

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

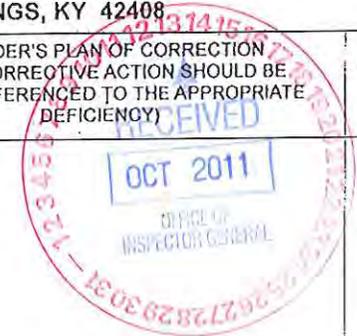
PRINTED: 09/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/31/2011
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NAME OF PROVIDER OR SUPPLIER DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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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	F 000		
F 282 SS=D	<p>An annual survey was conducted on 08/29/11 through 08/31/11 and a Life Safety Code survey was conducted on 08/31/11 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with deficiencies cited at the highest S/S of "F."</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, review of facility policy/procedure and record review, it was determined the facility failed to ensure care was provided in accordance with each resident's written plan of care for one resident (#3), in the selected sample of 15, related to the use of a self-release seatbelt alarm.</p> <p>The findings include: A review of the facility's policy/procedure "Assistive/Supportive Devices," revised 03/31/10, revealed the facility "would have a system in place to provide adequate assistive/supportive devices to prevent injury. All alarms would be checked each shift and throughout the shift, as care was provided, for proper working condition and placement. This would be documented on the nurse aide care plan."</p>	F 282	<p>F 282</p> <p>1. Corrective action: Resident #3</p> <p>Nursing staff inserviced by Compliance Nurse on 9-23 thru 9-30-11:</p> <p>The NASR care plan is to be followed at all times for each resident including the use of supportive/assistive devices such as self-release seat belts/alarms.</p> <p>All alarms are to be in place, checked each shift and throughout the shift as care is provided for proper functioning and placement.</p> <p>(See attachment #4 Nursing Inservice on Alarms/ Assistive Devices)</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael B. Carter</i>	TITLE Administrator	(X6) DATE 10-13-11
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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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F 282	Continued From page 1 A record review revealed Resident #3 was admitted to the facility on 01/14/11 with diagnoses to include Anxiety, Depression, Psychosis, Senile Dementia and Generalized Pain. A review of the quarterly Minimum Data Set (MDS), dated 06/02/11, revealed the facility identified the resident as severely cognitively impaired and required total assistance with transfers. A review of the Comprehensive Care Plan "At Risk for Falls/Injury," dated 08/26/11, revealed Resident #3 had a self-release seatbelt on his/her wheelchair to alert the staff of unassisted transfers. A review of the Nurse's Notes, dated 06/18/11, revealed the resident was found in front of the wheelchair, lying on the dining room floor with his/her face touching the floor. A review of the "Investigation Worksheet," dated 06/18/11 at 9:45 AM, revealed the resident was sitting in his/her wheelchair prior to the fall, and the resident had "undone" the seatbelt. There was no indication on the worksheet if the alarm sounded at the time of the fall. A review of the Nursing Assistant Care Plan, dated 06/11, revealed the resident was to have the self-release seat belt on the wheelchair, and the care plan was signed by Nurse Aide State Registered (NASR) #1, on 06/18/11 (dayshift). An interview with NASR #1, on 08/30/11 at 2:00 PM, revealed she was the caregiver for Resident	F 282	2. ID of others at risk: All residents with assistive/supportive devices reviewed by the DON and the Compliance Nurses on 9-21-11 for proper functioning and placement. No residents were identified with improper placement or function of their safety device. 3. Prevention measures: Nursing staff inserviced by Compliance Nurse on 9-23 thru 9-30-11: The NASR care plan is to be followed at all times for each resident including the use of safety devices such as self-release seat belts/alarms. All alarms, assistive/supportive devices, are to be in place, checked each shift and throughout the shift as care is provided for proper working condition and placement.	
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F 282	<p>Continued From page 2</p> <p>#3, on 06/18/11. She revealed the self-release seatbelt alarm was secured when she left the resident.</p> <p>A phone interview with Licensed Practical Nurse (LPN) #1, on 08/31/11 at 11:45 AM, revealed NASR #1 informed her about the resident's behaviors, but did not inform her that she left the resident unattended. She could not remember if the resident's self-release seatbelt was on prior to the fall. She revealed she did not remember hearing the alarm sound, but a witness to the fall yelled out for help. She revealed NASR #1 did not ensure the alarm was functioning.</p> <p>An interview with a witness, on 08/31/11 at 1:50 PM, revealed Resident #3 "wheeled" over to a dining room table and the seatbelt alarm was not fastened. The alarm was not sounding. She revealed the resident grabbed the table and went over "head first." She stated "I hollered for help."</p> <p>An interview with Certified Medication Technician (CMT) #1, on 08/31/11 at 10:25 AM, revealed she passed medications on 06/18/11. She revealed she was on "Hall 2" at the time of the resident's fall, but did not hear the resident's seatbelt alarm sound.</p> <p>An interview with the Director of Nursing (DON), on 08/31/11 at 6:10 PM, revealed she expected NASR #1 to follow the care plan and ensure the residents' alarms functioned.</p>	F 282	<p>4. Monitor:</p> <p>Monitor for assistive devices Added: - to the Charge Nurse Compliance Round Checklist for each shift -added to the NASR careplan attestation for checking every 2 hours and as care is provided -monitored by the Nursing Safety Inspection tool through the facility CQI program weekly x 4 weeks, if no problems noted, monthly x 3 months and then quarterly.</p> <p><i>(See attachments # 1, 2 & 3, Quality Improvement Rounds, Nursing Assistant Care Plan and Nursing Safety Inspection CQI Tool)</i></p>	
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards</p>	F 323	<p>5. Date Corrected:</p> <p>F 323</p> <p>1. Corrective action: Resident #3</p>	10/01/11

