

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

PRINTED: 04/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185465</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/17/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRECKINRIDGE PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>170 SYKES BOULEVARD MORGANFIELD, KY 42437</b>		
(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	F 000	Disclaimer: 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.		
F 371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed undated and outdated food items stored in the refrigerator and a sanitizer bucket with the improper level of sanitizer.</p> <p>Review of the facility's Census and Condition, dated 04/15/15, revealed there were twenty-two (22) residents in the facility and two (2) of those residents were tube feeders and did not eat food from the kitchen area.</p> <p>The findings include:</p> <p>1. Review of the facility policy for "Storing</p>	F 371	<p><b>F371 FOOD PREPARATION AND STORAGE</b></p> <p>1. Food Storage</p> <p>All undated items were immediately removed from the dietary department and disposed of appropriately. Staff education was conducted on 4/25/15 and 4/28/15 regarding the facility Storage of Leftover Food policy and Food Preparation and Handling Policy by the Dining and Hospitality Coordinator.</p> <p>The facility acknowledges that all residents have the potential to be affected by the cited deficiency.</p> <p>The Dietary Manager will conduct an audit three (3) times a week for six (6) months and one (1) time a week thereafter of stored foods to ensure all items are dated and used according to policy. Results will be reported quarterly at the Quality Assurance Committee Meeting. Staff education/inservicing will be conducted bi-annually by the Dining and Hospitality Coordinator.</p> <p>The Administrator or Dining and Hospitality Coordinator will conduct a weekly audit for three (3) months and continue monthly audits after the three (3) month period, of stored foods to ensure all items are dated and used within the policy guidelines. The results will be reported at quarterly at the Quality Assurance Committee Meeting; Medical Director, Administrator, Director of Nursing, Director of</p>		

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

TITLE

(X6) DATE

*Kathryn Fogue*

Administrator

4/30/2015

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

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F 371	<p>Continued From page 1</p> <p>Leftover Food", dated 03/01/10, revealed cooked food items, that were not served to residents, may be saved up to three (3) days, in the refrigerator. The facility policy for "Food Preparation and Handling," dated 02/01/10, revealed dairy products can be held for fourteen (14) days, after opening, up to the expiration date.</p> <p>Observation of the refrigerators, on 04/15/15 at 12: 15 PM, revealed undated and opened bags of cheese: two (2) five (5) pound bags of shredded mozzarella cheese, dated 03/21/15 and approximately forty (40) slices of American cheese, with no dates to state how long the packages had been opened.</p> <p>Interview with the Dietary Manager, on 04/15/15 at 12:30 PM and review of the policy, revealed the morning cook was to have ensured all food items were labeled and dated properly. The mozzarella cheese should have been discarded after fourteen (14) days, according to policy and the cheese had been opened twenty-two (22) days. There were no initiated task forms to indicate the work had been completed and the Dietary Manger stated she was recently hired and in the process of getting these completed and stated she should have been monitoring this closer.</p> <p>2. Review of the facility policy "Morning Cook Timeline and Task Checklist", the "Afternoon Cook Timeline and Task Checklist" and the "Prep Timeline and Task Checklist," undated, revealed the cook and the prep worker were to have filled all three (3) sanitation buckets with sanitizing solution, from the three (3) compartment sink at 5:30 AM, 10:00 AM and 2:00 PM</p>	F 371	<p>*Continued from page 1</p> <p>Environmental Services, Dietary Manager and Social Service/Activity Director are in attendance.</p> <p>2. Sanitation</p> <p>When observation was made, Sanitation Buckets were dumped immediately. Staff education was conducted on 4/25/15 and 4/28/15 regarding facility Sanitation Policy and Staff Time/Task check sheets by the Dining and Hospitality Coordinator.</p> <p>The facility acknowledges that all residents have the potential to be affected by the cited deficiency.</p> <p>The Dietary Manager will conduct a sanitation audit three (3) times a week for six (6) months, and one (1) time a week thereafter. Results will be reported at the quarterly Quality Assurance Committee Meeting. Staff education/inservicing will be conducted bi-annually by the Dining and Hospitality Coordinator.</p> <p>The Administrator or Hospitality and Dining Coordinator will conduct a random audit for six (6) months to ensure policy and guidelines for sanitation are being followed accordingly. The results will be reported quarterly at the Quality Assurance Committee Meeting; Medical Director, Administrator, Director of Nursing, Director of Environmental Services, Dietary Manager and Social Service/Activity Director are in attendance.</p> <p>Target Date</p>	5/1/2015	

