

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

PRINTED: 08/08/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/26/2014
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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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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  A Recertification Survey and an Abbreviated Survey investigating KY #21937 was conducted on 07/23/14 through 07/25/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of a "D". KY #21937 was unsubstantiated with no deficiencies cited.	F 000	<u>RESPONSE PREFACE</u>  Lake Way acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.  This REQUIREMENT is not met as evidenced by: Based on Interview, record review, and review of	F 280	Lake Way's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.  F280 Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;  On 08/07/2014 ADON reviewed resident #2 and wrote order to reflect all current allergies. On 08/11/2014 MDS reviewed resident #2 care plan to ensure that allergies are all current on care plan.	08/13/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Delma Beck TITLE: Administrator (X6) DATE: 08-14-2014

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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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026		
(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 280	<p>Continued From page 1</p> <p>the facility's policy/procedure, it was determined the facility failed to review and revise the care plan for one (1) resident (Resident #2), in the selected sample of sixteen (16) residents. Resident #2's care plan was not reviewed or revised to reflect his/her allergies after returning from the hospital.</p> <p>Findings Include:</p> <p>Review of the facility's policy, "Resident Care Plan," dated October 2007, revealed the Interdisciplinary Care Plan Team developed the care plans within seven (7) days after completion of the Minimum Data Set (MDS). Care plans were updated quarterly, annually, upon significant change in the resident's condition, or as indicated.</p> <p>Record review revealed the facility admitted Resident #2 on 02/22/14, and re-admitted the resident, on 07/14/14, after hospitalization with diagnoses which included Pneumonia and Failure To Thrive. Review of hospital records, as well as the History and Profile, dated 07/14/14, revealed the resident had a macular rash which had developed on his/her abdomen and lower extremities. Further review revealed the use of three (3) intravenous (IV) antibiotics administered during hospitalization contributed to the development of the rash.</p> <p>Review of the Admission MDS assessment, dated 07/21/14, revealed the facility assessed Resident #2 as severely cognitively impaired and totally dependent on the staff for assistance with activities of daily living (ADLs.)</p> <p>Review of the comprehensive care plan, dated</p>	F 280	<p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>On 08/01/2014 Medical Records began an audit of all residents allergies and completed this audit 08/07/2014 to ensure that allergies were current and listed in appropriate places.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;</p> <p>On 08/01/2014 Staff Facilitator Nurse began an in-service for all licensed nurses on reviewing orders and updating care plans and this was completed on 08/11/2014.</p> <p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Each admission and/or readmission chart will be brought to Administrative Nursing morning meeting and reviewed for correct medication orders and allergy orders as well as care plan updated by the DON, ADON, QI Nurse and MDS Coordinator.</p> <p>Quality Assurance Nurse will audit 10% of all care plan/care guides weekly x 4 weeks for compliance and will review the results of this audit each week during Friday department head morning meeting.</p>		

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F 280	<p>Continued From page 2</p> <p>07/23/14, revealed the resident was allergic to Vancomycin, Keflex, Levaquin, and Zosyn. Further review of the care plan revealed the resident had no known allergies (NKA).</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/25/14 at 10:55 AM, revealed she was a new hire at the facility and this was the first time she completed an admission. She stated she was aware of Resident #2's allergies; however, she failed to note his/her allergies correctly on the physician's orders and the Medication Administration Record (MAR), as well as, review and update the care plan.</p> <p>Interview with Registered Nurse (RN) #1, on 07/25/14 at 10:40 AM, revealed the allergies were listed on the front of the chart and on the face sheet in the computer. However, upon return to the facility on 07/14/14, the resident's allergies were not listed on the physician's orders or the MARs, and the care plan had conflicting information. The RN stated this should have been corrected.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 07/25/14 at 10:50 AM, revealed she was unaware of conflicting information related to Resident #2; however, she revealed she expected the care plan and the Nurse Aide Care Plan to be updated when a new Physician's order was written.</p> <p>Interview with the Director of Nursing (DON), on 07/24/14 at 1:55 PM, revealed she expected the care plan and the Nurse Aide Care Plan to be updated when a new Physician's order was written.</p>	F 280	The results of the audits will be forwarded to the Executive QA committee quarterly for review, identification of trends, for follow up action as deemed appropriate and determine the need for an/or frequency of continued monitoring.	

