

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

PRINTED: 02/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185427	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/07/2013
NAME OF PROVIDER OR SUPPLIER  NURSING FACILITY OF HARDIN MEMORIAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 913 N. DIXIE AVE. ELIZABETHTOWN, KY 42701	
(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)

F 000 INITIAL COMMENTS

F 000

A standard health survey for recertification was initiated, on 02/05/13, and concluded on 02/07/13. A Life Safety Code survey was conducted on 02/06/13. Regulatory violations were identified with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be imposed.

F 167 483.10(g)(1) RIGHT TO SURVEY RESULTS - SS=C READILY ACCESSIBLE

A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.

The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to have survey results for the past two years and failed to place those results in an area accessible to residents for one (1) of one (1) binders.

The findings include:

Review of the facility's policy regarding Nursing Facility General Information, not dated, revealed the following information was available in the

- F 167
1. Corrective Action: Added the past two year survey results to the binder. Place binder in patient activity room on shelf that is easily accessible for every patient to include those who may be limited to Wheel Chair.
  2. Residents affected: All residents had potential to be impacted.
  3. System changes: Develop new Public Disclosure of Information Policy outlining process for ensuring survey results will be available for residents and community to see in an easy accessible area after each survey for up to three years. Add a task to manager calendar to complete addition of survey results.
  4. Monitoring: Manager of Nursing Facility will monitor for accessibility and content of Public Disclosure Binder monthly for three months and then annually.
  5. Completion date: 03/15/2013

48 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  
REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 167 Continued From page 1  
resident dining room: the results of the most recent survey, and a copy of every inspection report.

Observation of the Activity/Dining Room during the environmental tour of the facility, on 02/06/13 at 10:10 AM, revealed a binder titled Skilled Facility Disclosure Binder, which was located on top of the upright piano. Review of the binder revealed survey letter notifications from the past two years; however, there was no evidence the statement of deficiencies and plans of correction (2567 Form) had been included for January 2011, and October 2010. The piano was observed to be approximately 5-6 feet tall, and was not accessible to wheelchair bound residents. In addition, the binder was not identified as having the survey results included.

Interview with the Nursing Manager, on 02/06/13 at 4:05 PM, revealed she had always put the notification letter only into the binder, and was not aware the statement of deficiencies and plan of correction had to be included with the letter.

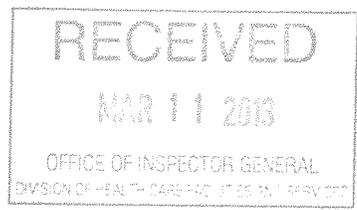
F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

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.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted

F 167

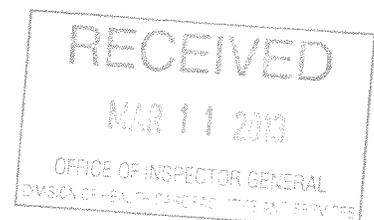
F 431 1. Corrective Action: Reviewed infection control policy. Policy addresses identification and removal of expired items. Developed log and process for conducting monthly audits to check for supply expiration dates. Educated staff on new process and added new process to the orientation checklist to orient new staff on hire. AMMENDED: Monthly audit log and new process developed on 02/27/2013. Education to nursing staff on new processes was completed



