

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

PRINTED: 02/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 605 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
(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 An annual survey was conducted on 02/07/12 through 02/09/12 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal requirements with deficiencies cited at the highest scope/severity of an "E."	F 000	PLAN OF CORRECTION GRAYSON MANOR NURSING HOME SURVEY COMPLETION DATE OF February 9, 2012	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure the resident's environment remained as free from accident hazards as is possible related to medications left at the bedside for one resident (#1), in the selected sample of fifteen residents. Additionally, an observation during the survey revealed the medication room, attached to the nursing station, was left unsecured for an undetermined period of time. The facility identified 14 residents that were determined to be wanderers. The findings include:	F 323	F 323 On February 7, 2012, resident #1 had a room audit completed and all unsecured medications were removed from her room immediately. Resident was educated on potential hazards of unsecured medication left in room due to wandering residents. A Physician order was obtained on February 16, 2012 by a RAI Nurse. She was found competent to keep topical medications at bedside. She will be reassessed quarterly or as needed. Resident was provided a box with a lock to keep medications in. She was able to do a return demonstration with RAI Nurse on locking and unlocking the box. The resident #1 voiced understanding of keeping the medications secure and the box locked when medications are not in use. On February 8, 2012 LPN#2 was counseled by Director of Nursing regarding leaving nurse's station unattended with medication room unsecured and nurses station gates unlatched. The door to the medication	3/25/2012



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

TITLE

(X6) DATE

Joseph B. Vance Administrator February 29, 2012

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

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F 323	<p>Continued From page 1</p> <p>1. A review of the facility's policy/procedure, "Self Administration of Medication," undated, revealed "a resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the physician and a self-administration of medication assessment is performed by the RAI nurse."</p> <p>A record review revealed Resident #1 was admitted to the facility on 03/29/11 with diagnoses to include Congestive Heart Failure, Diabetes Mellitus, Chronic Airway Obstruction and Pneumonia. A review of the Quarterly Minimum Data Set (MDS), dated 12/19/11, revealed no evidence of a self-administration medication assessment completed by the RAI nurse.</p> <p>A review of the physician's orders, dated February 2012, revealed no evidence of an order that allowed Resident #1 to self-administer medications or to have medications at his/her bedside.</p> <p>An observation, on 02/07/12 at 3:00 PM, revealed there were numerous medications on the resident's bedside table. These medications included: "No More Fungus" (liquid medication containing undecylenic acid), Orasol Oral Anesthetic Gel with Benzocaine, Ocean Sinus Irrigation Aerosol, and nail polish remover pads with ethylacetate.</p> <p>An interview with Licensed Practical Nurse (LPN) #3, on 02/08/12 at 7:30 AM, revealed there was no evidence of a physician's order for Resident #1 to self-administer medications, and the resident was not assessed by the RAI nurse to keep any medications at the bedside.</p>	F 323	<p>room at the nurse's station was immediately locked and gates latched. All resident's rooms have been audited by an Administrative Nurse to ascertain that no other unsecured medications were found in resident rooms. All nurse stations medications room doors, facility wide have been audited to ensure they were locked and gates at nurse's stations were also locked.</p> <p>The Staff Development Coordinator on March 1, 2012 has in-serviced all staff in the supervision and prevention of accidents related to residents having unsecured medications in their rooms. The Staff Development Coordinator has in-serviced all licensed nurses to ensure the medication room is secured by keeping the door closed and locked. All staff has been in-serviced on keeping the nurses station gates latched to ensure safety of wandering residents.</p> <p>An audit conducted by a charge nurse concerning supervision and prevention of accidents related unsecured to medications in resident's rooms has been completed. The audits will be completed weekly for 4 weeks and then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the facility's Quality Assurance Program. An audit</p>	

