PRINTED: 01/30/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186313	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 01/13/2012
NAME OF PROVIDER OR SUPPLIER: CREEKWOOD PLACE NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE: 683 E. THIRD STREET RUSSELLVILLE, KY 42276	

(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 A RecertificationSurvey was initiated on 01/10/12 and concluded on 01/13/12 with deficiencies cited at the highest scope and severity of an "E". Additionally, an Abbreviated Survey Investigating KY#00017558 was initiated and concluded simultaneously. KY#00017558 was substantiated with no deficiencies cited.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement in full or in part, by the provider, of the truth of the fact, or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and executed solely because it is required by the provisions set forth in Federal and State Law.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility's policy it was determined the facility failed to ensure the Physician's orders were followed for one (1) of seventeen (17) sampled residents (Resident #9). A review of the Physician's orders for Resident #9 revealed: his/her oxygen saturation level while on room air was to be assessed every week, on Sunday. However, a review of Resident #9's 2011 Treatment Administration Records (TAR) for October, November, and December 2011 revealed facility staff failed to comply with the Physician's order. The findings include: A review of the facility's policy entitled Physician's Orders, revised date of 06/28/11, revealed physician orders would be transcribed, noted and implemented in a timely manner. Allow facility specific practice for proper notation and	F 281	**483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS** It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure Physician's orders are followed. **Corrective Action taken for Resident identified in the Deficiency:** Resident #9 was assessed for the need of oxygen treatment and did not require any further treatment. **How other Residents were identified who may have been affected by the practice:** All resident records were checked by the Director of Nursing, Assistant Director of Nursing, Clinical Supervisor, or MDS Coordinator on January 27th, 28th, 29th, 30th, and 31st to verify MD orders were followed. **Measures implemented or Systemic Changes made to Prevent Re occurrence:** Licensed Nurses including R Ns and LPNs were re-educated by the Director of Nursing, The Assistant Director of Nursing, or the Clinical Supervisor on consistently following physician's orders This re-education was done on February 15, 2012, February 19, 2012, and February 21, 2012. Any licensed nurse not re-	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elizabeth Gerring TITLE: Administrator (X6) DATE: 2/29/12

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKWOOD PLACE NURSING & REHAB CENTER, INC	683 E. THIRD STREET RUSSELLVILLE, KY 42276

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F 281	Continued From page 1 implementation of the order. A review of the medical record revealed Resident #9 was originally admitted by the facility on 02/12/03 and had diagnoses which included Alzheimer's Disease, Dementia, Cerebrovascular Accident (stroke), Right Sided Hemiparesis (muscle weakness), Anemia, and Congestive Heart Failure. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 12/04/11, revealed the facility assessed Resident #9 as needing oxygen treatment. Further record review revealed a Physician's order to check oxygen saturation on room air every week on Sunday. Review of 2011 TARs for October, November, and December revealed the following: October 2011 treatment records revealed no documented evidence the facility performed a weekly assessment of Resident #9's oxygen saturation level on room air for two (2) consecutive weeks: Sunday, October 9 th and Sunday, 16 th. November 2011 treatment records revealed no documented evidence the facility performed a weekly assessment of Resident #9's oxygen saturation level on room air for the following times: Sunday, November 6 th, November 20 th, and November 27 th. December 2011 treatment records revealed no documented evidence the facility performed a weekly assessment of Resident #9's oxygen saturation level on room for the following times: Sunday, December 4 th and December 11 th.	F 281	educated by February 21, 2012 will be re-educated on or before their next scheduled shift. **Monitoring Measures to Maintain Ongoing Compliance:** Residents with orders to have O2 sats checked weekly on room air will have their sat checked per the physician's order. Following the weekly check, a 100% audit of these resident's TARs will be completed by the Director of Nursing, Assistant Director of Nursing, Clinical Supervisor, MDS nurse, or Administrator to verify the physician's order was followed. If there is any discrepancy noted, it will be addressed immediately and the O2 sat will be checked by the Licensed nurse on duty. The 100% audit will continue weekly for six (6) weeks. If there are no concerns identified by the 100% audit, the audit will continue with a random sample of 50% of the residents with orders for weekly O2 sats for four (4) weeks, then a 25% sample for four (4) weeks to verify the physicians orders were followed. At the conclusions of these audits, random unscheduled checks will be done by the same designees. Findings of these audits will be presented to the Quality Assurance Committee, (which consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Supervisor, MDS Coordinator, Social Services Director, Dietary Manger, Housekeeping Supervisor, Medical Director, Dietician, and Plant Services Director). If concerns are found during any of the audits, a 100% audit will resume for a duration of time to be determined by the Quality Assurance Committee. A 20% sample of randomly selected resident records will be audited by The	

