sprinkler Head Clearance</u> - Change or move light fixtures to provide 12 inch clearance around sprinkler located on the ceiling in:</p> <ul style="list-style-type: none"> a) Director's office b) Clean utility room c) Laundry room <p>Maintenance moved light fixture in Director's office to exceed 12 inches from sprinkler head on <u>6/7/13</u>. Maintenance replaced two existing light fixtures in Clean Utility room with four recessed light fixtures on <u>6/7/13</u>. Maintenance replaced light fixture in Laundry Room with a shorter fixture that is greater than 12 inches from sprinkler head on <u>6/7/13</u>. <u>6/10/13</u> Director of Maintenance completed a walk through and assessed entire skilled unit, identifying no additional light fixtures closer than 12 inches to any</p>	



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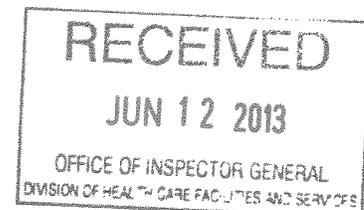
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K 056	Continued From page 12 sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to	K 056	sprinkler head. Any remodeling or construction within the facility includes the use of drop ceilings in which recessed lighting is utilized providing unobstructed flow for sprinkler heads. Current process includes a Hazardous Survey of facility by Safety Officer and others twice a year to assess for compliance and risks for life safety threats. Any identified issue is followed up with a work order request and reported through the facility Life Safety Committee monthly. The following month the committee assesses completeness of work orders and addresses any unresolved issues. The process was updated <u>6/10/13</u> to include sprinkler head clearance and be included in current quality assurance report process.	6-11-13



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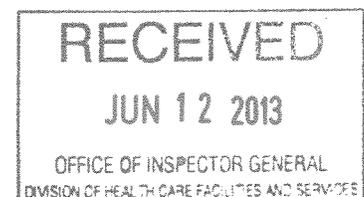
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K 056	Continued From page 13 activation time and distribution. Reference: NFPA 13 (1999 Edition) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)	K 056																										
	<p style="text-align: center;">Maximum Allowable Distance</p> <table border="0"> <tr> <td style="text-align: right;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td style="text-align: right;">of Deflector Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 Edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18			
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)																											
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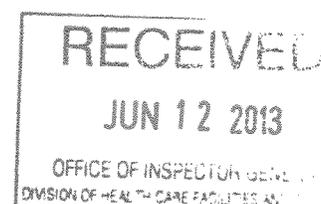
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K 056	Continued From page 14 Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. 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. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all	K 056		



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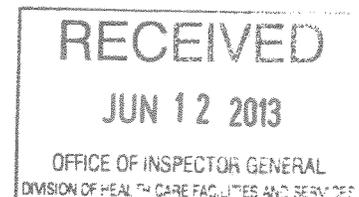
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K 056	<p>Continued From page 15</p> <p>sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of</p>	K 056		



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K 056	Continued From page 16 sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years	K 056			



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JUN 13 2013
CHIEF OF MEDICAL GENERAL
SERVICES

POC ACCEPTED
by Jim AUGEIER
LSC1
13 JUNE 2013

7:23:14 am	MON 10-JUN-13 NORTH WING - OUTSIDE PIV "TAM"	3:M1-5
	SPRINKLER MONITOR ABNORMAL	
7:23:21 am	MON 10-JUN-13 NORTH WING - OUTSIDE PIV "TAM"	3:M1-5
	SPRINKLER MONITOR ABNORMAL	
7:23:57 am	MON 10-JUN-13 NORTH WING - OUTSIDE PIV "TAM"	3:M1-5
	SPRINKLER MONITOR ABNORMAL	
7:24:03 am	MON 10-JUN-13 NORTH WING - OUTSIDE PIV "TAM"	3:M1-5
	SPRINKLER MONITOR ABNORMAL	
7:24:29 am	MON 10-JUN-13 NORTH WING - OUTSIDE PIV "TAM"	3:M1-5
	SPRINKLER MONITOR ABNORMAL	
7:27:58 am	MON 10-JUN-13 NORTH WING - OUTSIDE PIV "TAM"	3:M1-5
	SPRINKLER MONITOR ABNORMAL	
7:28:17 am	MON 10-JUN-13 ALARM SILENCE REQUESTED AT NODE 2	

RECEIVED

JUN 13 2013

OFFICE OF THE INSPECTOR GENERAL
STATE OF OHIO FACILITIES AND SERVICES

Wendy Moore

From: Mark Edwards
Sent: Thursday, June 13, 2013 8:29 AM
To: Wendy Moore
Subject: FW: piv
Attachments: tjsamson.pdf

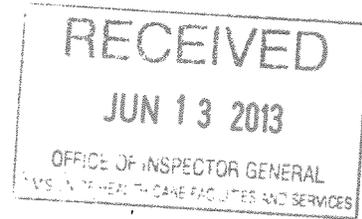
Here you go.
Mark

From: Jessie, Gregory [<mailto:Gjessie@simplexgrinnell.com>]
Sent: Wednesday, June 12, 2013 6:25 PM
To: Mark Edwards
Subject: piv

Here is your letter
Greg Jessie

SimplexGrinnell BE SAFE.

