

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

PRINTED: 10/15/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185457	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/11/2012
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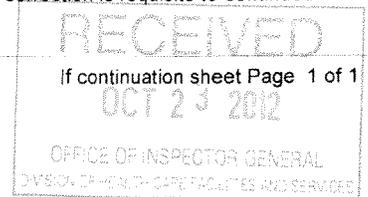
NAME OF PROVIDER OR SUPPLIER WINDSOR GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004
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F 000	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted 10/08/12 through 10/11/12 and a Life Safety Code survey was conducted on 10/09/12 with the highest scope and severity of a "F". The facility had an opportunity to correct the deficiencies before remedies would be recommended for imposition.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark Pendergrass</i>	TITLE Maintenance Director	(X6) DATE 10/23/12
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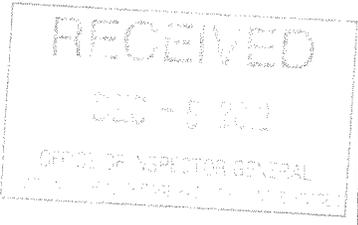
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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 000	<p>INITIAL COMMENTS</p> <p>Amended SOD 11/30/12 Deleted K025 and K027.</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2005</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: one (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/09/12. Windsor Gardens was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has thirty (30) certified beds with a census of twenty (20) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000			



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

TITLE
Executive Director

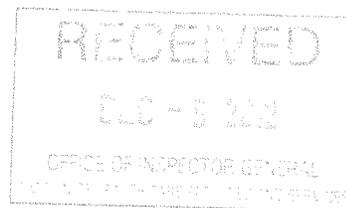
(X6) DATE
12/05/2012

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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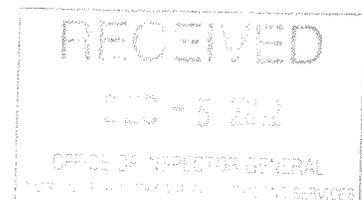
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000			
K 011 SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the common wall with a nonconforming building was in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff, and visitors. The facility is certified for thirty (30) beds with a census of twenty (20) the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/09/12 at 11:25 AM, with the Maintenance Director revealed the fire barrier wall separating the Skilled Nursing Facility from the Personal Care Facility, had a steel door and frame that was not rated.</p>	K 011	<p>K011 - Fire rating of door and frame to AL</p> <p>This issue does not affect any specific resident, but rather, as a fire safety hazard, could affect all residents, staff and visitors. The supervising construction engineer was contacted on 10/16/2012 and made an on-site inspection. The door frame has been replaced and the door has been inspected and tagged by the manufacturer. The door and frame are UL fire rated at 3 hours and both now have correct metal tags. Work was completed 11/30/2012. There are no more adjacent structures or any other passage which would require a fire door. All existing doors are as constructed and have been inspected and approved numerous times. Any new construction or changes would require approval and inspection by the State Fire Marshal's office and local building and fire inspectors. The local fire inspector has been called to survey the entire facility to verify that nothing has been overlooked in the original plan or subsequent inspections that would require the installation or additional fire doors. All doors are inspected monthly by the Maintenance Director. Door inspection logs will be submitted to QA for review. Please see attached photos.</p>	10/16/2012	



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K 011	Continued From page 2 Interview, on 10/09/12 at 11:25 AM, with the Maintenance Director revealed he was unaware the door did not have a rating. Reference: NFPA 101 (2000 edition) 18.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 18.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 18.1.1.4.2 Communicating openings in dividing fire barriers required by 18.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 18.1.1.4.3 Doors in barriers required by 18.1.1.4.1 shall normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 18.2.2.2.6. 8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following.	K 011			



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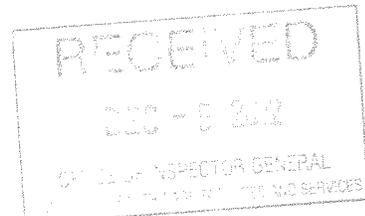
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K 011	Continued From page 3 (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.	K 011			
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit signage according to NFPA standards. The deficiency had the potential to affect one (1) of the two (2) smoke compartments, residents, staff and visitors. The facility has thirty (30) certified beds with a census of twenty (20) on the day of the survey. The findings include:	K 022	K022 - Exit Signs This issue does not affect any specific resident, but rather, as a safety hazard in the event of an emergency, could affect all residents, staff and visitors. Exit signs are in place at each emergency exit door. This is easily determined as there are only four emergency exits. The door in question has a working exit sign that can be readily seen from the approaching hallway, but is not directly over the door. This arrangement has passed numerous previous inspections. Tony Brey Electric has been to the site and installed an additional exit sign directly over the door. Work was completed on 11/12/2012. Testing of all exit signs has been performed by Maintenance Director and subsequent testing has been added to monthly checks performed by the Maintenance Director. Inspection and testing log for exit signs will be reviewed quarterly by the QA Committee.	11/13/2012	