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NAME OF PROVIDER OR SUPPLIER CREEKWOOD PLACE NURSING & REHAB CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 663 E. THIRD STREET RUSSELLVILLE, KY 42276	

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F 281	Continued From page 2 In addition, the oxygen saturation level on December 18 th was at 82% (below prior room air oxygen saturation levels which were above 90%). Interview, on 01/12/12 at 10:10 AM, with Licensed Practical Nurse (LPN) #3 revealed the Physician's orders for Resident #9 included checking the resident's oxygen saturation level on room air weekly every Sunday. After reviewing the November and December 2011 TARs for Resident #9, the LPN reported staff did not check the oxygen saturation level as ordered by the Physician. It was checked only one time in November. Interview, on 01/12/12 at 1:30 PM, with LPN #2 revealed if there was an order to check the oxygen saturation level on room air weekly, staff was responsible to make sure it was assessed as ordered. Interview, on 01/13/12 at 2:35 PM, with the Assistant Director of Nursing (ADON) revealed based on documentation in Resident #9's November and December 2011 treatment records, the room air oxygen saturation levels were not being assessed weekly as ordered. The nurses should have followed the Physician's order to take weekly room air oxygen saturation readings on Sundays. The ADON further stated if the oxygen saturation level recorded on December 18 th was at 82% the nurse should have further assessed the resident and retaken the oxygen saturation level because it was below normal.	F 281	Director of Nursing, Assistant Director of Nursing, Clinical Supervisor, MDS Coordinator, or Administrator to verify all physician's orders were followed. If there are any discrepancies they will be addressed immediately. The 20% sample will be a random selection of residents on all three units and will continue for six (6) weeks. The results of these audits will be presented to the Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Clinical Supervisor, Plant Services Manager, Housekeeping Supervisor, Medical Director, Social Services Director, Dietary Manager, and Dietician) The Quality Assurance Committee will review the results of the audits and will reduce the audit to a 10% random sampling of all residents unless otherwise determined by the committee upon review. The 10% audit will continue for six (6) weeks. The results of the audits will be presented to the Quality Assurance Committee. If concerns are identified the duration, frequency and/or sample size may be increased as determined by the Quality Assurance Committee. At the conclusion of these audits, random unscheduled audits will be done by the same designees.	February 22, 2012
F 441 S8=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 3 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS It is the normal practice of Creekwood Place Nursing and Rehab Center to implement an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. **Corrective Action Taken for Residents Identified in the Deficiency:** There were no residents identified in the deficiency. **How other Residents were identified who may have been affected by the Practice:** Residents Nurse Aide Data Sheets were reviewed b the Administrator on January 28, 2012 to identify residents requiring assistance with feeding. **Measures implemented or Systemic Changes made to Prevent Re-occurrence:** Nursing staff including State Registered Nursing Assistants, Medication Aides, and Restorative Techs were re-educated on January 17, 2012 by the ADON on proper hand hygiene (hand washing and use of sanitizing gel) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination. Nursing staff including State Registered Nursing Assistants, Medication Aides, and Restorative Techs were also re-educated on February 9, 2012 by the ADON on proper hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination including during meal service.	

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F 441	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies, it was determined the facility failed to implement an Infection Prevention and Control Program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. Observation of dining services revealed staff failed to implement hand hygiene (hand washing) practices consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination. State Registed Nursing Assistant (SRNA) #9 failed to perform proper hand hygiene when assisting residents in the restorative dining room on two different meal observations, at the lunch meal on 0/10/12 and at the dinner meal on 01/11/12. The findings include: Review of the facility's Infection Prevention and Control Policy, effective date 10/10/11, revealed it is the facility will attempt to control and prevent the transmission of infections. The facility will provide precautionary measures to prevent the spread of potential infection. Review of the facility's Infection Control Handwashing Policy, dated 01/27/11, revealed hadn-washing should be done before and after caring for each resident. Observation, on 01/10/12, of the lunch meal in the Restorative Dining area revealed SRNA #9 was going from resident to resident, seated at different tables, and assisting with their meals. SRNA #9 was observed making contact with the	F 441	**Monitoring Measures to Maintain Ongoing Compliance:** The ADON will assign a member of the Quality Assurance Committee (consisting of The Administrator, Director of Nursing, Assistant Director of Nursing, Clinical Supervisor, MDS Coordinator, Plant Service Director, Housekeeping Supervisor, Social Services Director, Dietary Manager, Dietician, and Medical Director) to do a random audit of at least 10% of residents requiring assistance with feeding to validate that staff members are following appropriate hand hygiene (hand washing) practices consistent with accepted standards of practice. The audits will be done randomly and will include staff feeding breakfast, lunch and supper. The audits will be conducted weekly for eight weeks, then monthly for six (6) months to verify ongoing compliance. Results of the findings will be reported to the Administrator and the Quality Assurance Committee. If any areas of concern are identified, the frequency and or duration of the audit may be increased. Members of the Quality Assurance Committee as designated by the Assistant Director of Nursing will complete infection control focus review rounds weekly for six (6) weeks then monthly for six (6) months. The focus review rounds will include observation of various disciplines (nursing, dietary, and housekeeping) on different shifts and building assignments, to verify staff follow appropriate infection control practices and transmission based precaution procedures including, but not limited to: Appropriate linen handling practices consistent with accepted standards of practice; appropriate hand washing/hygiene practices consistent with accepted standards of practice; appropriate equipment cleaning/disinfection practices	