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F 431	<p>Continued From page 2</p> <p>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 policy review, it was determined the facility failed to dispose of seventeen (17) of seventeen (17) packages of Angiocatheter's that were used for intravenous use, some of which had expired in 2010, 2011 and 2012.</p> <p>The findings include:  Review of the Infection Control Procedures policy, revised 04/2009, revealed expiration dates will be checked at the time mobile supply carts are restocked, and at each unit when that unit is</p>	F 431	<p>(continued)</p> <p>by the Manager of the Nursing Facility on 03/04/2013.</p> <ol style="list-style-type: none"> <li>Residents affected: All residents have the potential to be impacted non-compliance.</li> <li>System changes: Developed new process for monitoring and disposing of expired supplies. AMMENDED: The process for monitoring and disposing of expired supplies will be accomplished by the Nursing Staff on the second shift performing an audit of stored supplies and medications one time per month during the second shift on the second week of each month. The audit log is completed by the Nursing Staff and will include the Date of the Audit, Signature of who is completing the audit, expired supply and/or medications identified and action taken, i.e., supply discarded or medication returned to pharmacy.</li> <li>Monitoring: Nursing staff on second shift will conduct monthly audits to monitor expiration dates of supplies and remove any supplies that reach the expiration date prior to use. AMMENDMENT: The audit log will allow monitoring and tracking of expired supply and or medications. The Manager of the Nursing Facility will monitor this information and</li> </ol> <p>(continued on next page)</p>	



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F 431 Continued From page 3  
restocked. If it is impossible to use the item before its expiration date, storeroom staff notify purchasing so that credit can be obtained for the items. Expired stock was not to be used under any circumstances within the hospital.

Observations made of the Medication Room, on 02/05/13 at 9:30 AM, revealed seventeen (17) Angiocatheter's were expired: two eighteen (18) gauge Angiocatheter's expired 11/2010 and 12/2011, and fifteen (15) Angiocath (twenty-four (24) gauge) expired as follows; one (1) expired 11/2010, two (2) expired 02/2011, two (2) expired 05/2011, one (1) expired 04/2011, one (1) expired 06/2011, four (4) expired 11/2011, one (1) expired 01/2012 and three (3) expired 12/2012.

Interview with Registered Nurse (RN) #3, on 02/07/13 at 11:09 AM, revealed she thought the Store Room staff were to make sure expired items were removed, but the responsibility could fall on the nursing staff; however, RN #3 was not sure.

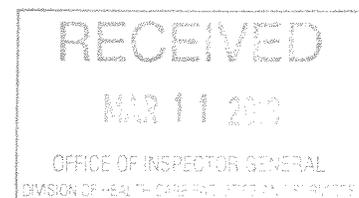
Interview with RN #1, on 02/05/13 at 11:23 AM, revealed it was her practice to look at the expiration date before use. RN #1 stated the staff never thought to send the unused angiocatheter's back to the Store Room. RN #1 stated if the staff used an expired angiocatheter, it could cause a defect or an allergy to occur. RN #1 stated it was everyone's responsibility to removed expired biologicals.

Interview with the Director of Nursing (DON), on 02/07/13 at 2:13 PM, revealed it was the responsibility of all nursing staff to dispose of expired biologicals. The DON stated the nurses

F 431 (continued)  
present at the quarterly QA Committee meeting on an ongoing basis. Data will be used to identify process improvement opportunities for improved utilization of stocking of supplies and/or medications.

5. Completion date: AMMENDED: 03/04/2013

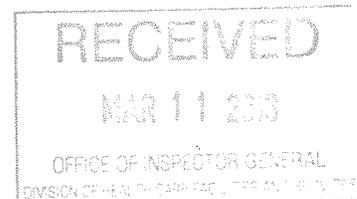
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per [signature]  
RUPB  
3-11-13



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F 431	Continued From page 4 voiced to her the non use of the angiocatheter when the surveyor brought it to their attention. The DON stated she had removed the angiocatheter's from stock, and if an expired angiocatheter had been used it could possibly malfunction and an incident report would need to be completed.	F 431	



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K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1954, 1967, 1979, 1983, 1989, 1993, 2005

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF  
TYPE OF STRUCTURE: Six stories, Type I (332)

SMOKE COMPARTMENTS: Two (2) smoke compartments

FIRE ALARM: Complete fire alarm system with heat and smoke detectors

SPRINKLER SYSTEM: Complete automatic wet sprinkler system

GENERATOR: Type I generator installed in 2005. Fuel source is diesel.

A standard Life Safety Code survey was conducted on 02/06/13. The Nursing Facility of Hardin Memorial Hospital was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for fifteen (15) beds with a census of thirteen (13) on the day of the survey.

