

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

PRINTED: 10/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185446	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/02/2015
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517
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{X4} ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	{X5} COMPLETION DATE
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{F 000}	INITIAL COMMENTS An offsite revisit was conducted, and based on the acceptable Plan of Correction (POC), the facility was deemed to be in compliance on 10/01/15 as alleged.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **09/29/2015**

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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10/21/15

Acceptable (BC-802)

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F 000 INITIAL COMMENTS

F241

A Standard Recertification Survey and Abbreviated Survey investigating Complaint KY00023721 was initiated on 09/01/15 and concluded on 09/03/15. Deficiencies were cited at the highest Scope and Severity of a "F". KY00023721 was unsubstantiated with no deficiencies cited.

1. The SRNA apologized to the resident in room 15 and resident's A, B, and C for not knocking on their doors before entering their rooms.
2. All other residents on the unit were questioned by the Social Worker and Social Worker assistant on 9/2/15 to see if they were affected by the SRNA not knocking on their door before entering. No other resident's were affected.
3. The entire staff in the facility on 9/2/15 were immediately in serviced by the Staff Development nurse on resident Dignity. In servicing continues for the rest of the facility and will be completed on 9/30/15. The in services are presented by the Staff Development nurse. Knocking on resident's doors will be re-iterated during orientation to all new staff.
4. A QA audit will be done by the QA nurse weekly for 4 weeks to ensure compliance. The audits will be both observing staff and questioning residents. If compliance is obtained, the results will be taken to the QA committee to discontinue the audit. If there is non-compliance with knocking on the doors, the staff will be re-educated. The administrator will be responsible for compliance.
Date of completion: 10-1-15

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and a review of the facility's policy, it was determined the facility failed to enhance the dignity and respect of one (1) of twenty two (22) sampled residents (Resident #15), and three (3) Unsampled residents (Unsampled Resident A, Unsampled Resident B, and Unsampled Resident C).

Staff was observed to enter Resident #15's room and Unsampled Residents A, B, and C's room before knocking or gaining permission to enter.

The findings include:

Review of the facility's policy titled "Quality of life-Dignity" revised October 2009, revealed resident's private space and property shall be respected at all times. Staff will knock and request permission before entering resident's

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joni Dorrnell Administrator</i>	TITLE	(X6) DATE 9/29/15
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F 241	<p>Continued From page 1 rooms.</p> <p>During lunch observation on the South hall on 09/02/15 starting at 12:50 PM, revealed State Registered Nurse Aide (SRNA) #1 was observed entering Resident #15, Unsampld Resident A, Unsampld Resident B, and Unsampld Resident C's rooms without knocking or gaining permission to enter.</p> <p>1. Review of Resident #15's medical record revealed the facility admitted the resident on 01/14/15 with diagnoses which included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Hypertension. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 08/12/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating moderate cognitive impairment. Interview on 09/03/15 at 3:45 PM with Resident # 15, revealed he/she would appreciate if staff would knock first before entering his/her room.</p> <p>2. Review of Unsampld Resident A's medical record revealed diagnoses which included, Atrial Fibrillation, Diabetes, Depression, and Dementia.</p> <p>3. Review of Unsampld Resident B's medical record revealed diagnoses which included Alzheimer's Disease, Hypertension, Depression and Atrial Fibrillation.</p> <p>4. Review of Unsampld Resident C's medical record revealed diagnoses which included, Alzheimer's Disease, Hypertension Depression and Atrial Fibrillation.</p> <p>Interview, on 09/02/15 at 2:20 PM, with State</p>	F 241		
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F 371 | Continued From page 3

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of facility policy, the facility failed to store and serve food under sanitary conditions as evidenced by dust like particle build up on the ingredient storage bins and dust like particles on the lids of food cans. Further observation revealed during meal service on the resident tray line staff touched the rim of a cup and placed the palm of their hand into the middle of a plate.

The findings include:

Review of the facility policy, titled "Sanitation/Infection Control" undated, revealed the storage shelves in the storeroom were scheduled to be cleaned once weekly.

Review of the facility policy, titled "Cleaning and Sanitizing Dietary Areas and Equipment" undated, revealed all kitchen areas should be maintained in a sanitary manner, free of buildup of food and other soil. Further review revealed the Food Service would provide sanitary service to meets State and Federal Regulations.

Review of facility policy, titled "Dish Handling" undated, revealed handle glasses and dishes with care.

Review of the August 2015 and September 2015 daily, weekly and monthly cleaning lists revealed the dry storage area was not listed.