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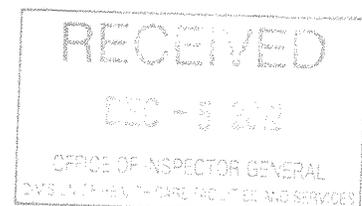
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K 022	Continued From page 4 Observation, on 10/09/12 at 12:24 PM, with the Maintenance Director revealed the exit door required for exiting the A Hall was not identified by approved, readily visible signage. An exit sign was located in the corridor, however there was no signage over the door making it apparent to occupants. Interview, on 10/09/12 at 12:24 PM, with the Maintenance Director revealed he was not aware the exit door did not have proper signage. NFPA 101 (2000 Edition) 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements.	K 022		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1	K 029		



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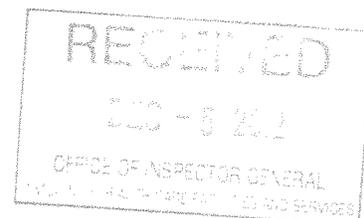
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K 029	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility has thirty (30) certified beds with a census of twenty (20) on the day of the survey. The findings include: Observation, on 10/09/12 at 11:53 AM, with the Maintenance Director revealed the door to the Medical Records Room did not have a self-closing device. The room was being used to store a large amount of combustible paper records. Interview, on 10/09/12 at 2:26 PM, with the Maintenance Director revealed he was unaware the Medical Records Room door was required to be self-closing. 18.3.2 Protection from Hazards. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated. Table 18.3.2.1 Hazardous Area Protection	K 029	K029 - Hazardous area protection (door closer medical records) This deficiency does not affect any specific resident, but rather, as a safety hazard, could affect all residents, staff and visitors. A door closer was installed on the Medical Records room by the Maintenance Director on 10/18/2012. All other hazardous areas have proper door closer mechanisms installed. All doors, latches and closers are inspected monthly by the Maintenance Director for proper operation, closure and latching. The Maintenance Director received NFPA code training by Robert Andrew on 5/25/2011. The Maintenance Director has also received training over a number of years as a former member of the Bardstown Volunteer Fire Department. The Maintenance Director is completing an additional training course by the NFPA (NFPA 101: Life Safety Code in Health Care Occupancies). All other doors are inspected monthly by the Maintenance Director. Monthly logs are kept and will be submitted to QA and safety committees for review and monitoring.	10/19/2012	



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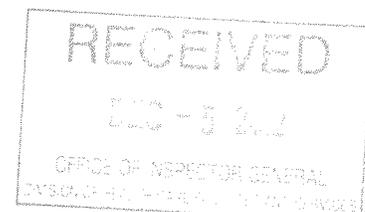
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K 029	Continued From page 6 Hazardous Area Description Separation/Protection Boiler and fuel-fired heater rooms 1 hour Central/bulk laundries larger than 100 ft2 (9.3 m2) 1 hour Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4 Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour Physical plant maintenance shops 1 hour Soiled linen rooms 1 hour Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) storing combustible material See 18.3.6.3.4 Storage rooms larger than 100 ft2 (9.3 m2) storing combustible material 1 hour Trash collection rooms 1 hour 8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1	K 029			
K 046 SS=F		K 046			



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K 046	Continued From page 7 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility has thirty (30) certified beds with a census of twenty (20) on the day of the survey. The findings include: Observation and record review, on 10/09/12 at 1:55 PM, with the Maintenance Director revealed they did not have documentation that the battery emergency lighting in the facility was tested for 1-1/2 hours within the last year. Interview, on 10/09/12 at 1:55 PM, with the Maintenance Director revealed they were not aware the annual test for the battery emergency light for 1-1/2 hours had to be documented. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than	K 046	K046 - Emergency Lighting Testing This deficiency does not affect any specific resident, but rather, as an emergency event safety issue, could affect all residents, staff and visitors. A monthly log for testing of emergency lighting systems was created by the Maintenance Director on 10/19/2012. The Maintenance Director performed the required annual 90 minute testes on each ELS on 10/22/2012. All systems passed the annual test and will be tested monthly for a minimum of 60 seconds illuminated by the Maintenance Director. All tests will then be logged. The Maintenance Director received NFPA training on 5/25/2011 by Bob Andrew, CHFS, Administrative Branch Manager in the Division of Health Care, OIG, Frankfort, KY. Maintenance Director is completing a training course by NFPA (NFPA101: Life Safety Code in Health Care Occupancies). He has also received training over a number of years as a former member of the Bardstown Volunteer Fire Department. As a technician for over 30 years, installation and maintenance of equipment and cabling required a working knowledge of National Electrical Code as well as NFPA codes. Emergency lighting test logs will be submitted to the QA committee and reviewed quarterly.	10/23/2012	