The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).

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

TITLE

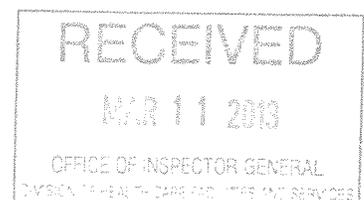
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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level.  K 045 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for fifteen (15) beds with a census of thirteen (13) on the day of the survey.  The findings include:  Observation, on 02/06/13 at 3:13 PM, with the Supervisor of Plant Engineering revealed an exterior exit with only one light bulb outside to light the egress path. The exit with only one light was located on the first floor at Stairwell E.  Interview, on 02/06/13 at 3:13 PM, with the Supervisor of Plant Engineering revealed he was not aware the exit did not have the required illumination for egress lighting.	K 000  K 045	1. Corrective Action: Replace existing light fixture on first floor at Stairwell E with new two-bulb L.E.D. device. AMMENDED: Supervisor of Plant Engineering placed a work order for new two-bulb fixture on 02/12/2013. Staff Electrician placed order for fixture on 02/13/2013. Light fixture arrived at facility on 03/07/2013. Installation of light fixture completed on 03/08/2013. 2. Residents effected: All residents in facility are affected. 3. System Changes: Check all exit passageways leading to public way to ensure dual light fixtures are in place. AMMENDED: Supervisor of Plant Engineering conducted survey exit passageways leading to the public way to assess lighting levels. on 03/082013. The assessment determined that the additional exits leading to the public way met the NFPA 101 Standards under 7.8.1.2 in that continuous lighting was present in excess 1 ft. candle luminance. (continued next page)



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K 045 Continued From page 2

Reference: NFPA 101 (2000 Edition)

19.2.8 Illumination of Means of Egress.  
Means of egress shall be illuminated in accordance with Section 7.8.

7.8 ILLUMINATION OF MEANS OF EGRESS

7.8.1 General.

7.8.1.1\*

Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.

7.8.1.2

Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.

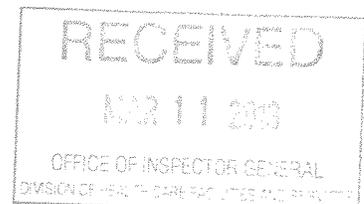
K 045

(continued)

4. Monitoring: Add egress lighting to nightly security lighting inspections.  
AMMENDED: Security Staff perform nightly rounds and monitor egress lighting. A log of the nightly checks is submitted to the Supervisor of Plant Engineering weekly. When any item is noted requiring repair/maintenance the Supervisor of Plant Engineering enters work order request into a computerized maintenance software system that provide a mechanism which allows for tracking of work orders to ensure they are completed.

5 Completion Date: AMMENDED: 03/08/2013

*3-9-13  
per John Horat PCY  
by PB 3-11-13*



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K 045 Continued From page 3  
7.8.1.3\*  
The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor.  
Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light.  
Exception No. 2\*: This requirement shall not apply where operations or processes require low lighting levels.  
7.8.1.4\*  
Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.

K 046 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F  
Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.

This STANDARD is not met as evidenced by:  
Based on staff interview and observation, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility has fifteen (15) certified beds with a census of thirteen (13) on the day of the survey.

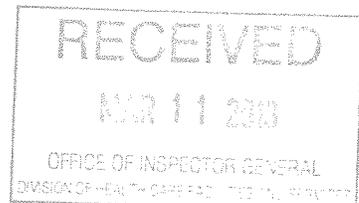
The findings include:

K 045

K 046 1. Corrective Action: Investigation found a short in the generator annunciator wiring which caused a breaker to trip and drain the battery which operates the light. Wiring was repaired and battery recharged.  
AMMENDED: Service engineer from Nixon Power Company conducted investigation of the emergency lighting failure on 02/08/2012. Electrical Service Engineer from Gene Ray Electric completed the repair of wiring on 02/09/2013.