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F 332 F 332 SS=D	Continued From page 3 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the medication administration rate was less than five (5) percent (%). Observation of twenty-nine (29) medication administration opportunities revealed two (2) medication errors resulting in a medication administration error rate of six (6) percent (%), related to an incorrect medication dose, and medication administered without a physician's order.  Findings include:  Review of the facility's policy/procedure, "Medication Administration," undated, revealed "the Medication Administration Record (MAR) shall be checked on a regular basis against the physician's orders, to assure continued and consistent accuracy. Any deviation from the following principles shall be considered a medication error: to the right resident; administration of the right medication; in the right dose; by the right route; by the right method; and at the right time".  1. Observation of a medication administration pass, on 07/23/14 at 9:42 AM, revealed Buspar, an antianxiety medication, was administered to	F 332 F 332	F332  Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;  On 07/24/2014 LPN #1 received written consultation related to not following medication administration record when giving medications. On 07/24/2014 the medication that was discontinued was removed from the medication cart and sent back to pharmacy.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice;  On 07/24/2014 through 07/26/2014 all medication carts were audited by assigned licensed nurses for any discharged medications and if any found were removed from carts.  Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	08/13/2014	

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F 332	<p>Continued From page 4</p> <p>Resident A by Licensed Practical Nurse (LPN) #1.</p> <p>Review of the Physician's orders, dated July 2014, revealed the resident was treated at the hospital on 07/14/14 through 07/17/14, and the medication (Buspar) was not reordered after the resident returned to the facility.</p> <p>Review of the MAR, dated 07/18/14, revealed there was no physician's order for the Buspar on the MAR.</p> <p>Interview with Certified Medication Aide (CMA) #1, on 07/24/14 at 8:30 AM, revealed there was no order for the Buspar on the MAR; however, the medication box for Buspar was still in the medication cart drawer and available for use. The CMA stated the medication box should have been removed from the drawer and sent back to the pharmacy when the resident returned from the hospital and the order was not renewed.</p> <p>Interview with the Director of Nursing (DON), on 07/24/14 at 10:00 AM, revealed the LPN was unavailable for interview, and the DON stated she would have expected the nurse to remove the discharged medications from the medication cart. She revealed the LPN should have followed the MAR instead of giving medications by the labels on the medication boxes in the drawer.</p> <p>2. Observation of a medication administration pass, on 07/23/14 at 9:42 AM, revealed Zantac, a medication given for heartburn relief, was administered to Resident A.</p> <p>Review of the physician's order and the MAR, dated July 2014, revealed the medication was ordered to be administered at 8:00 PM.</p>	F 332	<p>On 07/24/2014 – 08/11/2014 Director of Nursing in-serviced all licensed nurses and Kentucky medication assistants on removing medications from medication carts after they have been discontinued.</p> <p>On 08/07/2014-08/11/2014 Staff Facilitator Nurse educated all nurses and Kentucky medication assistants on the seven rights of medication administration and the importance of following the medication administration record when giving medications.</p> <p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Staff Facilitator Nurse will conduct random medication pass audits with licensed nurses/Kentucky medication assistants weekly x 4 weeks for compliance and will review the results of the audits at the Friday Department morning meeting.</p> <p>Quality Assurance Nurse will audit medication carts weekly x 4 weeks for any discontinued medications and the results of these audits will be reviewed at Friday Department morning meeting.</p>		

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F 332	Continued From page 5  Interview with CMA #1 and review of the MAR, on 07/24/14 at 8:30 AM, revealed the order on the MAR was initiated as administered at 8:00 PM.  Interview with the DON, on 07/24/14 at 10:05 AM, revealed she expected the staff to administer the medication as ordered.	F 332	The results of the audits will be forwarded to the Executive QA committee quarterly for review, identification of trends, for follow up action as deemed appropriate and determine the need for an/or frequency of continued monitoring.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the medical record was accurately maintained for one (1) resident (Resident #2), in the selected sample of sixteen (16) residents. The facility failed to accurately and consistently document the resident's allergies in the medical record.	F 514	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;  On 08/07/2014 ADON reviewed resident #2 and wrote order to reflect all current allergies. On 08/11/2014 MDS reviewed resident #2 care plan to ensure that allergies are all current on care plan.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice;  On 08/01/2014 Medical Records began an audit of all residents allergies and completed this audit 08/07/2014 to ensure that allergies were current and listed in appropriate places.  Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;	08/13/2014	