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CREEKWOOD PLACE NURSING & REHAB CENTER, INC	663 E. THIRD STREET RUSSELLVILLE, KY 42276

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F 441	Continued From page 5 residents and not performing hand sanitization between resident contact. Observation, on 01/11/12, of the dinner meal in the Restorative Dining area revealed SRNA #9 was assisting residents with their meals without performing hand sanitation between residents. The aide was observed touching some of the residents when assisting with their meals. Interview, on 01/11/12 at 6:20 PM, with SRNA #9 revealed staff was supposed to clean your hands whenever you go to another resident when assisting with meals or touching their food. She stated she did not clean her hands between residents during the dinner meal. She stated she should have washed her hands as it was important to wash hands for infection control to prevent cross contamination. Interview, on 01/13/12 at 2:10 PM, with the Assistant Director of Nursing, who also serves as the Infection Control Nurse, revealed when staff was helping residents with meals they were supposed to clean their hands between helping residents to prevent the spread of infection.	F 441	consistent with accepted standards of practice; adherence to standard precautions and related processes, including the use of PPE; Appropriate use of precautions and management of residents with special needs, etc The results of these audits will be presented to the Administrator and to the Quality Assurance Committee for monitoring of ongoing compliance. If concerns are identified in any areas, the frequency and or duration of the rounds may be increased and re-education will be given as determined by the Quality Assurance Committee. After completion of the scheduled audits/focus review rounds, random, unscheduled rounds will be completed by the same designees to monitor for ongoing compliance with accepted infection control standards of practice.	February 23, 2012

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	185313	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/11/2012

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1964, 1975, 1984 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type V (111) SMOKE COMPARTMENTS: Six (6) smoke compartments FIRE ALARM: Complete fire alarm system with heat and smoke detectors SPRINKLER SYSTEM: Complete automatic dry sprinkler system. GENERATOR: Type II generator. Fuel source is diesel. A standard Life Safety Code survey was conducted on 01/11/12. Creekwood Place Nursing and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one hundred four (104) beds with a census of seventy eight (78) 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)	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Elizabeth Gettys, Administrator — 2/9/12

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 Deficiencies were cited with the highest deficiency identified at a scope and severity of an "F".	K 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement in full or in part, by the provider, of the truth of the fact, or the conclusions set forth in this statement of deficiencies. This plan of correction is prepared and executed solely because it is required by the provisions set forth in Federal and State Law.	
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 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 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 six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred four (104) beds with a census of seventy eight (78) on the day of the survey. The findings include: Observation, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant	K 025	K025 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center, Inc. to maintain all smoke barriers. **Corrective Measures for Residents Identified in the Deficiency:** No residents were identified in this deficiency **How Other Residents were Identified who may have been affected by this practice were identified:** Residents in six (6) of the six (6) smoke compartments had the potential to be affected. **Measures Implemented or Systems Altered to Prevent Re-occurrence:** Penetrations in the ceiling of the 1 South Mechanical room, Heat room on 2, and the Sprinkler Room were caulked with fire rated caulking by the Maintenance Supervisor and Maintenance Assistant. The Smoke partition extending above the ceiling above station 2 was caulked with fire rated caulking by the Maintenance Supervisor and Maintenance Assistant. The Kwik Foam utilized in penetrations above the ceiling above Station 2 was removed by the Maintenance Assistant and replaced with fire rated caulking. A facility wide audit was conducted by members of the Quality Assurance Committee and all identified penetrations in the ceilings or smoke barriers were caulked with fire resistant caulking. The Plant Services Director, Plant Services Assistant, and the Housekeeping Supervisor were re-educated on NFPA 101 life safety code relating to smoke barriers on January 15, 1012 by the	