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F 323	<p>Continued From page 2</p> <p>Additionally, she stated there were many cognitively impaired and wandering residents in the facility who could possibly have access to the medications in the resident's room.</p> <p>An interview with the Director of Nursing (DON), on 02/07/12 at 6:05 PM, revealed Resident #1 was not assessed to self-administer medication and there was no physician's order permitting medications at the resident's bedside. The DON further stated the facility identified fourteen wanderers in the facility, who could have accessed those medications in Resident #1's room.</p> <p>2. An observation, on 02/08/12 at 5:00 PM, revealed two latching gates on either side of the west one nursing station were completely open. Further observation revealed the medication room was connected to the west one nursing station. The door to the medication room was observed to be open and unsecured, with all of the contents of the medication room in full view. There was no one available at the nursing station/medication room for an undetermined amount of time, until a nurse returned at 5:07 PM. Two residents were observed to pass by the unsecured nursing station/medication room during this time.</p> <p>Observation of the medication room revealed there were clear boxes with residents' names printed on them. Further observation revealed the boxes contained the following: Albuterol (inhalation medication), Atrovent (inhalation medication), tubes of antibiotic cream, Nystatin powder (antifungal), Bethemethasone cream (steroid), Hibiclens (disinfectant skin wash),</p>	F 323	has been conducted by the Director of Nursing/House Supervisor concerning supervision and prevention of accidents related to un-secured gates and unlocked doors at the nurse's station and medication rooms. This audit will be conducted daily times one week, then weekly for four weeks and then monthly until 100% compliance is achieved and then quarterly. This audit will be conducted as part of the facility's Quality Assurance Program.	

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F 323	Continued From page 3 Asorbline Junior (skin rub), Santyl cream (topical medication), Mupirocine cream (topical medication), Silvadene cream (topical medication), Triamcinolone cream (topical medication), laboratory test tubes that contained reacting solutions, bottles of peroxide and nail polish remover. An interview with LPN #2, on 02/08/12 at 5:08 PM, revealed she left the nursing station "to get something to drink" and did not think she would be gone very long. She stated the nursing station gates should be latched and the medication room should be secured due to multiple items which could be harmful if any wandering resident obtained them. An interview with the DON, on 02/09/12 at 3:00 PM, revealed the nurses were aware to ensure the medication room was to be kept secured by keeping the door closed and locked. The nursing station gates were to be kept closed, and it was the responsibility of the nurses and the nurse aides to ensure the area was secure. The DON stated there was not a facility policy/procedure specific to securing medication rooms or nursing stations. The facility had determined there were fourteen residents with cognitive impairment and behaviors of wandering.	F 323			
F 371 SS=E	483.35(i) 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	F 371	F 371 The Dietary manager on February 9, 2012 changed policy and procedure for all Dietary Personnel to stop handling money at the point of plating resident's	3/25/2012	

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F 371	<p>Continued From page 4</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 review of the facility's policy/procedure, it was determined the facility failed to ensure food was prepared and served under sanitary conditions. Dietary staff was observed to handle money and then return to plating residents' food without washing or regloving her hands. Additionally, observation of a test tray revealed food temperatures that were not in the appropriate temperature range.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Nutrition and Clinical Care," undated, revealed "Hot foods are to be held at the required temperature of 140 degrees Fahrenheit (F) or higher, and will not decrease more than 20 degrees by the time they reach the point of service."</p> <p>An observation during lunch, on 02/07/12 at 11:28 AM, revealed dietary staff was plating food for residents from the steam table whenever the dietary staff received money from a guest who purchased a lunch tray. The dietary staff handled the money with both gloved hands and then returned to plating residents' food trays without stopping to wash her hands or change her gloves.</p>	F 371	<p>food and dispose of gloves and wash hands and put on new gloves if contact with any non-sanitary items occurred. The Maintenance Director, on February 8, 2012 at 2:00 p.m. turned the steam table's electrical breaker back on after the Electrical Contractor installing the dishwasher that morning turned off steam table's electrical breaker by mistake.</p> <p>Dietary manager reviewed the entire food handling process facility wide on February 9, 2012. The review included handling money, pencils, pens, paper and all other non-sanitary items to minimize contact by Dietary employees of these items while handling food items. Also the Maintenance Director reviewed all electrical breakers within Dietary Department to make sure they had not been turned off accidentally.</p> <p>In-service Coordinator and Dietician conducted in-service to all Dietary and Nursing Staff February 14, 2012 that included proper techniques for handling food in a sanitary manner. Also the Dietician discussed the importance of maintaining proper food temperatures.</p> <p>The Quality Assurance Director helped Dietary Supervisor setup daily check offs of Sanitary Food Handling and</p>		

