

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

PRINTED: 04/02/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/19/2015
NAME OF PROVIDER OR SUPPLIER  CARMEL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 OLD HARTFORD RD. OWENSBORO, KY 42303	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification Survey was conducted on 03/17/15 through 03/19/15 to determine the facility's compliance with Federal Requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "E".	F 000	 <p><b>Criteria 1:</b> Resident #2 has been assessed by the RD, DON and MDS Coordinator on 3/19/15 and had review/revision of the care plan to address the nutritional supplement, and all appropriate interventions to address weight loss.</p> <p><b>Criteria 2:</b> All residents with weight loss in the last 30 days have been assessed by the RD, DON and MDS Coordinator on 3/31/15 and had review/revision of their care plans to determine that all appropriate nutritional interventions are documented.</p> <p><b>Criteria 3:</b> The MDS coordinator has had inservice education on the need to update the care plan timely with</p>	
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 the facility's policy and procedure, it was determined the facility failed to revise the care	F 280		

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

TITLE

(X6) DATE

*Anita Francis Teresa Scully*

Admin

5-4-15

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  CARMEL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 OLD HARTFORD RD. OWENSBORO, KY 42303
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F 280	<p>Continued From page 1</p> <p>plan for one (1) of eight (8) sampled residents (Resident #2), after a significant weight loss.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Comprehensive Care Plans", not dated, revealed the Comprehensive Care Plan was to include measurable objectives and timetables to meet the resident's medical and nursing needs. Further review revealed the care plans are revised as changes in the resident's condition dictates.</p> <p>Record review revealed the facility admitted Resident #2 on 02/12/13 with diagnoses to include Senile Dementia, Polyneuropathy, and Depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/20/14, revealed the facility had assessed Resident #2's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6), indicating the resident was not interviewable.</p> <p>Review of the facility's "Vital Sign and Weight Flow Sheet", not dated, revealed Resident #2's weight was noted on 02/07/15 to be 117 pounds, and on 02/14/15 Resident #2's weight was noted to be 111 pounds, with a loss of six (6) pounds in one (1) week.</p> <p>Review of the facility's "Nutritional Progress Note", dated 03/12/15, revealed Resident #2's weight was 105 pounds. Further review revealed a significant weight loss was identified and a House Supplement (nutritional supplement) was added at that time.</p>	F 280	<p>nutritional interventions when weight loss has been identified, as provided by the Nursing Consultant on 4-7-15.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of care plan interventions to address weight loss will be utilized quarterly as per the established CQI calendar under the supervision of the DON.</p> <p><b>Criteria 5:</b></p>	April 8 2015
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F 280	<p>Continued From page 2</p> <p>Review of the Comprehensive Care Plan, dated 03/17/15, revealed the facility assessed Resident #2 at risk for unintended weight loss; however, there was no documented evidence the care plan was updated until 03/09/15, when a new intervention was added for Speech and Occupational Therapy Screenings.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/19/15 at 10:35 AM, revealed she did not remember noting Resident #2's weight loss on 02/14/15; however, she stated she should have immediately notified the resident's physician and family and notified the Director of Nursing (DON). She also stated the Registered Dietitian should have been notified and a new intervention added to the resident's Comprehensive Care Plan.</p> <p>Interview with the Registered Dietitian, on 03/19/15 at 9:30 AM, revealed Resident #2 had a significant weight loss of six (6) pounds from 02/07/15-02/14/15 which was a five percent (5%) weight loss in one (1) week. She stated any weight loss of two percent (2%) or greater in one (1) week would be considered a significant weight loss. She further stated the physician and the resident's family should have been notified and an intervention should have immediately been put in to place to prevent further weight loss.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 03/19/15 at 10:15 AM, revealed it was her responsibility to review the weekly weights and report any noted weight loss to the DON. She further stated it was her responsibility to update the Comprehensive Care Plan with new interventions when weight loss was identified. She stated she was not sure what happened.</p>	F 280			

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F 280	Continued From page 3 Interview with the DON, on 03/19/15 at 10:00 AM, revealed any identified weight loss should be immediately reported to her. She further stated the Registered Dietitian, the resident's physician, and the resident's family would be notified and the Plan of Care would be updated per the Dietitian's and physician's recommendations.	F 280			
F 325 SS=D	483.25(I) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedure, it was determined the facility failed to ensure residents maintained his/her body weight for one (1) of eight (8) sampled residents (Resident #2). Resident #2 sustained a weight loss of six (6) pounds resulting in a five percent (5%) weight loss in one (1) week from 02/07/15 through 02/14/15, without consistent assessment and intervention until the resident's weight was stable.  The findings include:	F 325	<b>Criteria 1:</b> Resident #2 has been assessed by the RD, DON and MDS Coordinator on 3/19/15 and had review/revision of the care plan to address the necessary interventions to address weight loss. Resident #2 is being monitored by the Nutrition at Risk team.  <b>Criteria 2:</b> All residents with weight loss in the last 30 days have been assessed by the RD, DON and MDS Coordinator on 3/31/15 and had review/revision of their care plans to determine that all appropriate nutritional interventions are documented.  <b>Criteria 3:</b> The Nutrition at Risk team has had inservice education on the need to		