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K 025	Continued From page 2 revealed penetrations in the ceiling of the1 South Mechanical room, Heat room on 2, and the Sprinkler Room. Further observation revealed the smoke partition extending above the ceiling was penetrated by pipes and wires, above Station 2. The area around the penetrations was not filled with a material rated equal to the partition and could not resist the passage of smoke. The use of flammable Kwik Foam to seal penetrations was also noted in all smoke partitions. Interview, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed they were not aware of the penetrations. They were also not aware Kwik Foam was not a suitable product for use in smoke partitions. 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	K 025	Administrator: When smoke barriers are accessed by any contracted individuals, the Plant Services Director will check all smoke barriers to ensure that any openings created are sealed with fire rated materials. **Monitoring Measures to Maintain On-going Compliance:** The Plant Services Director will audit the smoke barriers monthly for the next six months and report findings to the Quality Assurance and Assessment Committee to validate ongoing compliance.	January 15 2012

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K 025	Continued From page 3 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=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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 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 access doors in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred four (104) beds with a census of seventy eight (78) on the day of the survey. The findings include:	K 027	K 027 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to ensure access doors in smoke barriers are installed in accordance with NFPA standards. **Corrective Measures for Residents Identified in the Deficiency:** No residents were identified in the deficiency **How Other Residents were Identified who may have been affected by this practice were identified:** Residents in three (3) of the six (6) smoke compartments had the potential to be affected. **Measures Implemented or Systems Alteredto Prevent Re-occurrence:** The two smoke barrier access doors located in the attic above Hall 3, and Nurses Station 2 were replaced with materials with a fire resistance rating of two (2) hours by the Plant Services Assistant. The Attic was audited by the Plant Services Manager and the Plant Services Assistant to identify any other access doors that did not meet NFPA standards. Identified doors were replaced with materials having a fire resistance rating of two (2) hours by the Plant Services Assistant. The Plant Services Manager, The Plant Services Assistant, and the Housekeeping Supervisor were re-educated on January 15, 2012 by the Administrator on NFPA Life Safety Code Standard related to access doors in smoke barriers.	

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K 027	Continued From page 4 Observation, on 01/11/12 at 3:50 PM, with the Plant Services Assistant revealed two (2) unrated homemade smoke barrier access doors located in the attic above Hall 3, and Nurses Station 2. Interview, on 01/11/12 at 3:50 PM, with the Plant Services Assistant revealed he was not aware the doors in the attic must be rated for use. Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. 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.	K 027	**Monitoring Measures to Maintain Ongoing Compliance:** The Plant Services Director will audit the smoke barriers monthly for the next six months to ensure there are no unrated smoke barrier access doors to validate ongoing compliance and will report findings to the Quality Assurance Committee.	February 5' 2012
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029		

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K 029	Continued From page 5 extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred four (104) beds with a census of seventy eight (78) on the day of the survey. The findings include: Observation, on 01/11/12 at 1:00 PM, with the Plant Services Assistant revealed the door to the Kitchen did not have a self closing device. Interview, on 01/11/12 at 1:00 PM, with the Plant Services Assistant revealed they were not aware the self closing device was required. Reference: NFPA 101 (2000 Edition).	K 029	K 029 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to meet the requirements of Protection of Hazards in accordance with NFPA Standards. **Corrective Measures for Residents Identified in the Deficiency:** No residents were identified in this deficiency. **How Other Residents were Identified that may have been affected by the practice:** Residents in one (1) of six (6) smoke compartments had the potential to be affected by the practice. **Measures Implemented or Systems Altered to Prevent Re-Occurrence:** A self closing device was installed on the door to the kitchen on January 11, 21012 by the Plant Services Assistant. The remaining hazardous areas in the facility were checked by the Plant Services Assistant to validate the presence of self closing devices on the doors. There were no hazardous areas identified without self closing devices present on the doors. The Plant Services Manager and the Plant Services Assistant were re-educated on January 15, 2012 by the Administrator on proper self closure devices on doors to the kitchen and all hazardous areas. **Monitoring Measures to Maintain On-going Compliance:** Hazardous areas in the facility will be audited by the Plant Services Manager monthly to validate the presence of self closing devices on the doors. The results of the audit will be reported to the Administrator and the Quality Assessment and Assurance committee to validate ongoing compliance.	January 15' 2012

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K 029	Continued From page 6 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