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F 371	<p>Continued From page 5</p> <p>An observation, on 02/08/12 at 1:22 PM, revealed a test tray was obtained from the room service cart where residents' trays were being passed. Temperatures were obtained by the dietary manager at that time and were as follows: potatoes 112 degrees F, carrots 107 degrees F, fish 109 degrees F, and chicken 105 degrees F.</p> <p>An interview with the Dietary Manager, on 02/07/12 at 11:45 AM, revealed she expected the kitchen staff to wash their hands and change gloves if they contaminated their hands by handling money for guest trays. There was no evidence of a policy/procedure provided by the facility which addressed proper handwashing procedures during food tray preparation. Further interview with the Dietary Manager revealed the temperatures obtained on the test tray were unacceptable.</p> <p>An interview with the Registered Dietician, on 02/07/12 at 5:40 PM, revealed she was unaware the kitchen staff handled money for guest trays during the resident food tray preparation without washing their hands or changing gloves. She expected the staff to wash their hands and change gloves after handling any object that contaminated their hands.</p>	F 371	<p>Food Temps. This will be done daily until 100% compliance then weekly, then monthly and then quarterly. The results will be reported to the Quality Assurance Committee at least annually.</p>		

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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: 1964, 2010</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system</p> <p>GENERATOR: Two (2) Type II generators, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/09/12 through 02/10/12. Grayson Manor Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>GRAYSON MANOR NURSING SURVEY COMPLETION DATE OF February 10, 2012</p> 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joseph B. Vance</i>	TITLE Administrator	(X6) DATE February 29, 2012
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1	K 000		
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 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 in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the</p>	K 018	<p>K 018</p> <p>Maintenance Director on February 13, 2012 removed hinged wooden gates on resident's rooms #32, 35, 37, 38, 40, 42, 45, 59, 62, 63 and 64.</p> <p>Maintenance Director inspected all resident's room's facility wide for hinged wooden gates and removed all.</p> <p>Administrator and Maintenance Director conducted an In-Service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 018 and specifically the hinged wooden gates.</p> <p>The Quality Assurance Director helped the Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K018 and specifically hinged wooden gates in resident's doorways. Any issue found that does not comply with Life Safety Code K018 will be reported immediately to the Administrator. Quarterly inspections regarding Life Safety code K018 will</p>	3/25/2012

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K 018	<p>Continued From page 2 survey.</p> <p>The findings include:</p> <p>Observation, on 02/09/12 between 1:30 PM and 4:00 PM, with the Maintenance Director revealed the facility had installed hinged wooden gates on resident room #32, 35, 37, 38, 40, 42, 45, 54, 59, 62, 63, and 64 to prevent wandering residents from entering these rooms. Further observation revealed the gates when closed impede access to the room door to enable closure during a fire.</p> <p>Interview, on 02/09/12 at 5:00 PM, with the Maintenance Director revealed the facility had placed the gates on the resident room doorframes due to residents wandering into other resident rooms.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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 the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and</p>	K 018	be reported to the Quality Assurance Team at least annually.	

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K 018	Continued From page 3 similar auxiliary spaces that do not contain flammable or combustible materials. 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. 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. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches 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=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 025	K 025 Maintenance Director and his staff on February 22, 24 & 27 of 2012 repaired all smoke barriers that had penetrations by wires, piping, open doors and holes that had not been repaired due to remodeling the attic. All spaces around the penetrations were filled with material rated equal to	3/25/2012	

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K 025	<p>Continued From page 4</p> <p>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 observations 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 NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/09/12 at 2:00 PM, with the Maintenance Director revealed the smoke partition extending above the ceiling located throughout the facility, were noted to have penetrations by wires, piping, open doors and holes that have not been repaired due to remodeling the attic. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke.</p> <p>Interview, on 02/09/12 at 2:00 PM, with the Maintenance Director revealed they had been working to make it safer by adding walk ways and rated doors in the attic.</p>	K 025	<p>the partition that could resist the passage of smoke.</p> <p>The Maintenance Director and Administrator inspected thoroughly, the entire facility, after the above work was completed for any more smoke barrier penetrations not properly repaired.</p> <p>Administrator and Maintenance Director conducted an In-Service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 025 and specifically the proper integrity of smoke barriers.</p> <p>The Quality Assurance Director helped the Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K025 and specifically smoke barrier penetrations, any issues found that do not comply with Life Safety Code K025 will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K025 will be reported to Quality Assurance Team at least annually.</p>		

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 505 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 5 Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive	K 027	K 027 Maintenance Director and his staff on February 29, 2012 order parts to repair the cross-corridor doors located next to room #43. The Administrator on February 28, 2012 ordered door coordinators for all cross corridor doors located throughout the facility.	3/25/2012