2. Residents affected: All residents, staff and visitors of affected smoke compartments.

(continued next page)



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K 046 Continued From page 4

Observation, on 02/06/13 at 4:34 PM, with the Supervisor of Plant Engineering revealed the emergency battery light located in the generator #2 enclosure did not function when tested. The facility did have documentation the lights were tested monthly as required.

Interview, on 02/06/13 at 4:34 PM, with the Supervisor of Plant Engineering revealed he was not aware the battery light had stopped functioning.

Reference: NFPA 101 (2000 edition)  
7.9.2.1\* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.

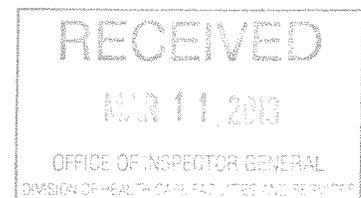
7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of

K 046 (continued)

3. System Changes: Added emergency lighting check to the generator inspection log. Frequency of checked increased to weekly. Functional test will be conducted and documented weekly. AMMENDED: The addition of emergency lighting check to the generator inspection log was completed on 03/04/2013. The weekly generator inspection checks began on 03/04/2013. The Mechanical Room Staff are responsible for conducting and documenting results of the weekly generator checks.

4. Monitoring: Weekly monitoring with discrepancies reported to supervisor. AMMENDED: The Mechanical Room Staff are responsible for the weekly monitoring and submission of the logs to the Supervisor of Plant Engineering. If discrepancies are found the Supervisor of Plant Engineering will enter a work order request into a computerized maintenance software system that provides a mechanism which allows for tracking of work orders to ensure they are completed. Results of inspections and any repairs will be Included in an Environment of Care report and be provided to the Nursing Facility Quarterly Quality Committee on an ongoing basis.

5. Completion Date: AMMENDED: 03/08/2013



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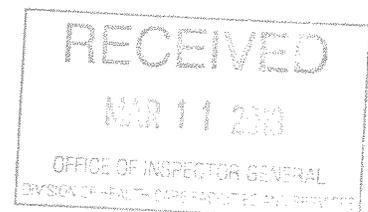
K 046 Continued From page 5  
visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.  
Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.

K 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 record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for fifteen (15) beds with a census of thirteen (13) on the day of the survey. The facility failed to ensure the fire drills were conducted at

K 046

K 050 1. Corrective Action: Review and revise Administrative policy 0070-0028, Fire Drills to include the following language - "drills are held at unexpected times under varying conditions". Fire drill schedule re-written and education provided to staff on policy and schedule changes.  
AMMENDED: The fire drill schedule was re-written on 02/25/2013. The policy on Fire Drills was revised and final approvals secured on 03/08/2013. Education was provided to the Security Staff by the Supervisor of Plant Engineering on 02/25/2013 and 03/08/2013.  
2. Residents affected: All residents within facility.  
3. System changes: Policy revised to ensure ongoing guideline for conducting fire drills. Fire drill schedule rewritten to provide for variations in times and conditions for drills.  
AMMENDED: Policy revision with final approvals secured on 03/08/2013. (continued next page)



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K 050 Continued From page 6  
unexpected times quarterly.

The findings include:

Fire Drill review, on 02/06/13 at 4:15 PM, with the Supervisor of Plant Engineering revealed the facility failed to conduct fire drills at unexpected times on both 1st and 2nd shifts.