F 371 |

3. The dietary manager in serviced the dietary staff on 9/2/15 about ensuring there is no dust or food particles or build up on the food cans. The store room in the dietary department was re-arranged by the dietary manager to put items that lost particle content from the container to an area that would not contaminate other articles. Paper will be placed under these items and will be changed as needed. The storage container lids were placed on the cleaning schedule to run through the dishwasher weekly. The dietary manager in serviced the dietary department on 9/16/15 about "Proper procedure for trayline service to avoid contamination of eating and drinking surfaces." Reiteration of this process will be done during orientation and basic training of new employees.

4. A QA audit will be done by the QA nurse weekly for four weeks during meal service to ensure the storage bins are clean and without food particles or buildup. The QA audit will also be weekly for four weeks to ensure the staff do not touch eating or drinking surfaces on the serving line. If issues of non-compliance are noticed during the audit, the items will be removed from the tray line and education will be given to the person not following the policy.

5. The dietary manager will be responsible for compliance.
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F 371 Continued From page 4

Observation on 09/01/15 at 10:45 AM, during initial kitchen tour revealed in the dry storage area there was loose bulk ingredient bins with a buildup of dust like particle film on the lids. This build up of dust like particles was also observed to be on the shelves above the loose bulk ingredient bins, and on the food can lids.

Observation on 09/01/15 at 4:30 PM, of the resident supper tray line, revealed a Dietary Aide touched the rim of the cup as they assembled the residents' tray.

Observation on 09/02/15 at 8:22 AM, during a revisit to the dry storage area, revealed loose bulk ingredient bins with a build up of dust like particle film on the lids and dust like particles remained on the food can lids.

Observation on 09/02/15 at 11:53 AM, of the resident lunch tray line revealed a Dietary Aide touched the center of the plate with the palm of their hand as they assembled the residents' tray.

Interview on 09/03/15 at 10:15 AM, with Cook #1 revealed he assigned cleaning as daily, weekly and monthly tasks and checked to see if staff has completed their assigned cleaning tasks. He stated the Dietary Staff should not touch the plate surface and should not touch the cup rim.

Interview on 09/03/15 at 10:40 AM, with the Dietary Manager (DM) revealed she cleaned and straightened the dry storage every two (2) weeks and sometimes checked the area twice a week. She further revealed her expectation was for Dietary Staff to complete the daily, weekly and monthly cleaning schedule as assigned. The DM acknowledged there was a build up of dust in the

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F 371	Continued From page 5 dry storage area and revealed if the dry storage was not clean this could attract pests and cause contamination of food products. She stated staff should not be touching the eating surfaces of the plate and the rim of the cup which could cause contamination. Interview on 09/03/15 at 4:55 PM, with the Director of Nursing, (DON) revealed staff should not touch the surface of plates or the rims of cups because this could cause infection control or contamination issues.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F431	1.The drug in the medication cart lying loose was removed from the cart. The carts were inspected to ensure medications were separated with dividers or in different drawers according to the route of administration. 2. Other medication carts were checked by the nursing staff to ensure there were no other loose medication in the cart. The carts were inspected to ensure medications were separated according to the route in which they are administered. 3. Licensed nurses and Kentucky Medication Aides (KMA) were in serviced Sept. 25 and 26, 2015 by the Staff Development nurse about removing any loose medication from the medication carts. They were also in serviced to ensure the medications were separated according to the route of administration.	

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F 431 Continued From page 6

permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and a review of the facility policy, it was determined the facility failed to ensure storage of drugs and biologicals was in accordance with currently accepted professional principles.

Observation of a medication cart revealed a Promethazine twenty-five (25) Milligram tablet (medication used to treat allergy symptoms or nausea/vomiting) which was not packaged to identify the resident's name, stored in a drawer labeled for nebulizer medication.

The findings include:

Review of the facility's policy titled "Storage of Medication" undated, revealed medication and biologicals were stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration.

Observation on 09/02/15 at 9:30 AM of the medication cart on the North Hall revealed a

F 431

4. The QA nurse will audit the medication carts weekly for four weeks to ensure the carts have no loose medications in them and drugs are separated according to the route in which they are administered. After four weeks, the results will be taken to the QA committee to be discontinued if compliance was achieved. If compliance is not achieved, the staff will be re-educated.

5. The DON will be responsible for compliance.
Date of completion: 10-1-15

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F 431	Continued From page 7 single dose tablet of Promethazine twenty-five (25) Milligrams (MG) which was not labeled to identify the resident's name, in a drawer labeled for Nebulizer medication. Interview, on 09/02/15 at 9:45 AM, with Registered Nurse (RN) #1, revealed she was not sure who placed the Promethazine in the Nebulizer drawer and did not notice the medication was in the wrong drawer when she passed her medication. Continued interview revealed the medication should be with the boxed medication packaged by pharmacy labeled with the resident's name and room number. Interview, on 09/03/15 at 5:05 PM, with the Director of Nurses (DON), revealed it was her expectation for all medication to be stored according to the policy and by the pharmacy's recommendations. Continued interview revealed it was important to have proper storage to prevent medication errors.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F441	1.All unidentified bagged wash basins, bed Pans and urinals on the bathroom floors were thrown away. The wedges on the floor were disinfected with disinfection wipes and reused on the resident. 2. All resident's bathrooms were audited toe ensure other disposable items were not on the bathroom floor.		