A tyco international Company



To all:

There is a PIV for TJ Samson Hospital, location is north wing M1-5 that has been tested for each quarterly that has been completed.

Greg Jessie



1301 North Race Street • Glasgow, KY 42141
P 270.651.4444 • www.tjsamson.org

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JUN 13 2013
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STATE OF KENTUCKY HEALTH CARE FACILITIES AND SERVICES

FAX: 270-651-4893

SEND TO: OIG
ATTENTION: PATTY BURK
FROM: WENDY MOORE
DATE: 6-13-13

4 TOTAL NUMBER OF PAGES (including the cover page)

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Comments: _____

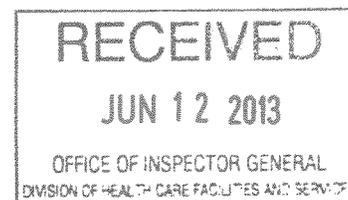
PATTY
I included the email from the sprinkler company as well.

Thank you!
Wendy Moore, MSN, LNHA

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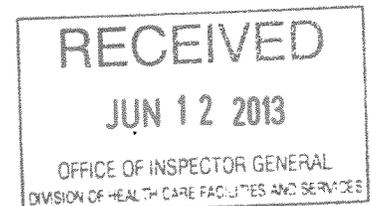
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K 056	Continued From page 17 thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 056			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on sprinkler testing record review 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 one (1) smoke compartments, residents, staff and visitors. The facility is certified for sixteen (16) beds with a census of eleven (11) on the day of the survey. The facility failed to calibrate or replace the gauges within the last five years. The findings Include: Sprinkler testing record review, on 05/15/13 at 11:05 AM, with the Plant Engineer revealed the facility failed to provide evidence that the gauges	K 062	K 062 5-29-13 Submitted work order to Maintenance Department, "OIG findings on SNU," requesting Sprinkler System gauges be calibrated to meet current standards or replace any gauges that do not calibrate to meet current standards. 5/29/13 Maintenance Director contacted Simplex Sprinkler Company and verbally contracted to have Sprinkler System calibrated and replace any necessary gauges including documentation of process, scheduled to provide service on 6/19/13. 6/10/13 Maintenance Director called and confirmed scheduled service for 6/19/13. 6/10/13 Director of Maintenance update Preventive Maintenance Schedule log to include next scheduled calibration / replacement including documentation for June of 2018 and every five years thereafter. Completion of process will be reported to Life		



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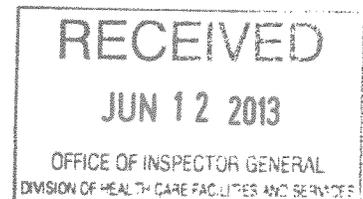
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K 062	Continued From page 18 on the sprinkler system had been calibrated or replaced within the last five years. Interview, on 05/15/13 at 11:05 AM, with the Plant Engineer revealed he was not aware the contracted company had not done all of the required testing of the sprinkler system. Reference: NFPA 13 (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. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers	K 062	Safety/ Safety Committee as a means to assist in monitoring compliance as one of the committee quality indicators.	6-21-13	



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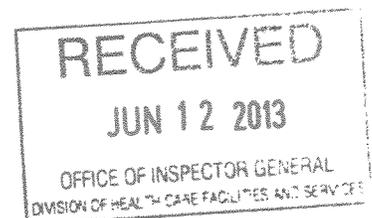
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K 062	<p>Continued From page 19</p> <p>are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p>	K 062			



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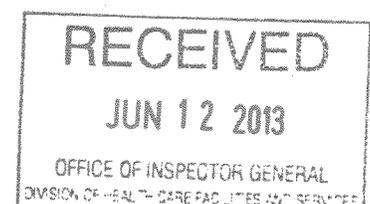
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K 062	<p>Continued From page 20 Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <p>Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1</p>	K 062		



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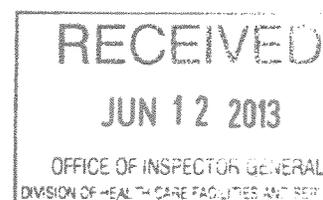
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K 062	<p>Continued From page 21</p> <p>Antifreeze solution Test Annually 2-3.4</p> <p>Gauges Test 5 years 2-3.2</p> <p>Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3</p> <p>Sprinklers - fast response Test At 20 years and every 10 years thereafter</p> <p>2-3.1.1 Exception No. 2</p> <p>Sprinklers Test At 50 years and every 10 years thereafter</p> <p>2-3.1.1</p> <p>Valves (all types) Maintenance Annually or as needed Table 9-1</p> <p>Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>6.2.9.6 A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. One sprinkler wrench shall be provided for each type of sprinkler installed.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development.</p> <p>5-5.5.2.1 Continuous or noncontiguous 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.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 062		
K 104		K 104		