Interview, on 02/06/13 at 4:15 PM, with the Supervisor of Plant Engineering revealed he was not aware 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 070 SS=D NFPA 101 LIFE SAFETY CODE STANDARD

Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8

This STANDARD is not met as evidenced by:  
Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for fifteen (15) beds with a census of thirteen (13) on the day of

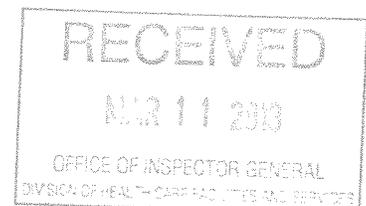
K 050 (continued)

Fire drill schedule rewritten on 02/25/2013. (attached copy at end of this document)

4. Monitoring: All fire drill results will be forwarded to Plant Engineering Supervisor for review. AMMENDED: The Supervisor of Plant Engineering reviews all fire drill results monthly. The results are reported to the EC Safety Committee and will be Included in an Environment of Care report and be provided to the Nursing Facility Quarterly Quality Committee on an ongoing basis. Any issues identified will have corrective actions taken.

5. Completion date: AMMENDED 03/08/2013-  
*3-9-13 JCC/Held/bravo*

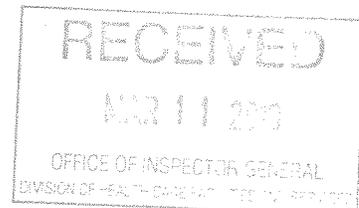
K 070 1. Corrective Action: Review of Departmental Policy #8270-4509, Electrical Equipment, and Policy #8200-3004, Portable Space-Heating Devices, were found to meet Life Safety Code Standard requirements. A survey of all spaces in the Smoke Compartments was conducted and all (three) space heaters were removed. Education was provided to staff on policy. AMMENDED: Policy reviews completed by Supervisor of Plant Engineering on 02/08/2013. Survey of smoke compartments and removal of space heaters completed on 02/07/2013 by Supervisor of Plant Engineering. Education was provided by Supervisor of (continued next page)



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K 070	<p>Continued From page 7 the survey.</p> <p>The findings include:</p> <p>Observation, on 02/06/13 at 2:35 PM, with the Supervisor of Plant Engineering revealed a portable space heater located in the Quality Assurance Office room #319, and the Coordination Managers Office. The facility failed to ensure the heaters did not exceed 212 degrees.</p> <p>Interview, on 02/06/13 at 2:35 PM, with the Supervisor of Plant Engineering revealed he was not aware the heaters element could not exceed 212°F in non-sleeping, staff, and employee areas.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD SS=F No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p>	K 070	<p>(continued)</p> <p>Plant Engineering by one-on-one education to Secretarial staff where space heaters were identified and removed. Additional Environment of Care Audit was conducted on 03/05/2013 by the Supervisor of Plant Engineering, Manager of Nursing Facility and Staff Electrician. Corrective action taken on findings / issues identified.</p> <ol style="list-style-type: none"> <li>Residents affected. All residents in facility are affected.</li> <li>System Changes: Add specific language to the semi-annual Environment of Care Rounds to include monitoring for use of space heaters Enforcement of existing policy. ADDENDUM: Revision to the Environment of Care Audits completed on 03/05/2013. The Manager of the Nursing Facility is responsible for completing the ongoing audits. If issues are identified they are reported to Secretary in Facilities Management who creates a work order for correcting deficiency.</li> <li>Monitoring: Conduct weekly rounding for one month to ensure compliance, followed by semi-annual Environment of Care rounds. ADDENDUM: Supervisor of Plant Engineering and Manager of SNF will conduct the weekly rounds. The semi-annual rounds was selected as it was an established practice for facility. Upon re-consideration, the survey will be conducted quarterly by Manager of SNF. Results will be reported quarterly at the SNF QA Committee Meeting.</li> <li>Completion Date: AMMENDED: 03/08/2013</li> </ol> <p>1. Corrective Action: Conducted a survey of the Smoke Compartments and removed all identified decorations that did not have documentation of flame retardant treatment.</p> <p>(continued next page)</p>
K 073		K 073	



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K 073 Continued From page 8

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to ensure that combustible decorations were used in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for fifteen (15) beds with a census of thirteen (13) on the day of the survey.

The findings include:

Observation, on 02/06/13 at 3:45 PM, with the Supervisor of Plant Engineering revealed the facility did not have a flame retardant policy or documentation that newly introduced personal decorations for patients or staff had been treated with a flame retardant material.