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F 323	<p>Continued From page 3 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, review of facility policy/procedure and record review, it was determined the facility failed to ensure each resident received adequate assistance devices to prevent accidents for one resident (#3), in the selected sample of 15. Resident #3 sustained a fall from the wheelchair, on 06/18/11, and was determined to have a non-displaced nasal bone fracture. The resident had a self-release seatbelt alarm on the wheelchair which did not sound.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure "Assistive/Supportive Devices," revised 03/31/10, revealed the facility "would have a system in place to provide adequate assistive/supportive devices to prevent injury. All alarms would be checked each shift and throughout the shift, as care was provided, for proper working condition and placement. This would be documented on the nurse aide care plan."</p> <p>A record review revealed Resident #3 was admitted to the facility on 01/14/11 with diagnoses to include Anxiety, Depression, Psychosis, Senile Dementia and Generalized Pain.</p>	F 323	<p>Nursing staff inserviced by Compliance Nurse on 9-23 thru 9-30-11:</p> <p>The NASR care plan is to be followed at all times for each resident including the use of supportive/assistive devices such as self-release seat belts/alarms.</p> <p>All alarms are to be in place, checked each shift and throughout the shift as care is provided for proper functioning and placement.</p> <p>2. ID of others at risk:</p> <p>All residents with assistive/supportive devices reviewed by the DON and the Compliance Nurses on 9-21-11 for proper functioning and placement. No residents were identified with improper placement or function of their safety device.</p>	
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F 323	<p>Continued From page 4</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 06/02/11, revealed the facility identified the resident as severely cognitively impaired and required total assistance with transfers.</p> <p>A review of the physician's orders, dated 08/11, revealed a self-release seat belt alarm was ordered for the resident on 04/29/11.</p> <p>A review of the Nurse's Notes, dated 06/18/11, revealed the resident was found in front of the wheelchair, lying in the dining room floor with his/her face touching the floor. At 2:25 PM, the resident was assessed to have discoloration of the nose with swelling. The nose was slanted to the right. A review of the "X-Ray Services" report, dated 06/18/11, revealed a nondisplaced nasal bone fracture.</p> <p>A review of the "Investigation Worksheet," dated 06/18/11 at 9:45 AM, revealed the resident was sitting in his/her wheelchair prior to the fall, and the resident had "undone" the seatbelt. There was no indication on the worksheet if the alarm sounded at the time of the fall.</p> <p>A review of the Nursing Assistant Care Plan, dated 06/11, revealed the resident should have the self-release seat belt to the wheelchair. The care plan was signed by Nurse Aide State Registered (NASR) #1, on 06/18/11 (dayshift).</p> <p>A review of the Comprehensive Care Plan "At Risk for Falls/Injury," dated 08/26/11, revealed the self-release seatbelt on the wheelchair was to alert the staff of unassisted transfers.</p>	F 323	<p>3. Prevention measures:</p> <p>Nursing staff inserviced by Compliance Nurse on 9-23-11:</p> <p>The NASR care plan is to be followed at all times for each resident including the use of safety devices such as self-release seat belts/alarms.</p> <p>All alarms, assistive/supportive devices, are to be in place, checked each shift and throughout the shift as care is provided for proper working condition and placement.</p> <p>4. Monitor:</p> <p>Monitor for assistive devices Added: - to the Charge Nurse Compliance Round Checklist for each shift - added to the NASR careplan attestation for checking</p>	
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F 323	<p>Continued From page 5</p> <p>An interview with NASR #1, on 08/30/11 at 2:00 PM, revealed she was the caregiver for Resident #3, on 06/18/11. She revealed the resident was "yelling out" on the hallway, and she took the resident up to the nurse's station. She revealed Licensed Practical Nurse (LPN) #1 was informed of the resident's behavior, and NASR #1 left the resident in the dining room (near the nurse's station). NASR #1 revealed the seatbelt alarm was secured when she left the resident.</p> <p>A phone interview with LPN #1, on 08/31/11 at 11:45 AM, revealed NASR #1 informed her of the resident's behaviors, but did not inform her she left the resident unattended. She could not remember if the resident's self-release seatbelt was in place prior to the fall. She revealed she did not remember hearing an alarm sound, but a witness to the fall yelled out for help. She revealed NASR #1 received disciplinary action because she left the resident unattended and did not ensure the alarm functioned.</p> <p>An interview with a witness, on 08/31/11 at 1:50 PM, revealed Resident #3 "wheeled" over to a dining room table and the seatbelt alarm was not fastened. The alarm was not sounding. She revealed the resident grabbed the table and went over "head first." She stated "I hollered for help."</p> <p>An interview with Certified Medication Technician (CMT) #1, on 08/31/11 at 10:25 AM, revealed she passed medications on 06/18/11. She revealed she was on "Hall 2" at the time of the fall, but did not hear the resident's seatbelt alarm sounding.</p> <p>An interview with the Director of Nursing (DON), on 08/31/11 at 6:10 PM, revealed Resident #3</p>	F 323	<p>every 2 hours and as care is provided -monitored by the Nursing Safety Inspection tool through the facility CQI program weekly x 4 weeks, if no problems noted, monthly x 3 months and then quarterly.</p> <p>5. Date Corrected:</p>	10/01/11
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F 323	Continued From page 6 took the self-release seatbelt off per himself/herself, but would not be able to turn the alarm off. She revealed Resident #3 was placed on 1:1 monitoring immediately after the fall until 5:00 PM. She stated no further interventions were put into place after the fall, as there was "nothing else to do." Staff were not inserviced, after the fall, to ensure proper placement and functioning of alarms. A review of the "Progressive Disciplinary Form," dated 06/18/11, revealed NASR #1 received disciplinary action (written warning) for the failure to properly supervise an upset resident and the failure to ensure alarms were in place, per the care plan.	F 323	F 332 1. Corrective action: Initiated policy and inserviced Nursing staff regarding the training of new licensed staff or CMT's for passing medications. Inservice for licensed staff and CMT's completed by the Compliance Nurse by 9-30-11. <i>(See attachment # 5, & 6, Policy on Medication Pass Training and CMT, Licensed Nsg Staff Inservice on Med Pass Training Policy)</i> New employees will be trained utilizing approximately one-half of the assigned residents of the trainer therefore requiring less time and assuring completion of the medication pass in a timely manner of one hour before or one hour after the scheduled time.	
F 332 SS=D	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, review of facility policy/procedure, record review and interview, the facility failed to ensure it was free of medication error rates of five percent or greater. During an observation of the medication pass, on 08/30/11 at 8:10 AM through 8:25 AM, there were a total of 41 opportunities with six (6) medication errors, which resulted in a six percent (6%) medication error rate. The findings include:	F 332		