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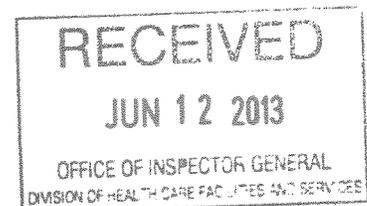
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K 104 SS=F	Continued From page 22 Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on fire damper testing record review, and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of one (1) smoke compartments, residents, staff and visitors. The facility is certified for sixteen (16) beds with a census of eleven (11) on the day of the survey. The facility failed to provide evidence that the smoke/fire dampers were tested within the last four (4) years. The findings include: Fire damper testing record review, on 05/15/13 at 11:10 AM with the Plant Engineer revealed the facility did not have evidence that fire/smoke dampers had been tested within the last four (4) years. Interview, on 05/15/13 at 11:10 AM, with the Plant Engineer revealed he was not aware of the requirements for fire/smoke damper testing. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible	K 104	K104 5/15/13 At the time of survey, Life Safety Surveyor reviewed the NFPA 101 components of fire/smoke damper, specifically NFPA 90A, maintenance review cycle requirements of every four years as a method to educate Maintenance Director of these requirement. 5-29-13 Submitted work order to Maintenance Department, "OIG findings on SNU," requesting fire/smoke damper testing to ensure fusible links removed and operate to verify full closure, latches checked and lubricate any moving parts as inspection indicates. 5-29-13 Director of Maintenance contacted and verbally contracted Rutledge Environmental to test dampers facility wide. 6/10/13 Director of Maintenance reported company currently in facility testing and will complete process 6-11-13. 6/10/13 Director of Maintenance update Preventive Maintenance Schedule log to include fire/smoke damper testing and including documentation for June of 2017 and every four years thereafter. Acute Care schedule will also be updated to every four years instead of every 6 years to provide consistency of preventive		



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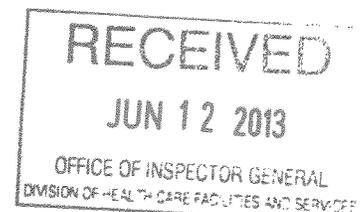
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K 104	<p>Continued From page 23</p> <p>links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers.</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>(1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) Where designs take transmission of vibration</p>	K 104	<p>maintenance processes. Completion of process will be reported to Life Safety/ Safety Committee as a means to assist in monitoring compliance as one of the committee quality indicators.</p>	6-12-13



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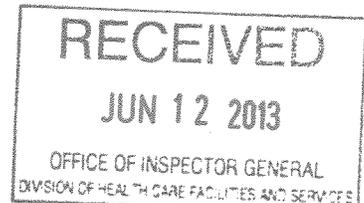
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K 104	Continued From page 24 into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 104		
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. This STANDARD is not met as evidenced by: Based on generator testing record review, 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 one (1) of one (1) smoke compartments,	K 144	K 144 <u>5/15/13</u> At the time of survey, Life Safety Surveyor reviewed the NFPA 101 components documentation of transfer times with alternate power source, specifically NFPA 99 as a means to education the Maintenance Director of requirement. <u>5-29-13</u> Maintenance Director updated Generator Test Logs to add a switch time column to document transfer time. Prior to update, the status column documented "OK" to indicate less than 10 seconds. We are now documenting OK if less than 10 seconds and then the actual transfer time each month. Completed on <u>6-3-13</u> . Maintenance	



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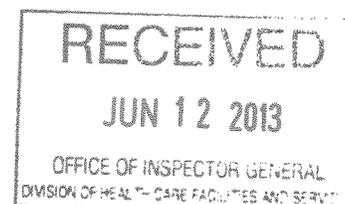
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K 144	Continued From page 25 residents, staff, and visitors. The facility is certified for sixteen (16) beds with a census of eleven (11) on the day of the survey. The facility failed to provide evidence for the generators monthly transfer times. The findings include: Observation, on 05/15/13 at 11:00 AM, with the Plant Engineer revealed the facility did not document the transfer times monthly while testing the generator. Interview, on 05/15/13 at 11:00 AM, with the Plant Engineer revealed he was not aware evidence of the transfer time was required Reference: NFPA 110 (1999 Edition). 5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturers' recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals. Reference: NFPA 99 (1999 Edition). 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	K 144	Director reviews all logs every month to ensure documentation is complete and all compliance is met. Compliance is submitted to Life Safety/ Safety committee as one of the committee quality indicators.	6-4-13	