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K 027	Continued From page 6 latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke. These doors must close all the way and be smoke tight to help prevent smoke from reaching other parts of the building in the event of an emergency. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the days of the survey. The findings include: Observation, on 02/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed the cross-corridor doors located next to room #43, would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Further observation revealed all of the cross corridor doors located throughout the facility had a T astragal to limit smoke when the doors were closed; however the doors were not equipped with a door coordinator to ensure the doors would close properly. Interview, on 02/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed they were not aware the doors would not close all the	K 027	Maintenance Director and Administrator review entire facility for life safety code K027 and specifically for door coordinators and proper closure. Administrator and Maintenance Director conducted an in-service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 027 and specifically the proper closure of smoke resistant doors. The Quality Assurance Director helped the Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K027, any issues found that do not comply with Life Safety Code K027, such as the improper closing of smoke doors will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K027 will be reported to Quality Assurance Team at least annually.	

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K 027	Continued From page 7 way leaving a gap between the doors in the closed position and acknowledged the doors would not resist the passage of smoke in the event of an emergency. He was also not aware of the door coordinators. Reference: NFPA 101 (2000 edition) 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. NFPA 101 LIFE SAFETY CODE STANDARD	K 027			
K 047 SS=D	Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey. The findings include: Observation, on 02/09/12 at 2:30 PM, with the	K 047	K 047 Contractor (Ready Electric) on February 14, 2012, installed exit signage by the exit doors in the Dining Room next to the Therapy Room. Maintenance Director and Administrator, on February 27, 2012, reviewed and examined all exit doors throughout the facility for proper exit signage. Administrator and Maintenance Director conducted In-Service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 047 and specifically the proper exit signage above all exits. The Quality Assurance Director helped Maintenance Director Setup Quarterly inspections that look for	3/25/2012	

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K 047	Continued From page 8 Maintenance Director revealed the exit doors in the Dining Room next to the Therapy Room did not have exit signage to identify the exits. interview, on 02/09/12 at 2:30 PM, with the Maintenance Director revealed he was not aware the doors were required to have proper exit signage. Reference: NFPA 101 (2000 edition) 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047	compliance with Life Safety Code K047 and specifically exit signage by the exit doors, any issues found that do not comply with Life Safety Code K047 will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K047 will be reported to Quality Assurance Team at least annually.		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on interview and fire drill review it was	K 050	K 050 A fire drill on third shift was conducted by the Maintenance Director and Administrator, at 12:48 a.m. C.S.T. (an unexpected time), on February 28, 2012. All fire drills on all shifts for the entire facility will be conducted at unexpected times. Administrator and Maintenance Director conducted In-Service on Feb 29, 2012 that educated all maintenance	3/25/2012	

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 805 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754		
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K 050	Continued From page 9 determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey. The findings include: Fire Drill review, on 02/09/12 at 1:30 PM, with the Maintenance Director revealed the fire drills were not being conducted at unexpected times under varied conditions. Third shift fire drills were being conducted predictably at 5:59 AM each quarter. Further review revealed the facility failed to document the time the fire drill was performed on 04/25/11 during 2nd shift. Interview, on 02/09/12 at 1:30 PM, with the Maintenance Director revealed they were unaware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 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	personnel regarding Life Safety Code K 050 and specifically executing fire drills at unexpected times. The Quality Assurance Director will help Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K050 and specifically conducting fire drills at unexpected times, any issues found that do not comply with Life Safety Code K050 will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K050 will be reported to Quality Assurance Team at least annually.		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K 052 The fire alarm system was tested in the Third Quarter of 2011 by a qualified Company (Interstate Securities).	3/25/2012	

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K 052	Continued From page 10 This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection review, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey. Findings include: Fire alarm inspection review, on 02/09/12 at 1:30 PM, with the Maintenance Director revealed the facility failed to provide documentation to show the fire alarm had been tested in the second quarter of 2011. Interview, on 02/09/12 at 1:30 PM, with the Maintenance Director revealed the facility had contacted the company that performs the sprinkler inspections; however the company failed to conduct the inspection during the second quarter. Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire	K 052	The fire alarm system for the entire facility has been tested in each of the quarters after skipping the 2 nd quarter of 2011. Administrator and Maintenance Director conducted In-Service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 052 and specifically quarterly inspections of the fire system. The Quality Assurance Director will help Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K052 and specifically quarterly inspections of the fire alarm system, any issues found that do not comply with Life Safety Code K052 will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K052 will be reported to Quality Assurance Team at least annually.	