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F 371	<p>Continued From page 2</p> <p>A check of the sanitizer bucket, used to wipe the counters, on 04/17/15 at 11:40 AM, revealed the sanitizer level did not register on the test strips.</p> <p>Interview with the Cook, on 04/17/15 at 11:45 AM, revealed the sanitizer buckets should have been emptied at 10:00 AM and refilled with a fresh solution. However, the cook stated it had been very busy that morning and this had not been completed.</p> <p>Interview with the Dietary Manager, 04/15/15 at 12:30 PM, revealed the recommended sanitizer level was 250 parts per million (PPM) and she should have monitored to ensure the sanitizer buckets were emptied and fresh solution acquired.</p> <p>Interview with the Administrator, on 04/17/15 at 2:25 PM, revealed she would have expected the Dietary Manager to have monitored these concerns and ensured the dietary staff were completing their tasks in a timely manner.</p>	F 371			

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K 000	<p><b>INITIAL COMMENTS</b></p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 2008.</p> <p>SURVEY UNDER: 2000 New.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (III).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2009, with thirty-three (33) smoke detectors and four (4) heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 2008.</p> <p>GENERATOR: Type II generator installed in 2009. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 04/15/15. The facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility has the capacity for twenty-two (22) beds with a census of twenty-two (22) 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</p>	K 000	<p>Disclaimer: 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.</p> 	

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

TITLE

(X8) DATE

*Kathy Pogue*

Administrator

4/30/2015

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K 000	Continued From page 1 Fire).	K 000		
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for twenty-two (22) beds and at the time of the survey, the census was twenty-two (22).</p> <p>The findings include:</p> <p>Observation, on 04/15/15 at 4:00 PM, with the Administrator revealed the corridor door to room #11 would not latch when tested.</p> <p>Interview, on 04/15/15 at 4:01 PM, with the Administrator revealed she was unaware the door would not latch.</p>	K 018	<p><b>K018 LIFE SAFETY CODE STANDARD</b></p> <p>The deficient practice was corrected by the Environmental Services Director (ESD) on 4/16/2015. The ESD, replaced the stricker latch on room #11 door to ensure proper closing.</p> <p>The facility acknowledges that all residents have the potential to be affected by the deficiency cited. The ESD completed an audit on 4/16/2015 of all resident room doors to ensure all doors were latching properly.</p> <p>Facility Door Checks have been added to the Monthly Preventative Maintenance Log, the Enviromental Services Director will report quarterly during the Safety Committee Meetings. Staff were inserviced on 4/24/2015 to complete work orders for any doors that did not latch when closed.</p> <p>The Administrator will conduct a quarterly audit of facility doors to ensure proper latching and compliance with regulations. The findings will be reported quarterly at the Safety Committee Meeting and to members of the Quality Assurance Committee.</p> <p>Target Date</p>	4/24/2015

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K 018	<p>Continued From page 2</p> <p>The census of twenty-two (22) was verified by the Administrator on 04/15/15. The findings were acknowledged by the Administrator and verified by the Administrator at the exit interview on 04/15/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 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 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.</p>	K 018			

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K 018	Continued From page 3 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 NFPA standards.	K 018		
K 025 SS=D	Reference: CMS: S&C-07-18 NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3  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 two (2) of five (5) smoke compartments, residents, staff and visitors. The facility has the	K 025	K 025 NFPA 101 LIFE SAFETY CODE STANDARD  Criteria 1 - The deficient practice has been corrected by the Environmental Services Director as of 4/16/2015. The Environmental Services Director removed the unrated expandable foam and patched around electrical wiring to enclose the opening.  Criteria 2 - The facility acknowledges that all residents have the potential to be affected by the deficiency cited. The Environmental Service Director completed a scan along the length of the fire wall to ensure all penetrations had been properly sealed.  Criteria 3 - The Environmental Services Director will do an inspection quarterly to ensure all smoke compartments are properly sealed. This will be reported during the quarterly Safety Committee Meeting.  Criteria 4 - The Environmental Service Director and/or Administrator will monitor all future installation projects to ensure contracted personnel properly seal any areas passing through the fire wall. The Environmental Service Manager will complete an inspection of the fire wall and report to the Quality Assurance team during quarterly meetings.  Criteria 5 - Target Date	4/24/2015

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K 025	<p>Continued From page 4</p> <p>capacity for twenty-two (22) beds and at the time of the survey, the census was twenty-two (22).</p> <p>The findings include:</p> <p>Observation, on 04/15/15 at 2:10 PM, with the Administrator revealed the use of unrated expandable foam being used to seal a penetration located in the smoke barrier extending above the ceiling of the 200 Hall.</p> <p>Interview, on 04/15/15 at 2:11 PM, with the Administrator revealed she was not aware of the penetration.</p> <p>The census of twenty-two (22) was verified by the Administrator on 04/15/15. The findings were acknowledged by the Administrator and verified by the Administrator at the exit interview on 04/15/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition).19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke</p>	K 025		