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K 038	Continued From page 7 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiencies had the potential to affect four (4) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred four (104) beds with a census of seventy eight (78) on the day of the survey. The findings include: Observation, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed the delayed egress doors located next to rooms #301, #312, #221, and #114, did not have the required signage stating the door was equipped with a fifteen (15) second delay before opening. Further observation revealed a concrete curb had been poured outside the exit door next to room #114, and the curb was approximately 3" high and blocked the exit door from fully opening. Interview, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed they were not aware the delayed egress	K 038	K 038 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to have exits readily accessible at all times. **Corrective Measures for Residents identified in the Deficiency:** No residents were identified in the deficiency. **How Other Residents were identified who may have been affected by this practice were identified:** Residents in four (4) of the six (6) smoke compartments had the potential to be affected. **Measures Implemented or Systems Altered to Prevent Re-occurrence:** Correct signage was placed at the delayed egress doors located next to rooms #301, #312, #221, and #114 by the Plant Services Manager. The curb outside the exit door next to room #114 was removed allowing the exit door to fully open. The Plant Services Manager, the Plant Services Assistant, and the Housekeeping Supervisor were re-educated on January 15th, 2012 by the Administrator on NFPA 101 Life Safety Code standard related to exit access. **Monitoring Measures to Maintain Ongoing Compliance:** The Plant Services Manager will audit the exits monthly for the next six months to validate ongoing compliance with signage and accessibility and will report findings to the Quality Assurance and Assessment Committee.	January 15' 2012

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K 038	Continued From page 8 signage was to be on the exit doors. Further interview revealed the curb was poured outside the exit door to help control a drainage problem. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. Reference: NFPA 101 (2000 Edition). 7.7.1*	K 038		

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K 038	Continued From page 9 Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. 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. CMS Ref: S&C-05-38	K 038		
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 review of the facility's fire drills it was determined the facility failed to ensure fire drills were conducted in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred four (104) beds with a census of seventy eight (78) on the day of the survey.	K 050	K 050 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to conduct fire drills at unexpected times under varying conditions. **Corrective Measures for Residents Identified in the Deficiency:** No residents were identified in the deficiency. **How Other Residents were Identified who may have been affected by this practice were identified.** Residents in six (6) of six (6) smoke compartments have the potential to be affected by the practice. **Measures Implemented or Systems Altered to Prevent Re-occurrence:** The schedule for quarterly fire drills was reviewed by the Administrator on January 31, 2012 to validate that fire drills are scheduled on a quarterly basis for all shifts and at unexpected times under varied conditions during the shifts. The Plant Services Director was re-educated by the Administrator on January 15, 2012 on conducting fire drills on all shifts at unexpected times under varied conditions.	

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K 050	Continued From page 10 The findings include: Fire Drill review, on 01/11/12 at 3:03 PM, with the Plant Services Assistant revealed the fire drills were not being conducted at unexpected times under varied conditions, on 1st and 2nd shifts. Further observation revealed the facility failed to perform a fire drill on 3rd shift, in the 4th quarter of 2011. Fire drills were being conducted as follows: First Shift 11/29/11 @ 10:30 AM 08/31/11 @ 10:15 AM 05/03/11 @ 11:00 AM 03/17/11 @ 6:30 AM Second Shift 12/27/11 @ 2:50 PM 09/28/11 @ 3:40 PM 06/29/11 @ 2:40 PM 03/17/11 @ 2:40 PM Third Shift Missed 07/29/11 @ 6:00 PM 04/28/11 @ 4:50 AM 03/17/11 @ 6:00 AM Interview, on 01/11/12 at 3:03 PM, with the Plant Services Assistant revealed they were not aware the fire drills were not being conducted as required. They were also not aware they had missed the 4th quarter on 3rd shift.	K 050	**Monitoring Measures to Maintain Ongoing Compliance:** The Plant Services Director will provide a quarterly schedule in advance for review by the Administrator to validate ongoing compliance with conducting fire drills at unexpected times under varied conditions. The Administrator will affirm that the schedule is followed or that changes are appropriate if indicated.	January 31,2012

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K 050	Continued From page 11 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		
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 six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred four (104) beds with a census of seventy eight (78) on the day of the survey. The findings include:	K 056	K 056 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to meet the Standard for the Installation of Sprinkler Systems. **Corrective Action for Residents Identified in the Deficiency:** No residents were identified in the deficiency **How Other Residents were Identified who may have been affected by the practice:** Residents in one (1) of six (6) smoke compartments had the potential to be affected. **Measures Implemented or Systems Altered to Prevent Re-Occurrence:** The Plant Services Manager received a quote on February 2, 2012 to complete the sprinkler system on the porch located outside the exit door next to room #221 so the porch will have sprinkler protection. Fire Guard Sprinkler Services has projected completion of this project to be March 1, 2012. The Plant Services Manager, the Plant Services Assistant, and the Housekeeping Supervisor were re-educated on January 15, 2012 by the Administrator on NFPA life safety relating to the standard for installation of sprinkler systems.	