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K 052	Continued From page 11 alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code.	K 052			
K 056 SS=D	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: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey. The findings include:	K 056	K 056 Mid West Sprinkler Company completed on February 17, 2012 the installation of sprinklers on porches outside the Dietary department and the Dining Room by Therapy. Maintenance Director and Administrator, on February 13, 2012, completed a thorough inspection of entire facility for sprinkler coverage according to K 056 and specifically to porches. Administrator and Maintenance Director conducted an in-service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 056 and specifically sprinklers covering porches. The Quality Assurance Director will help Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K056 and specifically sprinklers	3/25/2012	

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K 056	Continued From page 12 Observation, on 02/09/12 2:30 PM, with the Maintenance Director revealed one (1) porch to extend out four (4) foot or greater, made of combustible materials, and was not sprinkler protected. The porch is located outside the Dining Room Exit next to the Therapy Room. Further observation revealed another 8' x8' porch roof located outside the Dietary Storage area, that did not have sprinkler protection. Interview, on 02/09/12 at 2:30 PM, with the Maintenance Director revealed they were not aware the porches needed to be sprinkler protected. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	coverage on porches, any issues found that do not comply with Life Safety Code K056 will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K056 will be reported to Quality Assurance Team at least annually.	
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:	K 062	K 062 Mid West Sprinkler Company inspected every sprinkler head in the facility in April 2010. Mid West Sprinkler Company issued evidence that the sprinkler heads had been checked to confirm if the Star	3/25/2012

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K 062	<p>Continued From page 13</p> <p>Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings Include:</p> <p>Observation, and record review, on 2/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed the facility had STAR sprinkler heads located throughout the facility and the attic that could be part of a recall. The facility failed to produce evidence that the sprinkler heads had been checked to confirm if the Star sprinkler heads in the facility were part of the recall.</p> <p>Interview, on 2/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed he was not aware of the recall and did not know if the heads had been checked.</p> <p>Observation, on 2/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed the privacy curtains located in the resident rooms would block the sprinkler head when the curtain was not in use.</p> <p>Interview, on 2/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed he had never noticed the curtains were blocking the</p>	K 062	<p>sprinkler heads in the facility were part of the recall and Grayson Manor does not have any Star Sprinkler Heads associated with a recall. Maintenance Director put evidence in three ring binder that holds all evidence for inspections related to the facility. Maintenance staff ordered privacy curtains tracks on February 27, 2012 to replace privacy curtains observed during Life Safety Code inspection that were too close to sprinkler heads.</p> <p>Maintenance Director and Administrator on February 27, 2012 completed a thorough inspection of entire facility for sprinkler head obstruction according to K 062 and specifically obstruction by privacy curtains. On February 27, 2012 Maintenance Department ordered privacy curtains tracks to replace all privacy curtain tracks too close to sprinkler heads facility wide. In April 2010 Mid West Sprinkler Company has inspected the entire facility for sprinkler heads that were part of the recall and produced evidence to Administrator that states Grayson Manor does not have any Star Sprinkler Heads associated with a recall.</p>		

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K 062	Continued From page 14 sprinkler heads. Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a	K 062	Administrator and Maintenance Director conducted an in-service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 062 and specifically obstruction of sprinkler heads and maintaining evidence that supports certification of sprinkler heads. The Quality Assurance Director helped the Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K062 and specifically obstruction of Sprinkler heads by privacy curtains and keeping all inspections and certifications as evidence for future Life Safety Code Inspections, any issues found that do not comply with Life Safety Code K062, such as sprinkler head obstruction will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K062 will be reported to Quality Assurance Team at least annually.		

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NAME OF PROVIDER OR SUPPLIER GRAYSON MANOR NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 605 WILLIAM THOMASON BYWAY LEITCHFIELD, KY 42754	
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K 062	Continued From page 15 sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used. Reference: NFPA 25 (1998 Edition). 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections. 10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel. NFPA 101 LIFE SAFETY CODE STANDARD	K 062		
K 072 SS=F		K 072	K 072 Laundry Director on February 13, 2012 removed all laundry carts from hallways.	3/25/2012