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K 025	Continued From page 5 compartments adjacent to the smoke barrier.  19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2. Reference: NFPA 80 Standard for Fire Doors and Windows (1999 edition)	K 025		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for twenty-two (22) beds and at the time of the survey, the census was twenty-two (22).  The findings include:	K 046	<b>K046 LIFE SAFETY CODE STANDARD</b>  The deficient practice was corrected by the Enviromental Services Director on 4/16/2015. The ESD replaced the Emergency light battery in the Kitchen area and the transfer switch room.  The facility acknowledges that all residents have the potential to be affected by the deficiency cited. The ESD audited all emergency lights on 4/16/2015 to ensure all were working properly.  Emergency lights are on the weekly preventative maintenance log. This will be reported during the quarterly Safety Committee Meeting.  The Administrator will conduct a quarterly audit of emergency lights to ensure compliance with regulations. The findings will be reported quarterly at the Safety Committee Meeting; Administrator, Director of Nursing, Director of Environmental Services, Dietary Manager and Social Service/ Activity Director are in attendance.  Target Date	4/24/2015

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K 046	<p>Continued From page 6</p> <p>Observation, on 04/15/15 at 3:30 PM, with the Administrator revealed the battery powered emergency light located in the Kitchen to illuminate when tested.</p> <p>Interview, on 04/15/15 at 3:31 AM, with the Administrator revealed she was not aware the battery powered emergency light located in the Kitchen had stopped working.</p> <p>Observation, on 04/15/15 at 3:35 PM, with the Administrator revealed the battery powered emergency light located in the Transfer Switch Room failed to illuminate when tested.</p> <p>Interview, on 04/15/15 at 3:36 PM, with the Administrator revealed she was not aware the battery powered emergency light located in the Transfer Switch Room had stopped working.</p> <p>The census of twenty-two (22) was verified by the Administrator on 04/15/15. The survey findings were acknowledged by the Administrator and verified by the Administrator at the exit interview on 04/15/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to</p>	K 046			

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NAME OF PROVIDER OR SUPPLIER  <b>BRECKINRIDGE PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>170 SYKES BOULEVARD MORGANFIELD, KY 42437</b>	
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K 046	Continued From page 7 decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.  7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by:	K 062	K062 LIFE SAFETY CODE STANDARD  The deficient practice will be corrected 5/6/2015 with an internal pipe inspection being conducted by Koorsen Fire and Security.  The facility acknowledges that all residents have the potential to be affected by the cited deficiency. The facility opened March 2010, therefore this will be the first five year inspection.	

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NAME OF PROVIDER OR SUPPLIER  <b>BRECKINRIDGE PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>170 SYKES BOULEVARD MORGANFIELD, KY 42437</b>	
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K 062	<p>Continued From page 8</p> <p>Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for twenty-two (22) beds and at the time of the survey, the census was twenty-two (22).</p> <p>The findings include:</p> <p>Sprinkler testing record review, on 04/15/15 at 3:05 PM, with the Administrator revealed the facility failed to provide documentation that the internal pipe inspection for the sprinkler system had been performed within the last five (5) years.</p> <p>Interview, on 04/15/15 at 3:06 AM, with the Administrator revealed the facility relied on the Sprinkler Testing Contractor to ensure the system was inspected properly as required.</p> <p>The census of twenty-two (22) was verified by the Administrator on 04/15/15. The findings were acknowledged by the Administrator and verified by the Administrator at the exit interview on 04/15/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and</p>	K 062	<p>The Administrator will add the required inspection to the inspection log to ensure the inspection is completed for a second time before April 2020.</p> <p>The Administrator will ensure the task of a 5 year internal pipe inspection is completed timely to ensure a safe dwelling for all.</p> <p>Target Date</p>	5/7/2015

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K 062	Continued From page 9 maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1	K 062			

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K 062	Continued From page 10 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10  Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1	K 062			

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K 062	Continued From page 11 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2	K 062			

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K 062	Continued From page 12 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062			
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage was in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for twenty-two (22) beds and at the time of the survey, the census was twenty-two (22).  The findings include:  Observation, on 04/15/15 at 3:45 PM, with the Administrator revealed a light switch was installed below five (5) feet from the floor located in the	K 076	K076 LIFE SAFETY CODE STANDARD  Oxygen Cylinder storage will be moved to a different area.  The facility acknowledges that all residents have the potential to be affected by the cited deficiency.  Oxygen Cylinder storage will be in an area that meets criteria for electrical switches five feet above floor height in a metal cabinet.  The facility contacted the oxygen supply company, storage location will be in a large bathroom that is locked and placed in a locked cabinet, light switch was moved to five (5) height from floor and electrical outlet was disabled.  Target Date	5/8/2015	

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K 076	<p>Continued From page 13 Oxygen Storage Room.</p> <p>Interview, on 04/15/15 at 3:46 PM, with the Administrator revealed she was not aware of the requirements for oxygen storage.</p> <p>The census of twenty-two (22) was verified by the Administrator, on 04/15/15. The findings were acknowledged by the Administrator and verified by the Administrator at the exit interview on 04/15/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 Edition). 8-3.1.11.2 8-3.1.11.2 Storage for nonflammable gases less than 85 m3 (3000 ft3)</p> <p>(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for</p>	K 076			

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K 076	Continued From page 14 cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.  8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076			