

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

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PRINTED: 06/23/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2011
NAME OF PROVIDER OR SUPPLIER TANBARK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1121 TANBARK ROAD LEXINGTON, KY 40515	

(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		7/18/11
F 164 SS=D	<p>A standard health survey was conducted on June 7-9, 2011. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.10(e), 483.75(1)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 164	<p>During survey on 6/7/11 residents that were identified, had the cover sheet in front of the MAR, that was exposed, immediately turned to prevent PHI from being viewed by unauthorized persons.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>During survey on 6/7/11 all residents cover sheets in front of the MARs were turned to prevent PHI from being exposed to unauthorized persons.</p> <p>On 6/7/11 and ongoing all nurses and CMT's were in-serviced on the deficient practice, the need to insure PHI is not exposed to unauthorized people, and the process of turning cover sheets protecting the MAR's backwards to prevent the unauthorized sharing of PHI.</p> <p>The Administrator will complete bi-weekly rounds and visually monitor compliance to insure PHI is not being exposed to</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Conyina Collier TITLE: Administrator (X6) DATE: 6/29/11

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

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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure privacy of medical records was maintained during medication administration. Observations of the medication pass on June 7, 2011 and June 8, 2011, revealed the Medication Administration Record (MAR) was left open on the medication cart in the hallway, exposing residents' medical information to the public and other residents.</p> <p>The findings include:</p> <p>A review of the facility's policy (no date noted) regarding resident rights revealed all residents would have personal privacy and confidentiality of their personal and clinical records.</p> <p>1. Observation of medication pass on June 7, 2011, at 11:40 a.m., revealed Licensed Practical Nurse (LPN) #2 prepared two oral medications to administer to resident #8. LPN #2 entered resident #8's room to administer the medications; however, LPN #2 failed to ensure privacy of the Medication Administration Record (MAR). The MAR was left open on top of the medication cart which was sitting in the hallway.</p> <p>Continued observation revealed LPN #2 obtained the necessary supplies from the medication cart to perform a fingerstick blood sugar test for an unsampled resident. LPN #2 entered resident room 328 to perform the fingerstick blood glucose test. Observation revealed the MAR had been left open which exposed the resident's personal confidential information. Visitors were observed in the hallway and passed by the medication cart.</p>	F 164	<p>unauthorized people. During these rounds audits will occur viewing MAR cover sheets to insure turned backwards to prevent unauthorized sharing of PHI</p>	

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F 164	Continued From page 2 2. Observation of the medication pass on June 8, 2011, at 4:00 p.m., revealed Licensed Practical Nurse (LPN) #2 entered the room of an unsampled resident to administer medications to the resident (LPN #2 was training LPN #4) and LPN #4 entered the room as well. Further observation revealed the MAR on top of the medication cart in the hallway had been left open to an unsampled resident's cover sheet which exposed the resident's picture and personal, confidential information. Interview on June 8, 2011, at 4:30 p.m., with LPN #2 revealed the LPN was aware not to leave the MAR open, however, did not consider the resident cover sheet to be part of the MAR. Interview on June 9, 2011, at 10:00 a.m., with the Director of Nursing DON revealed the MAR should not be left open when medications are being administered.	F 164		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a sanitary, orderly, and comfortable interior. Three air conditioner control panel covers were observed lying unsecured on top of the air conditioners, a	F 253	The residents that were said to be affected by the unsecured air conditioners covers had the covers removed from the top of the units on 6/9/11. The room identified having had the loose call bell plate was not assigned to any resident. The plate was secured on 6/24/11. The resident room identified that had the loose base board had base board	7/18/11