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K 072	Continued From page 16 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey. The findings include: Observation, on 02/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed linen carts were being stored in each corridor throughout the facility. Interview, on 02/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed the facility routinely stored linen carts in the corridors. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	Laundry Director, Maintenance Director and Administrator on February 13, 2012 inspected all hallways for obstruction and removed all items. The In-Service Coordinator conducted an in-service on March 1, 2012 that educated all facility staff regarding Life Safety Code K 072 and specifically obstruction of hallways by linen carts. Also the Administrator and Maintenance Director conducted an in-service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 072 and specifically obstruction of hallways by linen carts. The Quality Assurance Director helped Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K072 and specifically obstruction of hallways by linen carts, any issues found that do not comply with Life Safety Code K072, such as linen carts obstructing hallway will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K072 will be reported to Quality Assurance Team at least annually.	3/25/2012	
K 076	NFPA 101 LIFE SAFETY CODE STANDARD	K 076	K 076		

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K 076 SS=D	<p>Continued From page 17</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen cylinders were stored in accordance with NFPA standards. This deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/10/12 at 9:50 AM, with the Maintenance Director revealed an excess of 12 oxygen tanks were stored within five (5) feet of combustible materials located in the oxygen storage room. There was no signage indicating full or empty tanks.</p> <p>Interview, on 02/10/12 at 9:50 AM, with the</p>	K 076	<p>Director of Nursing and Maintenance Director on February 13, 2012 removed the 12 oxygen tanks that were stored within five (5) feet of combustible materials and put signage indicating full or empty tanks.</p> <p>Maintenance Director and Administrator inspected the entire facility for proper oxygen storage which also included oxygen storage signage.</p> <p>The In-Service Coordinator and Administrator conducted an in-service on March 1, 2012 that educated all facility staff regarding Life Safety Code K 076 and specifically the proper storage of oxygen. Also the Administrator and Maintenance Director conducted an in-service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 076 and specifically the proper storage of oxygen.</p> <p>The Quality Assurance Director will help Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K076, any issues found that do not comply with Life Safety Code K076, such as improper storage of oxygen</p>	

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K 076	Continued From page 18 Maintenance Director revealed he was not aware combustible material could not be stored within five (5) feet of the oxygen tanks. Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (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. (B) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (C) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (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 (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 cylinder storage. 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	K 076	will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K076 will be reported to Quality Assurance Team at least annually.	

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K 076	Continued From page 19	K 076			
K 130	include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 130			
SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786		K 130	3/25/2012	
	<p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress in accordance with NFPA standards. The deficiency had the potential to affect one (1) of the eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/09/12 at 2:32 PM, with the Maintenance Director revealed an unapproved lock (slide bolt type) was installed on the egress side of the Therapy Room door, and the cross corridor doors outside the Therapy Room.</p> <p>Interview, on 02/09/12 at 2:32 PM, with the Maintenance Director revealed he was aware of the lock installed on the doors; however, he was not aware that slide bolt locks were prohibited.</p> <p>Reference: NFPA 101 (2000 Edition) 19.2.2.2.4</p>		<p>Maintenance Director on February 13, 2012 removed the slide bolts on doors by the egress side of the Therapy Room and the cross corridor doors outside the Therapy Room.</p> <p>Maintenance Director and Administrator on February 14, 2012 inspected the entire facility for unapproved locks.</p> <p>Administrator and Maintenance Director conducted an in-service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 130 and specifically the use of unapproved locks.</p> <p>The Quality Assurance Director will help Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K 130 and specifically the use of unapproved locks, any issues found that do not comply with Life Safety Code K 130, such as the use of unapproved locks will be reported to</p>		

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K 130	Continued From page 20 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.	K 130	Administrator immediately. Quarterly inspections regarding Life Safety Code K130 will be reported to Quality Assurance Team at least annually.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty nine (69) on the day of the survey. The findings include: Observation, on 2/10/12 at 10:40 AM, with the Maintenance Director revealed the facility was equipped with two (2) emergency generators. The generators were equipped with an annunciation panels; however the panels were not located in a location that was only monitored on 1st and 2nd shift. The annunciation panels were located in the Receptionist Office that was not staffed on 3rd shift.	K 144	K 144 Maintenance Director on February 13, 2012 contracted with Electrical Contractor to re-move and reinstalled both existing annunciation panels to Nurses Station at Skilled One. Maintenance Director reviewed entire facility regarding annunciation panels and Electrical Contractor will install third annunciation panel at Nurses Station at Skilled One for third generator. Administrator and Maintenance Director conducted an in-service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 144 and specifically the use and location of annunciation panels. The Quality Assurance Director helped Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K144, any issues found that do not comply with Life Safety Code K144,	3/25/2012

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K 144	Continued From page 21 Interview, on 2/10/12 at 10:40 AM, with the Maintenance Director revealed he was not aware the generators annunciation panels needed to be located in an area they were likely to be heard on all shifts. This is a Repeat Deficiency. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed	K 144	such as the proper location of annunciation panels will be reported to Administrator immediately. Quarterly inspections regarding Life Safety Code K144 will be reported to the Quality Assurance Team at least annually.		