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F 332	<p>Continued From page 7</p> <p>A review of the facility's policy/procedure "Medication Pass," dated 05/10/11, revealed the facility "adheres to Nursing Standards for medication passes. Begin medication pass on time. It is permissible to give the medication one hour before it was ordered and up to one hour after it was ordered. (Excluding medicine dependent on food or other specific factors.)"</p> <p>A review of current physician's orders for Resident #1 revealed "Stelazine (Anti-psychotic) 10 milligrams (mg) to be administered twice a day (BID) at 7:00 AM and 7:00 PM, Risperdal (Anti-psychotic) 6 mg to be administered BID at 7:00 AM and 7:00 PM, Neurontin (seizure disorder medication) 100 mg to be administered three times a day (TID) at 7:00 AM, 1:00 PM and 7:00 PM, Lasix (diuretic) 20 mg to be administered BID at 7:00 AM and 1:00 PM, Metformin (decreases blood glucose levels) HCL 1000 mg to be administered BID at 7:00 AM and 7:00 PM, and Metoprolol (blood pressure medication) 25 mg to be administered BID at 7:00 AM and 7:00 PM.</p> <p>An observation during the medication pass, on 08/30/11, revealed Resident #1's 7:00 AM medications were not administered until 8:25 AM.</p> <p>An interview with the Certified Medication Technician (CMT) #1, on 08/30/11 at 8:30 AM, revealed she had an hour before or an hour after the scheduled time to administer a resident's medication. She stated she was running behind and volced the medications were scheduled to be administered at 7:00 AM, but had until 8:00 AM to administer the medications. She stated "I would rather go slower in order to train a new employee</p>	F 332	<p>2. ID of others at risk:</p> <p>No residents are currently at risk as there are no new untrained staff passing medication.</p> <p>3. Prevention measures:</p> <p>Initiated policy and inserviced Nursing staff regarding the training of new licensed staff or CMT's for passing medications. New employees will be trained utilizing approximately one-half of the assigned residents of the trainer therefore requiring less time and assuring completion of the medication pass in a timely manner of one hour before or one hour after the scheduled time.</p> <p>Inservice completed by the Compliance Nurse on 9-30-11.</p>	