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F 253	Continued From page 3 baseboard was loose, a bathroom emergency call plate was loose, a towel bar was missing, and an overbed light cover was chipped. The findings include: During the environmental tour of the facility on June 7-9, 2011, the following items were observed to be in need of repair: -The air conditioner control panel covers in resident rooms 302, 304, and 306 were observed lying unsecured on top of the air conditioners. -The emergency call bell plate was loose from the wall in resident bathroom 306. -The baseboard was loose in resident bathroom 316. -The overbed light in resident room 306 was chipped. -A towel bar in resident bathroom 309 was missing. An interview conducted with the Maintenance Supervisor (MS) on June 8, 2011, at 4:15 p.m., revealed the facility utilized a work order system to inform the maintenance staff of items in need of repair. The MS stated all staff had access to the work order form that was kept at the nurses' station. The MS revealed he depended on the written work order log kept at the nurses' station but staff also informed him verbally of items in need of repair. The MS stated he recorded the water temperature in five resident rooms every week and would look for any items in need of repair in those resident rooms.	F 253	secured on 6/6/10/11. The resident light identified as having a chipped was ordered and will be in place by 7/18/11. The towel bar in the resident's room identified was replaced on 6/10/11. All residents have the potential to be affected by the deficient practice. Rounds will be completed on their rooms, any panels lying loose will be corrected, any loose call plates will be secured, any base board loose will be secured and any rooms without towel bars will have them replaced and any lights having chips in them will be replaced. On 7/7/11 and ongoing an in-service will be completed for nursing and housekeeping staff on completion of work orders to assist maintenance in identifying any areas that require repairs. On 7/7/11 an in-service will be completed for Maintenance personnel on need to perform on going rounds in attempts to identify issues that need repair. Through weekly rounds performed by the Administrator	7/18/11
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	or designee monitoring of the facility, including	

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F 431	<p>Continued From page 4</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to</p>	F 431	<p>resident rooms will be done to insure areas are in good repair and to maintain a sanitary, orderly and comfortable environment. Administrator or designee will monitor week maintenance work orders to insure compliance.</p>	

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F 431	<p>Continued From page 5</p> <p>store all drugs in accordance with currently accepted professional principles and according to manufacturer's recommendations. The facility failed to ensure Calcitonin-Salmon Nasal Spray was stored in an upright position as recommended by the manufacturer.</p> <p>The findings include:</p> <p>Observation on June 9, 2011, at 1:30 p.m., of the medication cart revealed two boxes that contained Calcitonin-Salmon Nasal Spray (used to treat osteoporosis) lying in a medication cart drawer. Further observation revealed the medications were prescribed for resident #4 and resident #9. Review of the pharmacy's printed label on the medication revealed the following instructions: Refrigerate until opened, store at room temperature in an upright position.</p> <p>Review of the manufacturer's recommendation printed on the two opened bottles of Calcitonin-Salmon Nasal Spray and on the manufacturer's insert found in the box of the nasal sprays, revealed an opened bottle of Calcitonin-Salmon Nasal Spray should be stored at room temperature in an "upright" position for up to 35 days.</p> <p>Interview on June 9, 2011, at 1:40 p.m., with LPN #1 revealed the LPN had forgotten about the requirement to store Calcitonin-Salmon Nasal Spray in the upright position and had laid the nasal spray on its side in the medication drawer. LPN #1 stated she remembered when the nasal spray was new on the market and she had been instructed to store Calcitonin-Salmon Nasal Spray in the upright position.</p>	F 431	<p>Resident #4 had medication identified discontinued related to longer being able to sniff spray to get accurate dose with a new medication being ordered. Resident #9 is a resident that is terminal receiving Hospice services and had medications Hospice and the family considered unnecessary discontinued. The medication identified was discontinued. Review of records indicated that no other residents had the medication identified ordered.</p> <p>All nurse and CMT's were in-serviced on 6/17/11 and ongoing on correct storage of medications.</p> <p>Audits of the medication carts will be completed To times weekly by Director of Nursing or designee and monthly by the consulting pharmacist to insure compliance.</p>	7/18/11

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F 431	Continued From page 6	F 431		
F 463 SS-E	<p>Interview on June 9, 2011, at 2:50 p.m., with the Pharmacist revealed Calcitonin-Salmon Nasal Spray should be stored in an upright position to maintain priming of the nasal spray pump.</p> <p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain fully accessible/functional call light systems in residents' bathrooms and in the shower rooms.</p> <p>The findings include:</p> <p>Observations during the environmental tour on June 7-9, 2011, revealed 11 resident bathrooms (resident rooms 302, 304, 305, 309, 313, 317, 320, 323, 326, 327, and 328) failed to be equipped with a fully accessible emergency call system activation pull chain. The emergency call pull chains measured from five inches to eleven inches from the emergency call bell wall plate.</p> <p>Further observation revealed the emergency call pull chain in the left shower room extended only one-half inch from the emergency call bell wall plate.</p>	F 463	<p>Residents that were identified as being affected by deficient had pull cords extended in bathrooms to allow for reaching of them per resident on 6/11/11 - 6/12/11.</p> <p>The shower room pull cord system is for employees no residents enter the shower room without an employee present. This facility has no residents that wander, who could wander in the shower room and be in need of using pull codes. Shower room pull cords were extended on 6/12/11.</p> <p>All residents have potential to be affected by the deficient practice therefore all bathroom pull cords were assessed were extended as needed</p>	7/18/11