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K 056	Continued From page 12 Observation, on 01/11/12 at 1:35 PM, with the Plant Services Assistant revealed one (1) porch located outside the exit door next to room #221, to extend out four (4) feet or greater, was made of combustible materials, and was not sprinkler protected. Interview, on 01/11/12 at 1:35 PM, with the Plant Services Assistant revealed they were not aware the porch 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. Reference: NFPA 13 (1999 Edition)	K 056	**Monitoring Measures to Maintain Ongoing Compliance:** The Plant Services Manager will audit the sprinkler system quarterly to validate ongoing compliance. Findings will be reported to the Quality Assurance Committee.	March 1,2012
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: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect six (6) of the six (6) smoke compartments, residents, staff and visitors. The facility is	K 062	K 062 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center to maintain the sprinkler system in accordance with NFPA standards. **Corrective Measures for Residents Identified in the Deficiency:** No residents were identified in the deficiency **How Other Residents were Identified who may have been affected by this practice:** Residents in six (6) of the six (6) smoke compartments had the potential to be affected.	

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K 062	Continued From page 13 licensed for one hundred four (104) beds with a census of seventy eight (78) on the day of the survey. The findings include: Observation, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed the escutcheon (trim piece) was missing from the sprinkler head in the bathroom of room #112, and the oxygen room on Hall 3. Further observation revealed the facility failed to provide a sprinkler head wrench in accordance with NFPA standards. Interview, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed they were not aware of the missing escutcheon pieces, or the missing sprinkler head wrench. Reference: NFPA 25 (1998 Edition). 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.	K 062	**Measure Implemented or Systems Altered to Prevent Re-occurrence:** The escutcheon (trim piece) was placed on the sprinkler heads in the bathroom of room #112 and the oxygen room on Hall 3 by the Plant Services Director on 2/3/12. The sprinkler head wrench will be replaced the sprinkler room by Fire Guard Sprinkler Service, Inc by February 15, 2012. The Plant Services Manager and the Plant Services Assistant were re-educated January 15, 2012 by the Administrator on NFPA standards for maintaining the sprinkler system. **Monitoring Measures to Maintain ongoing Compliance:** The Plant Services Manager will audit the sprinkler heads monthly to validate the placement of the escutcheons. The Plant Services Manager will audit the Sprinkler Room monthly to verify placement of the Sprinkler wrench. Findings will be reported to the Quality Assurance and Assessment Committee.	February 15, 2012
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in	K 070		

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K 070	Continued From page 14 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 two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is licensed for one hundred four (104) beds with a census of seventy eight (78) on the day of the survey. The findings include: Observation, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed portable space heaters located in the Assistant Director of Nursing Office, Dietary Office, and the Reception Area. Interview, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed they were aware the heaters were not permitted in patient care areas, but not aware the heating element could not exceed, 212°F (100°C) when used in non-sleeping staff and employee areas. Reference: NFPA 101 (2000 edition) 19.7.8 Portable Space-Heating Devices. Portable space-heating	K 070	K 070 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center not to use portable space heating devices where the heating elements of such devices do not exceed 212 degrees F. **Corrective Measures for Residents Identified in the Deficiency:** No residents were identified in the deficiency. **How Other Residents were Identified who May Have Been Affected by this Practice:** Residents in two (2) of six (6) smoke compartments had the potential to be affected. **Measure Implemented or Systems Altered to Prevent Re-occurrence:** The space heaters in the Assistant Director of Nursing Office, Dietary Office, and the Reception Area were removed by the Housekeeping Supervisor on January 11, 2012. Department Managers were re-educated on January 11, 21012 by the Administrator on NFPA 101 related to the use of portable heaters. Housekeeping Staff were re-educated on January 19, 2012 by the Administrator on NFPA 101 related to the use of portable heaters. Nursing Staff including Licensed Nurses, and Nurse Techs were re-educated January 19, 2012 by the Administrator on NFPA 101 related to the use of portable heaters. **Monitoring Measures to Maintain Ongoing Compliance:** The Housekeeping Supervisor will audit a minimum of 4 offices and/or work areas to verify no portable heaters are present. The audits will be conducted monthly	

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	185313	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/11/2012