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F 325	<p>Continued From page 4</p> <p>Review of the facility's policy and procedure titled, "Weights", dated 01/2014, revealed its policy was to monitor residents' weights. Further review revealed when a significant weight loss is identified, the Primary Care Physician and the Dietitian are to be consulted.</p> <p>Record review revealed the facility admitted Resident #2 on 02/12/13 with diagnoses to include Senile Dementia, Polyneuropathy, and Depression. Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/20/14, revealed the facility had assessed Resident #2's cognition as severely impaired with a Brief Interview for Mental Status (BIMS) score of six (6) indicating the resident was not interviewable.</p> <p>Review of the facility's "Vital Sign and Weight Flow Sheet", not dated, revealed Resident #2's weight was noted on 02/07/15 to be 117 pounds and on 02/14/15 Resident #2's weight was noted to be 111 pounds, with a loss of six (6) pounds in one (1) week.</p> <p>Review of the facility's "Nutritional Progress Note", dated 03/12/15, revealed Resident #2's weight was 105 pounds. Further review revealed a House Supplement (nutritional supplement) was added at that time.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/19/15 at 10:35 AM, revealed she did not remember noting Resident #2's weight loss on 02/14/15; however, she stated she should have immediately notified the resident's physician and family and notified the Director of Nursing (DON). She also stated the Registered Dietitian should have been notified and a new intervention added to the resident's plan of care.</p>	F 325	<p>identify, address and monitor Residents for weight loss and to address the necessary interventions on the care plan timely, as provided by the DON on 4/8/15.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of identification, care planning and monitoring of Resident weight loss will be utilized quarterly as per the established CQI calendar under the supervision of the DON.</p> <p><b>Criteria 5:</b></p>	April 9 2015	

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F 325	Continued From page 5  Interview with the Registered Dietitian, on 03/19/15 at 9:30 AM, revealed Resident #2 had a significant weight loss of six (6) pounds from 02/07/15-02/14/15, which was a five percent (5%) weight loss in one (1) week. She stated any weight loss of two percent (2%) or greater in one (1) week would be considered a significant weight loss. She further stated the physician and the resident's family should have been notified and an intervention should have immediately been put in to place to prevent further weight loss.  Interview with the DON, on 03/19/15 at 10:00 AM, revealed any identified weight loss should be immediately reported to her. She further stated the Registered Dietitian, the resident's physician, and the resident's family should be notified and the Plan of Care should be updated per the Dietitian's and physician's recommendations.	F 325			
F 371 SS=E	483.35(f) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of	F 371			

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F 371	<p>Continued From page 6</p> <p>the facility policies and procedures, it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Observation during the survey revealed open, unlabeled milk containers, a build-up of frozen condensation in the walk-in freezer, as well as a build-up of frozen condensation in the chest freezer. Additionally, two (2) observations revealed a facility staff walking through the kitchen food preparation area without any form of hair restraint.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Personal Hygiene", undated, revealed to wear a clean hat or other hair restraint. Hair must be appropriately restrained per State regulations. Head covering must be clean, and beards or any body hair that may be exposed (i.e., arms) must be covered.</p> <p>Review of the facility's policy, "Food Storage", undated, revealed to label and date all food items.</p> <p>Observation, on 03/18/15 at 8:00 AM, revealed two (2) open, partially used gallons of milk, without a label to indicate the date opened. Observation of the walk-in freezer revealed a two (2) to three (3) inch build-up of ice on the floor, located beneath the freezer fans, as well as a large build-up of ice on the ceiling of the walk-in freezer located in front of the fans. Further observation revealed the chest freezer was being utilized for ice cream, and miscellaneous food items were observed to have a large build-up ice on the sides of the chest freezer.</p> <p>Additional observation, on 03/18/15 at 8:15 AM,</p>	F 371	<p><b>Criteria 1:</b> -The pen/undated cartons of milk identified during the survey were discarded on 3/17/15.</p> <p>-On 3/17/15 the walk-in and chest freezers have been defrosted.</p> <p>-On 3/17/15 a sign was posted notifying all staff they are not permitted into the kitchen food preparation area unless they have a proper form of hair restraint.</p> <p><b>Criteria 2:</b> -All opened food items were inspected by the Dietary Manager on 3/17/15 to determine they are stored in a container or proper wrapping and dated when opened.</p> <p>-Beginning on 3/17/15 the walk-in and chest freezers have been added to the cleaning schedule for routine defrosting.</p> <p>-On 3/17/15 signs have been posted informing staff that no one is allowed to enter the kitchen food prep area without a form of hair restraint.</p> <p><b>Criteria 3:</b> -Dietary staff have received inservice</p>		