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F 463	Continued From page 7 An interview conducted with the Maintenance Supervisor (MS) on June 8, 2011, at 4:15 p.m., revealed the MS secured an extension string to the call bell chains to make the call bell more accessible for residents. The MS stated he was unaware of the shortened emergency call bell activation chains.	F 463	on 6/11/11 - 6/12/11. Maintenance and nursing staff will be In-serviced on 7/7/11 and on-going, on need to insure pull cords are an accessible length to the residents. Through weekly rounds, by the Maintenance Director or designee monitoring length of pull cords will occur to insure compliance.		

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	NAME OF PROVIDER OR SUPPLIER TANBARK HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1121 TANBARK ROAD Lexington, KY 40513 Division of Health Care Southern Enforcement Branch

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K 000	INITIAL COMMENTS K3 Building: 0101 K6 Plan Approval: 1988 K7 Survey under: 2000 Existing K8 SNF The census on the day of the survey was 32. The facility is licensed for 34 beds. Type of structure: One-story Skilled Nursing Facility connected to a one-story Personal Care Home with basement. The Personal Care Home and the Skilled Nursing Facility were separated by a two-hour fire barrier. TYPE III (Protected). Full automatic sprinkler system. The automatic sprinkler system was installed in 1989. A Life Safety Code survey was initiated and concluded on June 8, 2011, for compliance with Title 42, Code of Federal Regulations, 483.70(A), and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	The was no resident assigned to room 318 At the time the deficient practice was sited. At the time this practice was identified the trash can was removed. The door was repaired on 6/8/11. All residents have the potential to be affected by the deficient practice. Rounds were completed on 6/8/11 to insure nothing was in place impeding doors from closing. Staff will be In-serviced on 7/7/11 and on-going to insure nothing is used to prop doors open and the work order system identifying doors failing to freely stay open. Weekly rounds will be completed by Administrator or designee to observe for compliance of doors being propped open.	7/18/11
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 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	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Conyena Collier TITLE: Administrator (X6) DATE: 6/29/11

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K 018	<p>Continued From page 1</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 there were no impediments to the closing of doors located in the corridor, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of three smoke compartments, ten residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on June 8, 2011, at 11:38 a.m., revealed a trash can was placed in front of resident room 318. When the trash can was removed by the Director of Plant Operations the door self-closed. The observation was confirmed with the Director of Plant Operations. Doors located in the corridor cannot have any impediments to their closing in case the door needs to be shut to isolate a fire in that room.</p> <p>Interview on June 8, 2011, at 11:38 a.m., with the Director of Plant Operations revealed the facility has a policy in place for staff to place work orders with Maintenance when problems with doors are</p>	K 018		
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K 018	Continued From page 2 identified. The Director of Plant Operations indicated he had not received any work orders for the door.	K 018		
K 021 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening of a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain hazardous areas according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of three smoke compartments, 12 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on June 8, 2011, at 10:00 a.m., with</p>	K 021	<p>No residents were found to be affected by this deficient practice. The wire was removed from the mechanical room identified day of survey to eliminate risks of 12 residents who were identified as being at risk.</p> <p>All residents have potential to be affected by this deficient practice. All mechanical rooms were assessed on 6/8/11 with no deficient practice being identified.</p> <p>Maintenance personnel will be in-serviced On 7/8/11 on the regulation requiring No doors be held open with unapproved devices.</p> <p>Will insure that doors are not being inappropriately propped open through weekly rounds completed by Administrator or designee.</p>	7/18/11