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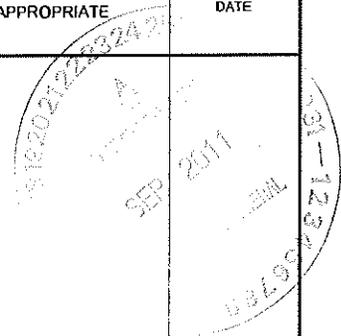
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F 332	Continued From page 8 right. An interview with the Director of Nursing (DON), on 08/31/11 at 2:00 PM, revealed she expected the staff to administer the medications as ordered. They had an hour before or an hour after the scheduled time to administer the medications. She stated "I should not have set up a new employee to train today. They were late administering the medications because CMT #1 was trying to train a new CMT about the correct way to complete a medication pass."	F 332	4. Monitor: Monitored by the Medication Pass tool through the facility CQI program weekly x 4 weeks, if no problems noted, monthly x 3 months and then quarterly. <i>(See attachment # 7, Med Pass CQI Tool)</i> 5. Date Corrected:	10/01/11	

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1962, 1971 Survey under: 2000 existing Facility type: S/NF Type of structure: Type III unprotected. Smoke Compartment: Five smoke compartments (5) smoke compartments Fire Alarm: Manual initiating devices located at exits. Smoke detectors located in Hall 100 and 300. Heat detectors located in the kitchen and 200 Hall. Sprinkler System: Complete automatic (dry) sprinkler system. Generator: Type II diesel A standard Life Safety Code survey was conducted on 08/31/2011. Dawson Pointe was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was sixty two (62). The facility is licensed for sixty two (62). The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (life Safety from Fire)	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping	K 018	K 018 I. Corrective action: Wooden gates were removed from all corridor door frames on 9-20-11 including rooms 317, 316, 315, 311, 312, 307, 303, 304, 210, 209, 208, and 201 by the Maintenance Department. Resident room doors repaired by Maintenance Dept on 9-20 thru 9-30 so each would latch shut including rooms 213, 211, 207, 208 and 111.	



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

TITLE

(X6) DATE

Margaret B. Cordis *Administrators* 9-22-11

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 DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408		
(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 018	<p>Continued From page 1</p> <p>the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in corridors were maintained according to National Fire Protection Association (NFPA). Doors must be maintained in order to prevent the spread of smoke and flames. The deficiency had the potential to affect three (3) of five (5) smoke compartments, sixty two (62) residents, staff, and visitors.</p> <p>The findings include: Observation on 08/31/2011 at 12:18 AM, with the Maintenance Director, revealed the facility had placed wooden gates on the following resident room door frames, resident room 317, 316, 315, 311, 312, 307, 303, 304, 210, 209, 208, and 201. Further observation revealed that the wooden gates would need to be opened in order to close the resident room doors, if the resident room doors were fully opened.</p> <p>Interview on 08/31/2011 at 12:18 AM, with the</p>	K 018	<p>Room 316's door 1" gap repaired by the Maintenance Department in above same time frame.</p> <p>2. ID of others at risk:</p> <p>All resident room doors reviewed by Maintenance Department on 9-20-11. No other doors found to be defective. No residents will be at risk with an improper closing door after the repairs are completed by the Maintenance Dept.</p> <p>3. Prevention measures:</p> <p>All wooden gates removed from corridor doors on 9-20-11 by the Maintenance Department.</p> <p>All corridor doors to be re-checked for closure ability by the Maintenance Department by 9-30-11 to assure working order.</p>		