Interview, on 02/06/13 at 3:45 PM, with the Supervisor of Plant Engineering revealed they were not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated.

Reference: NFPA 101 (2000 Edition)

19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.

K 144 NFPA 101 LIFE SAFETY CODE STANDARD  
SS=F

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

K 073 1. (cont.) Review and revise policy to include language that "all newly introduced personal decorations for patients or staff will require treatment with a flame retardant material if they do not meet fire retardant specifications. AMMENDED: An Environment of Care Survey was conducted on 03/05/2013 by the Supervisor of Plant Engineering, Manager of Nursing Facility, and Staff Electrician. Decorations without documentation of flame retardant treatment were removed by the Manager of Nursing Facility. Policy review and revision received final approvals on 03/08/2013.

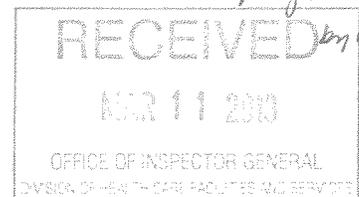
2. Residents affected: All residents in facility.

3. System Changes: Revise Administrative Policy # 0070-0067 to include language "that all newly introduced personal decorations for patients or staff will require treatment with a flame retardant material if they do not meet fire retardant specifications". Include monitoring for adherence to policy in semi-annual Environment of Care rounds. AMMENDED: Policy review and revision received final approvals on 03/08/2013. Environment of Care rounds are submitted to Secretary in Facilities for record keeping. Results of rounds are reported to EC Safety Committee and the quarterly SNF Quality Committee.

4. Monitoring: Conduct weekly inspections for one month to monitor compliance with policy followed by semi-annual Environment of Care rounds. ADDENDUM: Manager of SNF will conduct the monthly rounds. The semi-annual rounds was selected as it was an established practice for facility. Upon re-consideration, the survey will be conducted quarterly by Manager of SNF. Results will be reported quarterly at the SNF QA Committee Meeting.

K 144

5. Completion Date: ADDENDUM



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K 144 Continued From page 9

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 two (2) of two (2) smoke compartments, residents, staff, and visitors. The facility is certified for fifteen (15) beds with a census of thirteen (13) on the day of the survey.

The findings include:

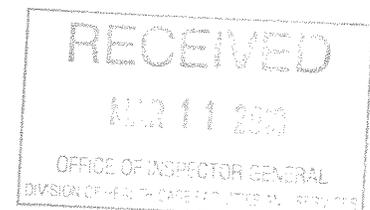
Observation, on 02/06/13 at 4:44 PM, with the Supervisor of Plant Engineering revealed the annunciator panel located in the security office (PBX) did not function when tested.

Interview, on 02/06/13 at 4:44 PM, with the Supervisor of Plant Engineering revealed he was not aware the annunciator panel was not functional.

Interview, on 02/06/13 at 4:44 PM, with the Security Staff that monitors the panels revealed they were not aware the panel did not function. Further interview revealed they were not aware of how long the panel had not been functional.

- K 144
1. Corrective Action: Service repair company completed an interrogation of the system and found and interruption in the power supply. The power supply for the annunciator panel was repaired, system tested and responded appropriately.  
AMMENDED: Service engineer from Nixon Power Company conducted investigation of the emergency lighting failure on 02/08/2012. Electrical Service Engineer from Gene Ray Electric completed the repair of wiring on 02/09/2013.
  2. Residents affected: All residents in the facility had potential to be affected.
  3. System Changes: Annunciator check was added to the weekly generator inspection list.  
AMMENDED: The addition of annunciator check to the generator inspection log was completed on 03/04/2013. The weekly generator inspection checks began on 03/04/2013. The Mechanical Room Staff are responsible for conducting and documenting results of the weekly generator checks.
  4. Monitoring: Weekly checks when completing generator inspection and reports to Plant Engineering Supervisor.