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NAME OF PROVIDER OR SUPPLIER TANBARK HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1121 TANBARK ROAD LEXINGTON, KY 40515	
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K 021	Continued From page 3 the Director of Plant Operations, revealed the Director of Plant Operations used a wire to hold open the door leading into the electrical/mechanical room when showing the smoke barrier to surveyors. Doors used in hazardous area enclosures have specific requirements for hold-open devices. Interview on June 8, 2011, at 10:00 a.m., with the Director of Plant Operations revealed he sometimes uses the wire to hold the door open, especially when using a ladder in the room. Reference: NFPA 101 (2000 Edition). 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 021		
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	K 025		

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K 025	<p>Continued From page 4</p> <p>panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two of three smoke compartments, 22 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on June 8, 2011, at 10:20 a.m., with the Director of Plant Operations revealed eight holes in the smoke barrier wall located in the Therapy Department. The holes were from various conduit and wire installations. Penetrations in smoke barriers must be filled with an approved material.</p> <p>Interview on June 8, 2011, at 10:20 a.m., with the Director of Plant Operations revealed he regularly checks smoke barriers for penetrations and the penetrations should not be there.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts,</p>	K 025	<p>The smoke barriers that were found to have the potential to affected residents that were identified will have repairs completed on them by 7/16/11.</p> <p>All residents have the potential to be affected by the deficient practice therefore all smoke barriers were assessed with repairs being completed by 7/18/11.</p> <p>Maintenance personnel will be in-serviced on 7/8/11 to educate them on the regulatory requirements of smoke barriers to provide at least 1 half hour fire resistance. Any outside contractor will be instructed prior to beginning a project that smoke barriers must remain intact.</p> <p>Will insure smoke barriers are in place to provide at least 1 half hour fire rating through observation of rounds done by Maintenance personnel monthly and after any outside contract services completes projects in the smoke barrier area.</p>	7/18/11

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K 025	Continued From page 5 pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 025		
K 062 SS-F	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062	<p>Continued From page 6</p> <p>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</p> <p>This STANDARD is not met as evidenced by. Based on record review and interview, it was determined the facility failed to document monthly inspections of valves located in the fire sprinkler system according to National Fire Protection (NFPA) standards. The deficiency had the potential to affect three of three smoke compartments, 34 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Record review on June 8, 2011, at 3:07 p.m., with the Director of Plant Operations revealed the facility did not have documentation for monthly inspection of valves located in the fire sprinkler system. Valves located in the fire sprinkler system must be inspected monthly and the records for the inspection made available for the authority having jurisdiction.</p> <p>Interview on June 8, 2011, at 3:07 p.m., with the Director of Plant Operations revealed he does check the valves located in the fire sprinkler system monthly when he checks the gauges for the fire sprinkler system but he has no documentation for it.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>1-8* Records. Records of inspections, tests, and</p>	K 062	<p>No residents were found to be affected by this deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice. Will continue weekly checks of sprinklers including valves with increased documentation indicating specifically valves were checked. Will continue quarterly checks of sprinklers including valves from an approved outside contractors with documentation supporting this assessment.</p> <p>Maintenance personnel will be In-serviced on 7/8/11 on the need to increase documentation of full sprinkler system assessment including valves.</p> <p>Administrator or designee will review sprinkler system inspection documentation weekly and quarterly to insure specific information on checking of valves is included.</p>	7/18/11

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K 062	Continued From page 7 maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves. 1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. 1-8.2 Records shall be maintained by the owner. Original records shall be retained for the life of the system. Subsequent records shall be retained for a period of one year after the next inspection, test, or maintenance required by the standard. 9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised. 9-3.3.2* The valve inspection shall verify that the valves are in	K 062		

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K 062	Continued From page 8 the following condition: (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification	K 062		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 ensure exits were free and clear of obstructions, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of three smoke compartments, 10 residents, staff, and visitors. The findings include: Observation on June 8, 2011, at 1:30 p.m., with the Director of Plant Operations revealed the facility had a table located in the main exit vestibule. The table prevented one of two main doors from fully opening. Exits must be kept clear for use in a fire or other emergency. Interview on June 8, 2011, at 1:30 p.m., with the	K 072	The table found to be potentially affecting the identified residents was removed 6/8/11 during survey. All residents have the potential to be affected by the deficient practice, therefore all areas of egress was assessed on 6/8/11 no impediments were found. Staff will be in-serviced on 7/8/11 and on going on the need to keep egresses free from obstructions. Through observation of weekly rounds completed by the Administrator or designee will insure egresses have no impediments.	7/8/11