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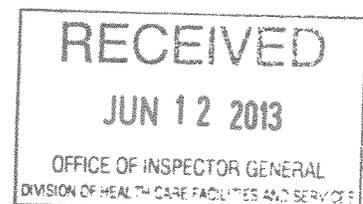
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K 144	Continued From page 26 operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual 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 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] Reference: NFPA 110 (1999 Edition). 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency	K 144			



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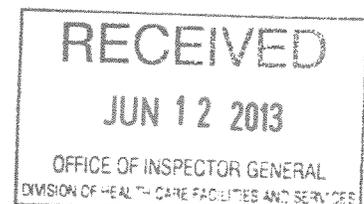
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K 144	Continued From page 27 lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Reference: NFPA 99 (1999 Edition) Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1. (b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches. (a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the	K 144		



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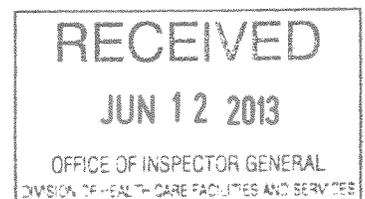
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K 144	<p>Continued From page 28</p> <p>shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p>	K 144		



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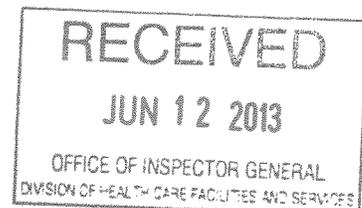
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K 144	Continued From page 29 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Reference: NFPA 101 (2000 edition) 7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment.	K 144			



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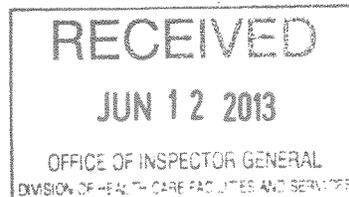
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K 144	Continued From page 30 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer. 5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures. Reference: NFPA 110 (1999 Edition) 5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.	K 144			
K 147	NFPA 101 LIFE SAFETY CODE STANDARD	K 147			



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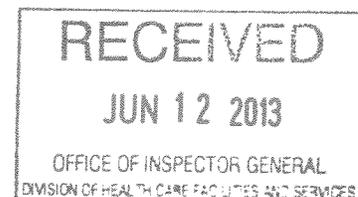
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K 147 SS=F	<p>Continued From page 31</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of one (1) smoke compartments, residents, staff, and visitors. The facility is certified for sixteen (16) beds with a census of eleven (11) on the day of the survey. The facility failed to maintain proper use of power strips, and extension cords.</p> <p>The findings include:</p> <p>Observations, on 05/15/13 between 10:30 AM and 5:00 PM, with the Plant Engineer revealed an Accudose Medicine Machine was plugged into a power strip located in the Med Room. Further observation revealed a candle warmer was plugged into an extension cord located in the Case Management Office.</p> <p>Interview, on 05/15/13 between 10:30 AM and 5:00 PM, with the Plant Engineer revealed he was not aware the power strips and extension cord had been misused.</p>	K 147	<p>K 147</p> <p><u>5-29-13</u> Submitted work order to Maintenance Department, "OIG findings on SNU," requesting an additional emergency generator electrical plug in medication room to allow all 3 Medication Accu-Dose units to be plugged directly into power source and remove power strip. Maintenance staff added additional receptacle on <u>6-7-13</u>. All three Accu-Dose units are plugged directly into power source and no power strips are in use.</p> <p><u>5-15-13</u> Upon identification by Life Safety Surveyor, the Case Management office extension cord was removed from office. Staff re-educated on non-tolerance for use of extension cords by Director of Maintenance. Case Management office area inspected and no additional extension cords identified. Case Manager Director will monitor in an ongoing basis by direct observation for noncompliance and will address immediately by current HR process of verbal, written, suspension and possible termination in escalating order. Current process also includes a Hazardous Survey of facility twice a year by Safety Officer and others to assess for compliance and risks for life safety</p>		



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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185387	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2013
NAME OF PROVIDER OR SUPPLIER T J SAMSON COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RACE ST GLASGOW, KY 42141	
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K 147	Continued From page 32 Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. Reference: NFPA 70 (1999 edition) Reference: NFPA 70 (1999 edition) 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding	K 147	threats. Any identified issue is followed up with a work order request and reported through the facility Life Safety Committee monthly. The following month the committee assesses completeness of work orders and addresses any unresolved issues. The process was updated 6/10/13 to removal of any extension cords and be included in current quality assurance report process. Completion of process will be reported to Life Safety/ Safety Committee as a means to assist in monitoring compliance.	6-11-13



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K 147	<p>Continued From page 33</p> <p>requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:</p> <ul style="list-style-type: none"> (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces 	K 147		