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F 441 Continued From page 8

(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for two (2) of twenty-two (22) sampled Residents (Resident #5 and Resident #7) and two (2) unsampled Residents (Unsampled Resident #A and Unsampled Resident #E).

F 441

3. The maintenance director is installing bedpan and urinal holders in the resident's bathrooms to hold urinals and bedpans. The disposable items will have the residents name written on it and bagged. Until all bed pan and urinal holders are installed, the bags will be hung on the resident's towel rack in the bathroom. The licensed and non-licensed nursing staff were in serviced on 9/15/15 by the Staff Development nurse on the way to properly store wash basins, bed pans, urinals and wedges when not in use.

4. The QA nurse will audit twenty (20) resident rooms weekly to ensure all disposable items, i.e., Bedpans, bathpans, urinals and wedges are Labeled with the resident's name, bagged and Placed in the urinal/bedpan holder or tied on The towel bar in the bathroom. This audit will Continue for 4 weeks. The results will be taken To the QA committee to ask for the audit to Be discontinued if compliant.

5. The DON will be responsible for compliance.
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F 441

Observation revealed there was unidentified, bagged wash basins, bed pans and urinals on the bathroom floors and there was also position wedges on the floor unbagged.

The findings include:

Review of facility policy, titled "Cleaning and Disinfection of Resident-Care Items and Equipment" revised 2009, revealed resident care equipment that is reusable should be cleaned and disinfected according to current Centers for Disease Control (CDC) recommendations for disinfection and the Occupational Safety Health ACT (OSHA) Blood borne Pathogens Standard. Reusable items were cleansed and disinfected between uses by a single resident such as bedpans, urinals and wash basins.

Observation during the initial tour revealed;

On 09/01/15 at 10:45 AM, Resident #7's room had two (2) bedpans which were bagged, and unlabeled on the bathroom floor and there was also two (2) urinals bagged which hung on the towel rack without identification in the bathroom.

On 09/01/15 at 10:48 AM, Resident #5's room had two (2) un-bagged positioning wedges on the floor.

On 09/01/15 at 10:50 AM, Unsampled Resident #A's room had two (2) wash basins bagged on the bathroom floor without identification.

On 09/01/15 at 10:55 AM, Unsampled Resident #E's room had one (1) wash basin on the bathroom floor without identification.

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F 441	<p>Continued From page 10</p> <p>Further observation on 09/03/15 at 2:50 PM, of Resident #7's room revealed two (2) bagged urinals hung on the towel rack without identification in the bathroom, one (1) bagged bedpan without identification was on the bathroom floor and one (1) bagged wash basin without identification was in the seat of the wheelchair in the bathroom.</p> <p>Continued observation on 09/03/15 at 2:55 PM of Resident #5's bathroom revealed three (3) bagged wash basins, one (1) under the foot of the bedside commode and two (2) on the bathroom floor, all without identification. There was also a soiled bedpan bagged on the bathroom floor without identification.</p> <p>Further observation on 09/03/15 at 2:58 PM of Unsampld Resident A's bathroom revealed one (1) wash basin and two (2) bed pans bagged on the floor</p> <p>Interview with SRNA #3, on 09/03/15 at 8:40 AM revealed CNA's were trained on how to sanitize and store resident's equipment. She further stated positioning wedges should be in the closet and off the floor. Further interview at 3:40 PM revealed staff was in-serviced on how to sanitize and store bedpans, urinals and wash basins and these items should be labeled with resident identification, bagged and stored off the floor.</p> <p>Interview with State Registered Nurse Aide (SRNA) #2, on 09/03/15 at 8:45 AM, revealed she received infection control training in orientation and had further education since orientation. Further interview revealed she was educated on how to store, label, and sanitize resident</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER BLUEGRASS CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3576 PIMLICO PARKWAY LEXINGTON, KY 40517		
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F 441	Continued From page 11 equipment and acknowledged equipment should not be on the floor. She further revealed she would sanitize Resident #5's wedges and put them in the resident's closet. Interview with SRNA #4, on 09/03/15 at 3:50 PM, revealed she was in-serviced on infection control and how to store and sanitize bedpans, urinals and wash basins. She revealed these items should be labeled with the resident's identification, bagged and stored off the floor. Further interview revealed she had witnessed other CNA's use labeled bedpans which had been on the floor but she had never witnessed another CNA use an unlabeled item. Interview with the Staff Development Coordinator (SDC), on 09/03/15 at 4:15 PM, revealed she had no documented evidence of in-services or education which addressed infection control concerning bedpans, wash basins, urinals or wedges. Interview with Director to Nursing (DON), on 09/03/15 at 5:00 PM, revealed her expectation was for bedpans, urinals and wash basins to be labeled with resident's names, and bagged and kept off the floor. Further interview revealed the SDC needed to educate staff on infection control, specifically the proper storage of bedpans, urinals and wash basins. Continued interview revealed Department Heads were assigned rooms and completed weekly audits of assigned rooms. She stated the proper storage of bedpans, urinals and wash basins was a part of the audit. Interview on 09/03/15 at 6:00 PM, with the Administrator revealed all residents' wash basins, urinals and bedpans should be disinfected,	F 441			