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K 072	Continued From page 9 Director of Plant Operations revealed he was not aware that the table was blocking the exit. Interview on June 8, 2011, at 1:35 p.m., with the Administrator revealed she thought the table was acceptable in that area due to a previous surveyor telling her it was acceptable. Reference: NFPA 101 (2000 Edition). 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress therefrom, or visibility thereof. 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 maintain the emergency generator according to NFPA standards. The deficiency had the potential to affect three of three smoke compartments, 34 beds, staff, and visitors. The findings include:	K 072	No residents were found to be affected by the deficient practice. All residents were found to be affected by the deficient practice. Battery operated lights were installed on 6/24/11 in the boiler room for the transfer station and outside at the garage for the generator. Maintenance personnel will be in-serviced that the battery operated lighting is in place and functioning on 7/8/11. Maintenance personnel will document weekly that battery lighting is in place and functioning.	7/18/11
K 144 SS=F		K 144		

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K 144	<p>Continued From page 10</p> <p>Observation on June 8, 2011, at 3:25 p.m., with the Director of Plant Operations revealed the facility did not have any battery-powered lighting installed in the room where the transfer switch for the emergency generator was located. The room where the transfer switch for the emergency generator is located must have battery-powered lighting in case there is a failure of the emergency generator and staff must operate the transfer switch manually.</p> <p>Interview on June 8, 2011, at 3:25 p.m., with the Director of Plant Operations revealed he was not aware of the requirement.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p>	K 144		
K 147 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was</p>	K 147		

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K 147	<p>Continued From page 11</p> <p>determined the facility failed to ensure electrical wiring was installed according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one of three smoke compartments, 10 residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 06/08/2011 at 1:40 PM, with the Director of Plant Operations, revealed the facility had a small yard pond located at the front of the facility. The small yard pond had an orange flexible electrical cord providing power to the fountain for the yard pond. The orange flexible electrical cord was plugged into a GFCI electrical plug. The orange flexible electrical cord was ran under the mulch surrounding the yard pond. Flexible electrical cord cannot be used for permanent electrical wiring or to take the place of the buildings wiring and splicing must be in accordance with NFPA standards.</p> <p>Interview on June 8, 2011, at 1:40 p.m., with the Director of Plant Operations revealed the cord for the fountain of the yard pond was too short to reach the outside electrical plug. Further interview revealed he had taken the flexible orange electrical cord and the cord from the yard pond fountain, removed their ends, and then spliced them together using electrical tape and buried the electrical cord under the mulch. The Director of Plant Operations indicated the yard pond was in use for six months at a time, such as spring and summer, and he believed it was acceptable to use the electrical cord in this manner.</p>	K 147	<p>No residents were found to be affected by the deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice. On 7/8/11 upon identifying the deficient practice during survey the cord was removed eliminating the risks.</p> <p>All rooms and outside areas of this building were assessed with no cords being used that fail to meet the standard set by NFPA.</p> <p>Staff will be in-serviced on 7/8/11 and on going on the requirement of use of electrical cords. Family and residents will be told in admission the requirement of use of electrical cords.</p> <p>Through observation of weekly rounds completed by the Administrator or designee will insure no inappropriate electrical cords will be used.</p>	7/18/11

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K 147	Continued From page 12 Reference: NFPA 70 (1999 Edition). 400-8. Uses Not Permitted. Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors Where installed in raceways, except as otherwise permitted in this Code 400-9. Splices. Flexible cord shall be used only in continuous lengths without splice or tap where initially installed in applications permitted by Section 400-7(a). The repair of hard-service cord and junior hard-service cord (see Trade Name column in Table 400-4) No. 14 and larger shall be permitted if conductors are spliced in accordance with Section 110-14(b) and the completed splice retains the insulation, outer sheath properties, and usage characteristics of the cord being spliced. 305-3. Time Constraints. (b) 90 Days. Temporary electrical power and lighting installations shall be permitted for a period not to exceed 90 days for Christmas decorative lighting and similar purposes.	K 147		