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K 070	Continued From page 15 devices shall be prohibited in all health care occupancies. Exception: Portable space-heating devices shall be permitted to be used in nonsleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C).	K 070	for three (3) months, then will begin again monthly during the winder months. Findings will be reported to the Quality Assurance and Assessment Committee.	January 19, 2012
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 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. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred four (104) beds, with a census of seventy eight (78) on the day of the survey. The findings include: Observation, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed an unapproved lock (slide bolt type) was installed on the egress side of the bathroom door in room #116, the closet in room #208, and the Ice Room. Interview, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed they were aware of the locks, but not aware they were prohibited.	K 130	K 130 NFPA 101 MISCELLANEOUS It is the normal practice of Creekwood Place Nursing and Rehab Center not to utilize unauthorized locking mechanisms on doors within a required means of egress. **Corrective Measure for Residents Identified in the Deficiency:** No residents were identified in the deficiency **How Other Residents were Identified who may have been affected by the practice:** Residents in three (3) of six (6) smoke compartments had the potential to be affected. **Measures Implemented or Systems Altered to Prevent Re-occurrence:** The Plant Services Assistant removed the unapproved locks from the bathroom door in room #116, the closet in room #208, and the Ice Room on January 11, 2012. The Plant Services Manager, The Plant Services Assistant, and the Housekeeping Supervisor were re-educated January 15, 2012 by the Administrator on required means of egress in accordance with NFPA standards.	

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K 130	Continued From page 16 Reference: NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	**Monitoring Measures to Maintain Ongoing Compliance:** The Housekeeping Supervisor will audit all doors to verify the locks on all doors are in accordance with the required means of egress. The audit will be conducted monthly for six months. The findings will be reported to the Quality Assurance and Assessment Committee Meeting to validate ongoing compliance.	January 15, 2012
K 147 SS=F	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 four (4) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for one hundred four (104) beds with a census of seventy eight (78) on the day of the survey. The findings include: Observation, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed: 1) A power strip was plugged into another power strip located in the Admissions Office. 2) A resident bed was plugged into a power strip located in room #115. 3) An oxygen concentrator and two (2) resident	K 147	K 147 NFPA 101 LIFE SAFETY CODE STANDARD It is the normal practice of Creekwood Place Nursing and Rehab Center maintain electrical wiring in accordance with NFPA 70 standards. **Corrective Measures for Residents Identified in the Deficiency:** No residents were identified in the deficiency **How Other Residents were identified who may have been affected by the practice:** Residents in four (4) of four (4) smoke compartments had the potential to be affected. **Measures implemented or systems altered to prevent re-occurrence:** 1: The power strip in the Admissions office was used for non medical equipment. It was removed from the additional power strip and was plugged into the wall receptacle by the Admissions Coordinator on 1/15/12. 2: The resident bed in room #115 was removed from the power strip and was plugged into a wall receptacle by the Housekeeping Supervisor on 2/3/12. 3: The oxygen concentrator and two (2) resident beds in room #112 were removed from the power strip and were plugged into wall receptacles by the Administrator on 2/3/12. 4: The Resident bed in room #113 was removed from the power strip and was plugged into a wall receptacle by the Administrator on 2/3/12.	

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K 147	Continued From page 17 beds were plugged into a power strip located in room #112. 4) A resident bed was plugged into a power strip located in room #113. 5) A refrigerator was plugged into a power strip located in the Housekeeping Office. 6) Storage in front of electrical panels located in the North 1 Heating Room. 7) A resident bed was plugged into a power strip located in room #110. 8) An extension cord was plugged into a power strip located in the Dietary Office. 9) Storage shelving was in front of an electrical panel located in the Dish Room. 10) An ice machine was plugged into a power strip located in the Kitchen. 11) An air mattress, air compressor, feeding tube pump, oxygen concentrator and a resident bed were plugged into a power strip located in room #208. 12) A resident bed was plugged into a power strip that was plugged into another power strip located in room #220. 13) A refrigerator and microwave were plugged into a power strip located in the Activities Office. 14) A circulation pump for the hot water system was plugged into a power strip. 15) A feeding machine, two (2) suction pumps, a resident bed, and an air mattress were plugged into a power strip located in room #201. 16) A portable heater was plugged into a power strip located in the reception area. 17) An open electrical junction box located in the Sprinkler Room. 18) Two (2) refrigerators were plugged into a power strip located in Building 3 Treatment Room. 19) Two (2) soap dispensing units to the	K 147	5: The refrigerator in the Housekeeping Office was removed from the power strip and plugged into a wall receptacle by the Housekeeping Supervisor on 2/3/12. 6: The storage in front of the electrical panels located in the North 1 Heating Room were removed by the Plant Services Manager on 1/27/12. 7: The resident bed in room #110 was removed from the power strip and plugged into the wall receptacle by the Administrator on 2/3/12. 8: The extension cord was removed from the Dietary Office by the Plant Services Assistant on 1/11/12. 9: The shelving was removed from in front of the electrical panel in the Dish Room by the Plant Services Assistant on 2/7/12. 10: The ice machine in the Kitchen was removed from the power strip and was plugged into a receptacle by the Plant Service Assistant on 1/28/12. 11: The air mattress, air compressor, feeding tube pump, oxygen concentrator, and resident bed in room #208 were removed from the power strip by the Administrator and plugged into wall receptacles on 2/6/12. 12: The resident bed in room # 220 was removed from the power strip and plugged into a wall receptacle by the Housekeeping Supervisor on 2/6/12. 13: The refrigerator and microwave in the Activities Office were removed from the power strip and plugged into a receptacle by the Housekeeping Supervisor on 2/8/12. 14: The circulation pump for the hot water system was removed from the power strip and plugged into a receptacle by the Plant Services Manager on January 31, 2012. 15: The feeding machine, two (2) suction pumps, resident bed, and an air mattress in room #201 were removed from the power strip and plugged into a wall receptacle by the Housekeeping Supervisor on 2/6/12. 16: The portable heater and power strip were removed from the reception area. 17: The electrical junction box located in the Sprinkler room will have an adapter box and cover plate installed by February 18, 2012 by the Plant Services Manager.	