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F 441	Continued From page 12 bagged, labeled and not placed on the floor.	F 441		
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K 000	INITIAL COMMENTS	K 000		
	Building: 01 Plan Approval: 06/15/77 Survey under: NFPA 101 (2000 Edition) Facility type: SNF/NF Type of structure: Type V (111) Unprotected Smoke Compartment: Six (6) Fire Alarm: Complete Fire alarm System Sprinkler System: Complete Sprinkler System (Dry) Generator: Type II Diesel and Type II Natural Gas A Standard Life Safety Code Survey was initiated and concluded on 09/01/2015. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The facility is licensed for one hundred twenty-four (124) beds and the census during the survey was one hundred nine (109). Deficiencies were cited at the " F " level.			
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core	K 018		

09/01/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jeni Groszek, Administrator</i>	TITLE	(X6) DATE 9/20/15
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018 Continued From page 1
wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure corridor doors were maintained according to National Fire Protection Association standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, thirty (30) residents, staff and visitors.

The findings included:

Observation on 09/01/15 at 1:58 PM, with the Maintenance Director, revealed the door for resident room thirteen (13) did not latch when closed. Further observation revealed the door for resident room twelve (12) had a curtain blocking the door from closing, the door of resident room eleven (11) was blocked from closing by a resident bed, and the door of resident room eight

K 018
K018
1.The resident rooms that had doors Impeded by curtains, trash cans, etc. had the impediments removed 9/1/15 by the maintenance director.
2.All resident room doors were checked for impediments that prevent door closures. No other doors were impeded from closing.
3.All facility employees will be in serviced by the maintenance director on September 25 and 16, 2015 to ensure resident doors are not blocked from shutting.
4. The QA nurse will audit door impediments in resident rooms weekly for 5 weeks. The results will be taken to the monthly QA meeting in November to ask to discontinue if compliant or continue if non compliance continues.
5. The administrator will be responsible for overseeing compliance.
Date of completion: 10-1-15

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K 018: Continued From page 2
(8) was blocked by a trash can. Interview, with the Maintenance Director, at the time of observations, revealed the facility did not have a maintenance schedule for inspecting resident room doors and he was unaware of the problems affecting the resident room doors.

The Administrator acknowledged the findings during the exit conference.

Reference: NFPA 101 (2000 Edition)
19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1 3/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than twenty (20) minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding one (1) inch (2.5 centimeter (cm) shall be permitted for corridor doors.
Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.
Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.
19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.

K 018:

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K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and review of the fire drill records, it was determined the facility failed to ensure fire drills were conducted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, one hundred twenty four (124) residents, staff and visitors.</p> <p>The findings include:</p> <p>Review of the facility's fire drill records on 09/1/15 at 2:38 PM, with the Maintenance Director, revealed the facility had conducted all fire drills for third (3rd) shift between 6:00 AM and 6:10 AM. Interview, with the Maintenance Director, at the time of the review, revealed he conducted the fire drills during this time because of his schedule.</p> <p>The Administrator acknowledged the findings during the exit conference.</p> <p>Reference: NFPA 101 (2000 Edition)</p>	K 050	<p>K050</p> <ol style="list-style-type: none"> 1. A fire drill was held for the 11-7 shift at 11:30 p.m. on 9/1/15 by the maintenance assistant. 2. Fire drills were reviewed by the Maintenance director to see when and what time the previous drill for the shift was held. 3. Drill times will be staggered by the Maintenance director and assistant so fire drill times will not be routine but surprises to the staff. 4. QA will monitor the fire drills monthly for three months to ensure fire drill times are staggered each month. After three months, the results will be taken to the QA committee for further instructions. 5. The administrator will be responsible for compliance. <p>Date of completion: 10-1-15</p>	

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K 050	Continued From page 4 4.7.5* Simulated Conditions. Drills shall be held at expected and unexpected times and under varying conditions to simulate the unusual conditions that can occur in an actual emergency. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 PM (2100 hours) and 6:00 AM (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		