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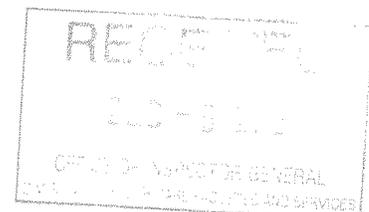
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K 046	Continued From page 8 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.	K 046			
K 062 SS=F	7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to	K 062			



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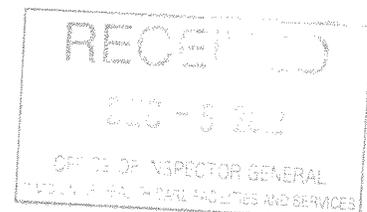
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 9 maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility has thirty (30) certified beds with a census of twenty (20) on the day of the survey. The findings Include: Observation, on 10/09/12 at 12:11 PM, with the Maintenance Director revealed corrosion on the sprinkler heads located outside under the Nursing Home Canopy. Interview, on 10/09/12 at 12:11 PM, with the Maintenance Director revealed he was not aware of the corrosion on the sprinkler heads. Review of the sprinkler testing record and interview, on 10/09/12 at 1:50 PM, with the Maintenance Director revealed the facility did not have documentation that the sprinkler gauges on the sprinkler riser had been calibrated or replaced within the last five (5) years. In addition, he was not aware of the requirement. Review of the sprinkler testing record, on 10/09/12 at 1:50 PM, with the Maintenance Director revealed the facility did not have documentation that an internal pipe inspection had been performed on the sprinkler system. However, in the comments section of a quarterly sprinkler inspection report from the sprinkler testing company, dated 08/25/09, revealed the sprinkler system had not had an internal pipe inspection.	K 062	K062 - Corrosion on canopy sprinkler heads The cited deficiency does not affect any particular resident, but rather, as a fire safety hazard, could affect all residents, staff and visitors. Canopy sprinkler heads were cleaned of corrosion by the Maintenance Director on 10/31/2012. A quarterly sprinkler system inspection was performed by Dalmation Sprinkler on 11/01/2012. No corrosion was found on any other sprinkler heads and the canopy sprinkler heads were judged satisfactory by the inspector. All sprinkler heads are inspected and logged monthly by the Maintenance Director as per NFPA. Previous inspections by sprinkler service companies indicated some corrosion on exterior sprinkler heads was normal and did not affect their operation. Maintenance Director was educated on NFPA code by Robert Andrew, CHFS, Administrative Branch Manager, OIG, Frankfort, KY on May 25th, 2011. Maintenance Director is completing additional training by NFPA (NFPA 101: Life Safety Code in Health Care Occupancies). Monthly logs will be submitted for review by QA Committee on a quarterly basis.	11/02/2012



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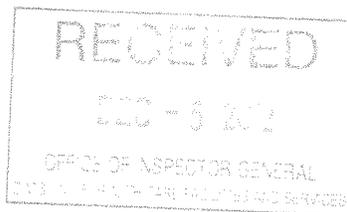
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K 062	<p>Continued From page 10</p> <p>Interview, on 10/09/12 at 1:50 PM, with the Maintenance Director revealed he was not aware of the requirement, and had not noticed the comments. This was confirmed with the Administrator at the exit conference.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>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.</p> <p>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</p>	K 062			