(continued next page)



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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

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]

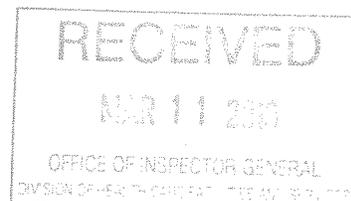
K 147 NFPA 101 LIFE SAFETY CODE STANDARD

K 144 (continued)

AMMENDED: The Mechanical Room Staff are responsible for the weekly monitoring and submission of the logs to the Supervisor of Plant Engineering. If discrepancies are found the Supervisor of Plant Engineering will enter a work order request into a computerized maintenance software system that provides a mechanism which allows for tracking of work orders to ensure they are completed. Results of inspections and any repairs will be included in an Environment of Care report and be provided to the Nursing Facility Quarterly Quality Committee on an ongoing basis.

5. Completion date: 03/08/2013

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K 147  
SS=D

Continued From page 11  
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 one (1) of two (2) smoke compartments, residents, staff, and visitors. The facility is certified for fifteen (15) beds with a census of thirteen (13) on the day of the survey. The facility failed to ensure the proper use of power strips.

The findings include:

Observations, on 02/06/13 at 2:51 PM, with the Supervisor of Plant Engineering revealed a refrigerator was plugged into a power strip located in the Director of Performance Improvements Office. Further observation revealed portable heaters plugged into a power strip located in the Quality Assurance Office room #319, and the Coordination Managers Office.

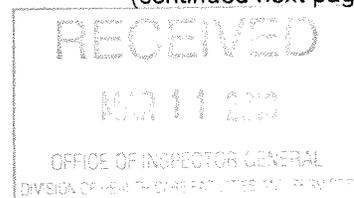
Interview, on 02/06/13 at 2:51 PM, with the Supervisor of Plant Engineering revealed he was aware of the proper use of power strips; however, he was not aware the power strips had been misused.

Reference: NFPA 101 (2000 Edition)

K 147 1. Corrective Action: Review Administrative Policy 0070-0015, Physical Hazards - Extension Cords and Adapters and 0070-0044, General Safety - Electrical Equipment. Policies meet NFPA standards for appropriate use. Surveyed each room in the Long Term Care Facility and corrected any deficiencies of use. AMMENDMENT: Review of policy was completed on 02/08/2013 by the Supervisor of Plant Engineering. Environment of Care Survey conducted on 03/05/2013 with the following issues identified and corrected: 1. In staff office space found printer plugged into power strip (corrected - education provided), 2. In staff office space, found toaster (removed - education provided), 3. In staff office space, found power strip mounted to wall behind desk, (corrected - education provided)

2. Residents affected: All residents in facility had potential to be affected by inappropriate use of power strips.

3. System Changes: Add specific language into the semi-annual Environment of Care Survey to note compliance with appropriate utilization power strips. Provide education to all staff regarding appropriate use of power strips. AMMENDMENT: Environment of Care Survey revisions completed 03/05/2013. Education was provided by Supervisor of Plant Engineering through one-on-one education to staff where



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9.1.2 Electric.

Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.

Reference: NFPA 70 400-8

( Extensions Cords) Uses Not Permitted. Unless specifically permitted in 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

Reference: NFPA 99 (1999 edition)

3-3.2.1.2 D

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.

K 147 (continued)

deficiencies were identified at time of survey on 03/05/2013. Staff included secretary and nursing personnel.

- 4. Monitoring: Weekly rounds will be completed for one month to ensure compliance with policy and ongoing monitoring of use during the semi-annual Environment of Care Survey. ADDENDUM: Manager of SNF and Supervisor of Plant Engineering will conduct the weekly rounds. The semi-annual rounds was selected as it was an established practice for facility. Upon reconsideration, the rounds will be conducted quarterly by Manager of SNF. Results will be reported quarterly at the SNF QA Committee Meeting.

5. Completion Date: AMMENDED: 03/08/2013