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K 018	<p>Continued From page 2</p> <p>Maintenance Director, revealed the facility had placed the wooden gates on the resident room door frames because residents had complained about other residents wandering into their rooms.</p> <p>Observation on 08/31/2011 at 10:20 AM, with the Maintenance Director, revealed the following resident room doors would not latch when shut, resident room door 213, 211, 207, 208, and 111. Further observation revealed resident room door 316 had an approximate one (1) inch gap between the door facing and the door jamb.</p> <p>Interview on 08/31/2011 at 10:20 AM, with the Maintenance Director, revealed the Maintenance Director was unaware of the doors not latching or the door having an approximate one (1) inch gap between the door facing and the door jamb.</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3 Corridor Doors.</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and</p>	K 018	<p>4. Monitor:</p> <p>A review of the facility Life Safety Code compliance, including the use of doors and wooden gates will be monitored monthly for 12 months and findings reported through the facility CQI program.</p> <p><i>(See LSC Attachment #1—Life Safety Code CQI Tool)</i></p> <p>5. Date Completed:</p>	9-30-11	

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K 018	<p>Continued From page 3</p> <p>the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: Existing roller latches</p>	K 018			

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K 018	Continued From page 4 demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</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 ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. Smoke barriers must be maintained in order to prevent the spread of smoke and flames. The deficiency had the potential to affect five (5) of five (5) smoke compartments, sixty two (62) residents, staff and visitors.</p> <p>The findings include:</p>	K 025	<p>1. Corrective action:</p> <p>Maintenance Department ordered UL approved smoke barrier doors on 9-20-11 to replace those located in the areas of hall 200 and other additional smoke barrier areas including those located on 100 and 200 halls. Doors will be installed upon arrival.</p> <p><i>(See LSC attachment #4, Mike Russell Mechanical, invoice for smoke barrier doors)</i></p> <p>2. ID of others at risk:</p> <p>No residents are determined to be at risk as smoke barrier doors will be replaced.</p>	

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K 025	<p>Continued From page 5</p> <p>Observation on 08/31/2011 at 9:20 AM, with the Maintenance Director, revealed the facility had an unapproved makeshift door in the smoke barrier located in the attic area of the 200 Hall. Further observation, with the Maintenance Director, revealed two (2) additional makeshift doors in the smoke barriers located in the attic area of Hallways 100 and 300.</p> <p>Interview on 08/31/2011 at 9:20 AM, with the Maintenance Director, revealed he was aware of the doors located in the smoke barriers needing to be of an approved type, and that the facility had plans to change the doors.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4 Doors.</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>8.3.4.2* Where a fire resistance rating for smoke barriers is specified elsewhere in the Code, openings shall be protected as follows: (1) Door opening protectives shall have a fire protection rating of not less than 20 minutes where tested in accordance with NFPA 252, Standard Methods of Fire Tests</p>	K 025	<p>3. Prevention measures:</p> <p>Maintenance Department ordered UL approved smoke barrier doors on 9-20-11 to replace those located in the areas of hall 200 and other additional smoke barrier areas including those located on 100 and 200 halls. Doors will be installed upon arrival.</p> <p>4. Monitor:</p> <p>Monitor will be initiated through the Preventive Maintenance CQI tool monthly x 12 months and reviewed by the CQI Committee.</p> <p><i>(See LSC #2—Preventive Maintenance Tool)</i></p> <p>5. Date Corrected:</p>	10-14-2011	