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F 371	<p>Continued From page 7</p> <p>revealed a facility staff entered the kitchen, walked past the food preparation area without any type of hair restraint, and exited the kitchen through a second door. At 8:20 AM, the same facility staff re-entered the kitchen and walked through the kitchen, past the food preparation area a second time, without any type of hair restraint.</p> <p>Interview with the Dietary Manager, on 03/18/15 at 8:20 AM, revealed anyone who entered the facility kitchen should have a hair restraint in place. She stated facility staff walked through the kitchen area on multiple occasions without a hair restraint.</p> <p>Further interview with the Dietary Manager, on 03/18/15 at 8:30 AM, revealed the build-up of ice on the walk-in freezer floor and the ceiling had been a problem in the past and it was addressed. The Dietary Manager could not recall if anything was done at the time to correct the problem, or the date that someone had looked at it. She revealed she was responsible to ensure there was no build-up of ice in the chest freezer, and stated the freezer was not on the schedule for defrosting or cleaning. The Dietary Manager also revealed moisture dripping in the walk-in freezer could potentially drip on the food and was problematic.</p>	F 371	<p>education by the CDM on 3/19/15 on the proper storage and dating of opened food items, the routine defrosting of the walk-in and chest freezers, and prevention of anyone from entering the kitchen food prep area without a proper form of hair restraint.</p> <p>-On 3/19/15 all facility staff have received inservice education from the Administrator on the requirement for the use of a proper hair restraint to enter the kitchen food prep area.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of dietary sanitation compliance, including but not limited to proper storage and dating of opened food items, the absence of frost on the freezers, and the use of hair restraints in the kitchen food prep area will be utilized monthly under the supervision of the Administrator.</p> <p><b>Criteria 5:</b></p>	<p>March 30, 2015</p>
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NAME OF PROVIDER OR SUPPLIER  CARMEL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2601 OLD HARTFORD RD. OWENSBORO, KY 42303
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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: 1984, 1986</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222)</p> <p>SMOKE COMPARTMENTS Five (5) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with 85 heat and 140 smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 03/18/15. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for eighteen (18) beds and at the time of the survey, the census was eighteen (18).</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. Francis Teresa Scully</i>	TITLE Admin	(X6) DATE 5-4-15
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A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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.

Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.

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K 050 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>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 record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for eighteen (18) beds and at the time of the survey, the census was eighteen (18).</p> <p>The findings include:</p> <p>Review of the facility's Fire Drill documentation, on 03/18/15 at 3:10 PM, with the Maintenance Director revealed the facility failed to conduct fire drills in the second (2nd) quarter for the first (1st) shift and second (2nd) shift staff.</p>	K 050	<p><b>Criteria 1 and 2:</b> Fire drills are conducted on each shift monthly on the certified unit of the facility under the supervision of the Maintenance Supervisor and monitored by the Administrator.</p> <p><b>Criteria 3:</b> The Director of Maintenance has received inservice education on the need to conduct a fire drill on each shift monthly on the certified unit as provided by the Administrator on March 19, 2015.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of conduction of fire drills will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Maintenance Supervisor and monitored by the Administrator.</p> <p><b>Criteria 5:</b></p>	March 30 2015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185226	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  03/18/2015
NAME OF PROVIDER OR SUPPLIER  CARMEL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2501 OLD HARTFORD RD. OWENSBORO, KY 42303	
(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 050	Continued From page 2  Interview, on 03/18/15 at 3:11 PM, with the Maintenance Director revealed he was unaware the fire drills were not being conducted as required.  The census of eighteen (18) was verified by the Administrator on 03/20/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 03/20/15.  Actual NFPA Standard:  Reference: NFPA 101 (2000 edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by:	K 056		