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K 144	Continued From page 22 Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect five (5) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy two (72) beds with a census of sixty (69) on the day of the survey. The findings include: Observations, on 02/09/12 between 1:30 PM and 4:30 PM, with the Maintenance Director revealed: 1) An open electrical junction box on the ceiling of the Dining Room. 2) A Hydrocollator located in the Therapy Room, was not plugged into an outlet that was ground fault protected. 3) A feeding machine, air pump for the mattress	K 147	K 147 Maintenance Director, his staff and Electrical Contractor (Ready Electric) – worked to remedy the issues associated with (1) Closed junction box in Dining Room (2) Installed ground fault outlet for Hydro Collator in Therapy Department (3) Plugged feeding machine, and air mattress into wall outlet in RM #58 (4) Plugged all medical devices in RM #56 into a wall outlet. (5) Locked all electrical panels in West 2 corridor. (6) Replaced extension cords in RM #52 and plugged all medical devices into wall outlets. (7) Removed extension cords in Skilled Lobby and Administrator's office. (1b) Extension cords in RM #48 were removed (2b) Air mattress in RM #46 was plugged into wall outlet. (3b) The mini nebulizer and resident bed in RM #49 was plugged into a wall outlet. (4b) Extension cord was removed and daisy chaining power	3/25/2012

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K 147	<p>Continued From page 23</p> <p>were plugged into a power strip located in room #58.</p> <p>4) An oxygen concentrator, a power strip with a wheelchair charger plugged in, and an extension cord were plugged into a multi plug adaptor located in room #56.</p> <p>5) Unlocked electrical panels located in the West 2 corridor.</p> <p>6) Two (2) extension cords were in use located in room #52.</p> <p>7) An extension cord was in use located in Med Room West 2, Skilled Lobby, and the Administrators Office.</p> <p>Observations, on 02/10/12 between 9:30 AM and 11:00 AM, with the Maintenance Director revealed:</p> <p>1) Two extension cords were being used in room #48.</p> <p>2) An air mattress pump was plugged into a power strip located in room #46.</p> <p>3) A mini nebulizer was plugged into an extension cord, and the resident bed was plugged into a power strip located in room #49.</p> <p>4) A power strip was plugged into a power strip that was plugged into an extension cord located in the West 1 Nurses Station Med Room.</p> <p>5) A microwave was plugged into an extension cord located in the Director of Nursing Office.</p> <p>6) Oxygen tanks were stored in front of electrical panels located in the oxygen storage room.</p> <p>Interviews, on 12/20/11 between 5:15 PM and 5:25 PM, with the Plant Services Director</p>	K 147	<p>strips was discontinued at West 1 Nurses Station Med Room. (5b) Extension cord was removed from Director of Nurses office. (6b) Oxygen tanks were removed from electrical panels in oxygen storage room.</p> <p>Maintenance Director and Administrator on February 14, 2012, reviewed entire facility for proper extension cord and power strip usage.</p> <p>The In-Service Coordinator conducted an in-service on March 1, 2012 that educated all facility staff regarding Life Safety Code K 147 and specifically the proper usage of extension cords and power strips. Also the Administrator and Maintenance Director conducted an in-service on Feb 29, 2012 that educated all maintenance personnel regarding Life Safety Code K 147 and specifically the use of extension cords and power strip use.</p> <p>The Quality Assurance Director helped Maintenance Director Setup Quarterly inspections that look for compliance with Life Safety Code K 147, any issues found that do not comply with Life Safety Code K147, such as the proper use of extension cords and power strips will be reported</p>		

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K 147	<p>Continued From page 24</p> <p>revealed they were not aware of the extension cords and power strips being misused.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding</p>	K 147	<p>to Administrator immediately. Quarterly inspections regarding Life Safety Code K147 will be reported to Quality Assurance Team at least annually.</p>		

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K 147	Continued From page 25 requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147			