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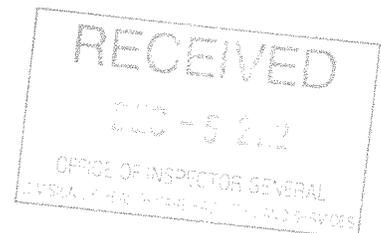
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K 062	<p>Continued From page 11</p> <p>conditions are satisfied:</p> <p>(1) Wet pipe system</p> <p>(2) Light hazard or ordinary hazard occupancy</p> <p>(3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall 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 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>	K 062			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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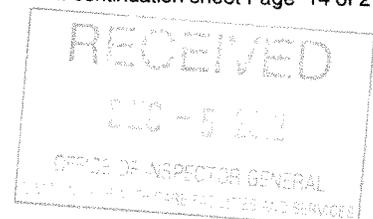
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K 062	Continued From page 12 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. Reference: NFPA 25 (1998 Edition). 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. 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	K 062			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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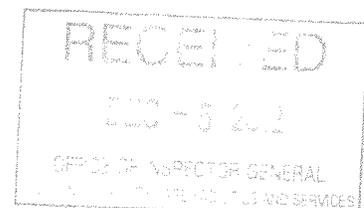
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K 062	Continued From page 13 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 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 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 062			
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on interview and record review, 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 two (2) of two (2) smoke compartments, residents, staff and visitors. The facility has thirty	K 104			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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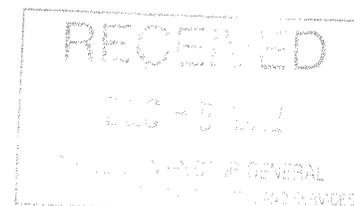
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K 104	Continued From page 14 (30) certified beds with a census of twenty (20) on the day of the survey. The findings include: Review of the Fire Damper Testing Record, on 10/09/12 at 1:50 PM with the Maintenance Director revealed the facility did not have documentation for fire damper testing. Interview, on 10/09/12 at 1:50 PM, with the Maintenance Director revealed that no maintenance documentation was kept on the fire/smoke dampers. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible 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.	K 104	K104 - Fire damper testing The cited deficiency does not affect any particular resident, but rather, as a fire safety hazard, could affect all residents, staff and visitors. Fire damper test log was created on 11/06/2012 by the Maintenance Director and added to the Maintenance Binder as a periodic inspection. Inspection and testing was performed on 11/07/2012 by the Maintenance Director and logged as it was done. Test consisted of removal of fusible link and assessment of operation of fire damper, ensuring free movement, full and adequate closure and latching. Subsequent inspections will be carried out every four years as per NFPA 90A, 3-4.7. Maintenance Director received NFPA training in May of 2011 by Robert Andrew, CHFS, Administrative Branch Manager, OIG, Frankfort, KY. Maintenance Director is completing additional training by NFPA (NFPA 101: Life Safety Code in Health Care Occupancies). Fire damper test log will be submitted to QA Committee for full review at quarterly meeting.	11/08/2012	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the hazardous areas in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility has thirty	K 130			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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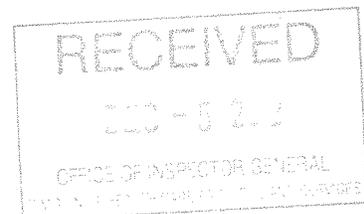
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K 130	Continued From page 15 (30) certified beds with a census of twenty (20) on the day of the survey. The findings include: Observation, on 10/09/12 at 12:28 PM, with the Maintenance Director revealed a heavy build-up of lint in the top of the dryer located in the Laundry Room. Interview, on 10/09/12 at 12:28 PM, with the Maintenance Director revealed they clean the top of the dryers regularly but he was not aware the lint build up was so excessive. NFPA 101 (2000 Edition) 4.6.12 Maintenance and Testing. 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction.	K 130	K103 - Lint build-up on dryer and sprinkler head This cited deficiency does not affect any particular resident, but, as a fire safety hazard, could affect all residents, staff and visitors. Lint build-up was removed from top, back and sides of dryer on 10/10/2012. Sprinkler head was also cleaned by Maintenance Director. The dryer will be examined for excess lint build-up and cleaned monthly. Inspection and cleaning will be logged. Logs will be submitted to QA Committee for quarterly review. Washing machine and entire area will be inspected at the same time. There are no other pieces of laundry equipment. Maintenance Director will assume responsibility for seeing that dryer, washer and general area are checked, cleaned and logged monthly to ensure compliance with applicable NFPA code. dryer logs will be reviewed by QA Committee on a quarterly basis. Maintenance Director is completing NFPA training course on NFPA 101: Life Safety Code in Health Care Occupancies.	10/11/2012	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 147			