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K 056	<p>Continued From page 3</p> <p>Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect three (3) of five (5) smoke compartments, twelve (12) residents, staff and visitors. The facility has the capacity for eighteen (18) beds and at the time of the survey, the census was eighteen (18). According to CMS S&amp;C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.</p> <p>The findings include:</p> <p>Observation, on 03/18/15 at 2:30 PM, with the Maintenance Director revealed a sprinkler head located in the Dining Room Hall and Restroom were obstructed from developing a full pattern by a light fixture installed within twelve (12) inches of the sprinkler head and extending down below the sprinkler deflector.</p> <p>Interview, on 03/18/15 at 2:31 PM, with the Maintenance Director revealed he was aware of the requirement; however, he had not noticed the sprinkler heads being obstructed by the light fixtures.</p> <p>Observation, on 03/18/15 at 2:39 PM, with the Maintenance Director revealed a sprinkler head located in the Zone fourteen (14) Whirlpool Room was obstructed from developing a full pattern by a light fixture installed within twelve (12) inches of the sprinkler head and extending down below the sprinkler deflector.</p> <p>Interview, on 03/18/15 at 2:40 PM, with the</p>	K 056	<p><b>Criteria 1 and 2:</b></p> <ul style="list-style-type: none"> <li>-The light fixture within 12 inches of the sprinkler head in the dining room hall and restroom has been relocated on 5/5/15.</li> <li>-The light fixture within 12 inches of the sprinkler head in the Zone 14 whirlpool room has been relocated 5/5/15.</li> <li>-The light fixture within 12 inches of the sprinkler head in the Zone 14 linen room has been relocated 5/5/15.</li> <li>-The exterior porch roof has been has been sprinkled 4/27/15.</li> </ul> <p><b>Criteria 3:</b> The maintenance staff have received inservice education on 3/19/15 by the Administrator on the need to verify that all sprinkler heads are unobstructed as per the Life Safety Code.</p> <p><b>Criteria 4:</b> The CQI tool for the monitoring of the automatic</p>	
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K 056	<p>Continued From page 4</p> <p>Maintenance Director revealed he was aware of the requirement; however, he had not noticed the sprinkler heads being obstructed by the light fixtures.</p> <p>Observation, on 03/18/15 at 2:42 PM, with the Maintenance Director revealed a sprinkler head located in the Zone fourteen (14) Linen Room was obstructed from developing a full pattern by a light fixture installed within twelve (12) inches of the sprinkler head and extending down below the sprinkler deflector.</p> <p>Interview, on 03/18/15 at 2:43 PM, with the Maintenance Director revealed he was aware of the requirement; however, he had not noticed the sprinkler heads being obstructed by the light fixtures.</p> <p>Observation, on 03/18/15 at 2:49 PM, with the Maintenance Director revealed an exterior porch roof, extending out greater than four (4) feet that was constructed of combustible wood material and did not have sprinkler protection installed below the ceiling. The porch roof was located outside the Zone nine (9) Exit door.</p> <p>Interview, on 03/18/15 at 2:50 PM, with the Maintenance Director revealed he was not aware the exterior roofs were to be sprinkler protected due to being constructed of combustible wood materials.</p> <p>The census of eighteen (18) was verified by the Administrator on 03/18/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 03/18/15.</p>	K 056	<p>sprinkler system will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Maintenance Supervisor and monitored by the Administrator</p> <p>Criteria 5:</p>	May 6 2015

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K 056	<p>Continued From page 5 Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered. 19.3.5.2* Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria: (1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>Reference: NFPA 101 (2000 Edition) 9.7 AUTOMATIC SPRINKLERS AND OTHER EXTINGUISHING EQUIPMENT 9.7.1 Automatic Sprinklers.</p>	K 056		

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K 056	<p>Continued From page 6</p> <p>9.7.1.1*</p> <p>Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Exception No. 1: NFPA 13R, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height, shall be permitted for use as specifically referenced in Chapters 24 through 33 of this Code.</p> <p>Exception No. 2: NFPA 13D, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, shall be permitted for use as provided in Chapters 24, 26, 32, and 33 of this Code.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures.</p> <p>Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: right;">Distance from Sprinklers to above Bottom of Side of Obstruction (A)</td> <td style="text-align: center;">Maximum Allowable Distance of Deflector</td> <td style="text-align: left;">Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td></td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td></td> <td>2 1/2</td> </tr> </table>	Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector	Obstruction (in.)	(B)			Less than 1 ft		0	1 ft to less than 1 ft 6 in.		2 1/2	K 056		
Distance from Sprinklers to above Bottom of Side of Obstruction (A)	Maximum Allowable Distance of Deflector	Obstruction (in.)														
(B)																
Less than 1 ft		0														
1 ft to less than 1 ft 6 in.		2 1/2														