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K 025	Continued From page 6 of Door Assemblies, without the hose stream test, unless otherwise specified by Chapters 12 through 42. (2) Fire windows shall comply with 8.2.3.2.2. Exception: Latching hardware shall not be required on doors in smoke barriers where so indicated by Chapters 12 through 42. 8.3.4.3* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.	K 025		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was maintained according to National Fire Protection Association (NFPA) standards. Exit access must be maintained to ensure exits are useable in an emergency. The deficiency had the potential to affect five (5) of five (5) smoke compartments, five (5) of six (6) exits, sixty two (62) residents, staff, and visitors.	K 038	K 038 I. Corrective action: Staff members inserviced by Compliance Nurse on 9-23 thru 9-30-11 regarding key pads and exit door codes to assure that all staff members can readily unlock facility doors in this predominantly behavioral-related resident nursing facility. In addition, all staff are provided information upon hire regarding exit door codes and the location of the master power over-ride switch providing instant egress for all door locks and key pads. <i>(See LSC attachment # 3, Fire and Safety/ Door Code Inservice)</i> Per NFPA 101 (2000 edition): Door locking arrangements without delayed egress are permitted in health care occupancies where the clinical needs of the patients require	

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K 038	<p>Continued From page 7</p> <p>The findings include:</p> <p>Observation on 08/31/2011 at 10:23 AM, with the Maintenance Director, revealed all exterior exits, a total of four (4), and vertical exits (cross corridor doors) a total of one (1), could only be exited after a code was entered into a key pad located next to the doors. There were a total of five (5) exits that required a code to be entered before one could exit. The doors were not equipped with any kind of delayed egress hardware. Further observation revealed two (2) gates located outside leading from the facility ' s exterior exits that had keypads; these gates required a code to be entered before one could exit. The gates were not equipped with any delayed egress hardware. These exits were not located within close proximity of a nurse ' s station.</p> <p>Interview on 08/31/2011 at 10:23 AM, with the Maintenance Director, revealed the facility thought the Life Safety Code was being met, because they had received permission from the State Fire Marshal ' s office and a previous Life Safety Code inspector on 05/22/06 to remove the delayed egress hardware from the facility exits. Further observation revealed the facility had done this due to wandering residents. The information was confirmed by the Administrator at time of exit conference.</p> <p>Reference: NFPA 101 (2000 edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.</p>	K 038	<p>specialized security measures for their safety provided that staff can readily unlock such doors at all times.</p> <p>Greater than 75% of all patients in this facility have either cognitive impairment (BIMS score of 13 or less), MR/MI related diagnosis, and/or are under the care of the facility's licensed psychiatrist. The residents in this facility require specialized security measures for their safety as determined by the assessments of their physician, the Medical Director, the psychiatrist and the Interdisciplinary Team.</p> <p>2. ID of others at risk:</p> <p>No residents are at risk for entrapment as all staff members can readily unlock facility exit doors.</p> <p>3. Prevention measures:</p> <p>Staff members inserviced by Compliance Nurse on 9-23 thru 9-30-11 regarding key pads and door codes to assure that all staff members can readily unlock facility doors in this predominantly behavioral-related resident nursing</p>		

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K 038	<p>Continued From page 8</p> <p>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)</p> <p>Exception No. 2:* Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p> <p>Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. 19.1.1.1.5 It shall be recognized that, in buildings housing certain types of patients or having detention rooms or a security section, it might be necessary to lock doors and bar windows to confine and protect building inhabitants. In such instances, the authority having jurisdiction shall make appropriate modifications to those sections of this Code that would otherwise require means of egress to be kept unlocked. 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool</p>	K 038	<p>facility. In addition, staff will continue to be provided information upon hire regarding exit door codes and the location of the master power over-ride switch providing instant egress for all door locks and key pads.</p> <p>4. Monitor:</p> <p>Monitor will be initiated through the Maintenance Life Safety CQI tool monthly x 12 months and reviewed by the CQI Committee.</p> <p>5 Date Corrected:</p>	09/30/11

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K 038	<p>Continued From page 9 or key from the egress side.</p> <p>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)</p> <p>Exception No. 2:* Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path.</p> <p>Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.</p> <p>19.2.2.2.5 Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door.</p> <p>Exception No. 1: Locks in accordance with</p>	K 038			

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K 062	<p>Continued From page 11</p> <p>Further interview, with the Maintenance Director, revealed the facility did not have documentation stating what temperature the portable heater operates.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>4-2.5.2 Valve rooms shall be lighted and heated. The source of heat shall be of a permanently installed type. Heat tape shall not be used in lieu of heated valve enclosures to protect the dry pipe valve and supply pipe against freezing.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p>	K 062	<p>Preventative Maintenance CQI Tool and reviewed by the CQI Committee monthly.</p> <p>5. Date Corrected:</p>	10/14/11