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

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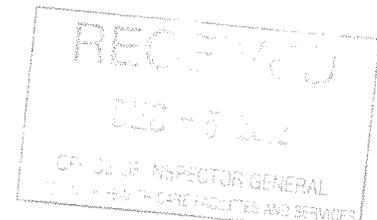
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K 147	<p>Continued From page 16</p> <p>determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility has thirty (30) certified beds with a census of twenty (20) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 10/09/12 between 11:30 AM and 2:00 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) An open electrical junction box located in the attic above the B Hall. 2) A long extension cord with work lights attached that had been cut and spliced back together. 3) Medical equipment was plugged into a power strip located in the Med Room. 4) A power strip was plugged into another power strip located in the Rehab Services Room. 5) A bed was plugged into a power strip located in room C01. 6) A mini nebulizer was plugged into a power strip located in room C08. 7) A microwave was plugged into a power strip located in the staff lounge. 8) Two (2) full size soda vending machines were plugged into a power strip located in the staff 	K 147	<p>K147 - Power strips/extension cords</p> <p>This deficiency has the potential to affect all residents, staff and visitors. AN open junction box in attic above B hall was covered with a metal plate and the extension cords and lights were removed on 10/16/2012. This work was supervised by the Maintenance Director. All other findings of improper use of extension cords and power strips were remedied on or before 10/16/2012. A subsequent room by room inspection found no other violations. A policy regarding extension cords and power strips has been written and was put into effect by same date. A Safety Committee composed of the Maintenance Director and Skilled Nursing Facility staff has been formed and will be responsible for conducting monthly checks of every room in the Skilled Nursing Facility. Residents, staff and family members will be regularly reminded of the restrictions. Extension cord/power strip policy has been made part of the admission procedure. Monthly logs will be presented to full QA Committee and reviewed on a quarterly basis. Maintenance Director was educated on NFPA code May 25, 2011 by Robert Andrew. Maintenance Director is completing additional training by NFPA on Life Safety Code in Health Care Occupancies.</p>	10/17/2012	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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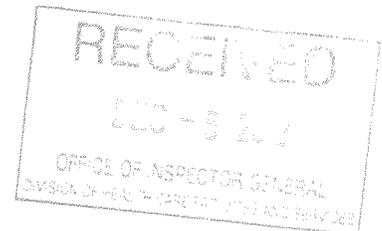
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K 147	<p>Continued From page 17 lounge.</p> <p>9) A lamp was plugged into an extension cord located in room A02.</p> <p>10) A mattress air pump was plugged into a power strip located in room A04.</p> <p>Interview, on 10/09/12 between 11:30 AM and 2:00 PM, with the Maintenance Director revealed he thought he had removed all power strips and extension cords that were being misused. Further interview revealed he was not aware the old extension cord work light was in bad repair and needed to be removed and was not aware of the open electrical junction box in the attic.</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: (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</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p>	K 147			



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

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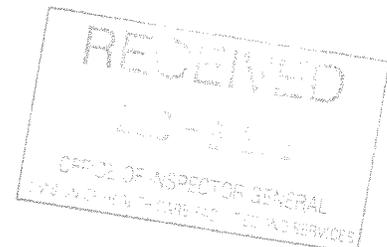
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K 147	Continued From page 18 Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. 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 requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147			
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on interview and review of the facility's policy and procedure, it was determined the facility failed to develop a fire watch policy in accordance with NFPA standards. The deficiency	K 154	K154 - Fire Watch Policy As a fire safety issue the cited deficiency has the potential to affect all residents, staff and visitors. A Fire Watch Policy was written by the Executive Director on 10/11/2012 and approved by QA and implemented on 10/15/2012. Any time the fire alarm or sprinkler systems are out of service, a fire watch will be initiated as detailed in the Fire Watch Policy. Staff was educated on the policy on 10/15/2012 by the Director of Nursing. The Safety Committee will monitor for compliance and report findings to the QA Committee.	10/16/2012	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 154	Continued From page 19 had the potential to affect two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility has thirty (30) beds with a census of twenty (20) on the day of the survey. The findings include: Review of the facility's Policy and Procedure, on 10/09/12 at 2:00 PM, with the Maintenance Director revealed the facility failed to provide a written policy outlining an approved fire watch system in the event the sprinkler system or fire alarm system is shut down for four (4) or more hours in a twenty four (24) hour period. Interview, on 10/09/12 at 2:00 PM, with the Maintenance Director revealed they were unaware the facility did not have a fire watch policy. Reference; NFPA 101 (2000 edition) 9.7.6* Sprinkler System Shutdown. 9.7.6.1 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. Reference; NFPA 101 (2000 edition) 9.6.1.8* Where a required fire alarm system is out of	K 154		



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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185457	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WINDSOR GARDENS B. WING _____		(X3) DATE SURVEY COMPLETED 10/09/2012
NAME OF PROVIDER OR SUPPLIER WINDSOR GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004		
(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	
K 154	Continued From page 20 service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.	K 154			