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F 514	<p>Continued From page 6</p> <p>Findings include:</p> <p>Interview with the Administrator, on 07/25/14 at 12:25 PM, revealed there was no specific policy for maintaining the clinical record.</p> <p>Record review revealed the facility admitted Resident #2 on 02/22/14, and re-admitted the resident, on 07/14/14, after hospitalization with diagnoses which included Pneumonia and Failure To Thrive. Further review revealed several intravenous (IV) antibiotics were administered during his/her hospital stay, which contributed to a macular rash.</p> <p>Review of Resident #2's Face Sheet revealed allergies to Vancomycin, Keflex, Levaquin, and Zosyn. Further review revealed the medication allergies were flagged on the front of the resident's medical chart; however, review of the physician's order and the Medication Administration Records (MARs) revealed "No Known Allergies (NKA)". Additional review of the resident's face sheet and care plans revealed conflicting information, as evidenced by an area listing his/her allergies, and in another area, listing him/her with "NKA".</p> <p>Review of the Admission Minimum Data Set (MDS) assessment, dated 07/21/14, revealed Resident #2 was severely cognitively impaired and totally dependent on the staff for care.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/25/14 at 10:55 AM, revealed she failed to note his/her allergies correctly on the physician's orders and the MARs.</p> <p>Interview with Registered Nurse (RN) #1, on</p>	F 514	<p>On 08/01/2014 Staff Facilitator Nurse began an in-service for all licensed nurses on reviewing orders and updating care plans and this was completed on 08/11/2014.</p> <p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Each admission and/or readmission chart will be brought to Administrative Nursing morning meeting and reviewed for correct medication orders and allergy orders as well as care plan updated.</p> <p>Quality Assurance Nurse will audit 10% of all care plan/care guides weekly x 4 weeks for compliance and will review the results of this audit each week during Friday department head morning meeting.</p> <p>The results of the audits will be forwarded to the Executive QA committee quarterly for review, identification of trends, for follow up action as deemed appropriate and determine the need for an/or frequency of continued monitoring.</p>	

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F 514	Continued From page 7 07/25/14 at 10:40 AM, revealed the allergies were listed on the front of the chart and on the face sheet in the computer. However, upon return to the facility on 07/14/14, the resident's allergies were not listed on the physician's orders or the MARs, and the care plan had conflicting information. The RN stated this should have been corrected.  Interview with the Assistant Director of Nursing (ADON), on 07/25/14 at 10:50 AM, revealed she was unaware of conflicting information related to Resident #2.	F 514			

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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: 1978.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1978, and upgraded in 2005 with 26 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1978.</p> <p>GENERATOR: Type II generator installed in 1979. Fuel source is Liquid Propane.</p> <p>A standard Life Safety Code Survey was conducted on 07/23/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for ninety-six (96) beds with a census of eighty (80) 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	<p><u>RESPONSE PREFACE</u></p> <p>Lake Way acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Lake Way's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.</p> 	

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

*Selma Beck*

TITLE

*Administrator*

(X6) DATE

*08-14-2014*

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K 000	Continued From page 1	K 000		
K 025 SS=F	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility has the capacity for ninety-six (96) beds and at the time of the survey, the census was eighty (80).</p> <p>The findings include:</p> <p>Observation, on 07/23/14 at 9:00 AM with the Maintenance Supervisor, revealed the smoke</p>	K 025	<p><b>K025</b></p> <p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>On 07/23/2014 the penetrations located at room #114 and #211 were sealed by Maintenance Director. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;</p> <p>All smoke barrier walls were inspected for penetrations by the Maintenance Director and his assistant on 07/29/2014.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur</p> <p>On 08/11/2014 the Administrator in-serviced the Maintenance Director on the NFPA 101(2000 Edition) Life Safety code standard on requirements that no penetrations be through smoke barrier walls and to inspect after any updates to the facility.</p>	08/13/2014

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  07/23/2014
NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42026	
(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 025	Continued From page 3  (b) 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 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose.  (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.  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 025		

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K 025	<p>Continued From page 2</p> <p>partition, extending above the ceiling located at room #114 was penetrated by a sprinkler pipe and was not properly sealed around the pipe.</p> <p>Interview, on 07/23/14 at 9:01 AM with the Maintenance Supervisor, revealed he was unaware of the penetration around the pipe since he had checked the walls within the last month.</p> <p>Observation, on 07/23/14 at 9:05 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at room #211 was penetrated by a sprinkler pipe and was not properly sealed around the pipe.</p> <p>Interview, on 07/23/14 at 9:06 AM with the Maintenance Supervisor, revealed he was unaware of the penetration around the pipe since he had checked the walls within the last month.</p> <p>The census of eighty (80) was verified by the Administrator on 07/23/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 07/23/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol>	K 025	<p>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</p> <p>Maintenance Director will audit monthly for any penetrations through the smoke barrier walls and after any construction to the facility involving the smoke barrier walls.</p> <p>The results of the audits will be forwarded to the Executive QA committee quarterly for review, identification of trends, for follow up action as deemed appropriate and determine the need for an/or frequency of continued monitoring</p>	