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K 056	Continued From page 7 1 ft 6 in. to less than 2 ft 31/2 2 ft to less than 2 ft 6 in. 51/2 2 ft 6 in. to less than 3 ft 71/2 3 ft to less than 3 ft 6 in. 91/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 161/2 5 ft and greater 18  For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain electronic supervision (tamper switches) for a water supply control valve installed on the	K 062	

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K 082	<p>Continued From page 8</p> <p>sprinkler system in accordance with National Fire Protection (NFPA) standards. The deficient practice has the potential to affect five (5) of five (5) smoke compartments, eighteen (18) residents, staff and visitors. The facility has the capacity for eighteen (18) beds and at the time of the survey, the census was eighteen (18).</p> <p>The findings include:</p> <p>Observation, on 03/18/15 at 2:20 PM, with the Maintenance Director revealed the sprinkler system main valve tamper switch failed to sound an alarm to indicate the valve was closed.</p> <p>Interview, on 03/18/15 at 2:20 PM, with the Maintenance Director revealed he depended on the sprinkler contractor to keep the tamper switch working as required.</p> <p>The census of eighteen (18) was verified by the Administrator on 03/18/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 03/18/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 19.3.5 Extinguishment Requirements. 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall</p>	K 082	<p><b>Criteria 1:</b> The sprinkler system main valve tamper switch alarm was repaired to sound when the valve was closed by the outside contractor on April 15, 2015.</p> <p><b>Criteria 2:</b> The sprinkler system main valve tamper switch alarm will be tested by the outside contractor with annual sprinkler system inspections.</p> <p><b>Criteria 3:</b> The outside contractor that conducts the automatic sprinkler inspection was provided the NFPA Life Safety Code Standard information for the automatic sprinkler system requirements. The maintenance staff were provided inservice education on these requirements by the Administrator on March 19, 2015.</p>	
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K 062	<p>Continued From page 9</p> <p>be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>19.3.5.2*</p> <p>Where this Code permits exceptions for fully sprinklered buildings or smoke compartments, the sprinkler system shall meet the following criteria:</p> <p>(1) It shall be in accordance with Section 9.7. (2) It shall be electrically connected to the fire alarm system. (3) It shall be fully supervised.</p> <p>Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.</p> <p>Reference: NFPA 101 (2000 Edition) 9.7.2.1*. Where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm Code, and a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Monitoring shall include, but shall not be limited to, monitoring of control valves, fire pump power supplies and running conditions, water tank levels and temperatures, tank pressure, and air pressure on dry-pipe valves. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is</p>	K 062	<p><b>Criteria 4:</b> The CQI indicator for the monitoring of the automatic sprinkler systems requirements will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the Maintenance Supervisor and monitored by the Administrator.</p> <p><b>Criteria 5:</b></p>	April 16 2015
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K 062  K 144 SS=F	<p>Continued From page 10 constantly attended by qualified personnel or at an approved, remotely located receiving facility.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility has the capacity for eighteen (18) beds with a census of eighteen (18) on the day of the survey.</p> <p>The findings include:</p> <p>Generator documentation review, on 03/18/15 at 3:25 PM, with the Maintenance Director revealed the facility did not have an annual load bank test performed on the generator. Further record review revealed the facility did not have documentation of the percentage of load the generator was under or the exhaust temperature during monthly tests to determine if an annual load bank test was required.</p>	K 062  K 144	<p><b>Criteria 1:</b> An annual load bank test was performed on the generator on April 15, 2015 with documentation of the percentage of load the generator was under.</p> <p><b>Criteria 2:</b> The exhaust temperature will be documented with monthly generator load testing to determine if an annual load bank test is required.</p> <p><b>Criteria 3:</b> The maintenance staff have received inservice information from the Administrator on the need to document the exhaust temperature for the generator as part of the monthly generator load test information, as provided on March 19, 2015.</p> <p><b>Criteria 4:</b> The CQI indicator for the monitoring of documentation of the generator testing will be utilized</p>	
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K 144	<p>Continued From page 11</p> <p>Interview, on 03/03/15 at 3:26 PM, with the Maintenance Director revealed he was not aware of the requirements for generator testing.</p> <p>The census of eighteen (18) was verified by the Administrator on 03/18/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 03/18/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations.</p> <p>6-4.2.2 Diesel-powered EPS installations that do not</p>	K 144	<p>monthly X 2 months and then quarterly thereafter under the supervision of the Maintenance Supervisor and monitored by the Administrator.</p> <p>Criteria 5:</p> <p>April 16 2015</p>

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K 144	Continued From page 12 meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.	K 144		
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