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K 147	Continued From page 18 washers, and an air conditioning unit were plugged into a power strip located in the Laundry Room. 20) Open junction boxes in the Attic above Nurses Station 2. Interview, on 01/11/12 between 11:30 AM and 4:00 PM, with the Plant Services Assistant revealed they were not aware of the extension cords and power strips being misused. Further interview revealed they were also not aware of the storage in front of the electrical panels, or the open junction boxes. 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. 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to	K 147	18: The two (2) refrigerators located in Building 3 Treatment room were removed from the power strip and plugged into wall receptacles by the Housekeeping Supervisor on 2/8/12. 19: The two (2) soap dispensing units to the washers and the air conditioning unit in the Laundry were removed from the power strips and plugged into wall receptacles by the Housekeeping Supervisor on 2/8/12. 20: The junction boxes in the attic above Nurses Station two will have an adapter box and a cover plate installed by February 18, 2012 by the Plant Services Manager. All resident rooms were audited by the Quality Assurance Committee members on January 26th and January 27th to validate that no extension cords were present in the facility. All resident rooms on Building Three were audited on February 1, 2012 by the Administrator, The Medical Records Coordinator, and the Housekeeping Supervisor to validate that all medical equipment is plugged directly into the wall receptacles. All resident rooms on Building Two were audited on February 7th by the Administrator, The Housekeeping Supervisor, The Medical Records Coordinator, and The Admissions Coordinator to validate that all medical equipment is plugged directly into the wall receptacles. Electrical Work for Building One is still in progress by licensed electricians and will be completed by February 10, 2012. All resident rooms on Building One will be audited on February 10, 2012 by the Administrator, The Housekeeping Supervisor, and The Medical Records Coordinator to validate all medical equipment is plugged directly into the wall receptacles. The Plant Services Manager, The Assistant Plant Services Director, and the Housekeeping Supervisor were re-educated on electrical wiring and equipment in accordance with the NFPA cods by the Administrator on January 15, 2012. All employees were re-educated by the Administrator on January 19th, 2012 on properly plugging medical equipment into wall receptacles, and non use of extension cords.	

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K 147	Continued From page 19 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. Reference: NFPA 70 (1999 edition) 370.28(c) Covers. 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 requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	**Monitoring Measures for Ongoing Compliance:** The Plant Services Manager or the Housekeeping Supervisor will audit four (4) rooms weekly for eight (8) weeks then weekly for four (4) weeks, then monthly for six (6) months to verify ongoing compliance with properly plugging medical equipment into wall receptacles on no use of extension cords. The four rooms will include resident and offices. This is approximately 10% of facility rooms. Results of the findings will be reported to the Administrator and the Quality Assessment Assurance Committee. If any areas of concern are identified, the frequency and or duration of the audit may be increased. The Plant Services Assistant will audit the electrical panels in the facility weekly for eight (8) weeks, then weekly for four (4) weeks, then monthly for six (6) months to verify ongoing compliance with no items being stored in front of the panels. Results of the findings will be reported to the Administrator and the Quality Assessment Assurance Committee. If any areas of concern are identified, the frequency and or duration of the audit may be increased. The Plant Services Manager will audit two junction boxes on each unit weekly for eight (8) weeks, then weekly for four (4) weeks, then monthly for six (6) months to verify ongoing compliance with junction boxes being closed. Results of the findings will be reported to the Administrator and the Quality Assessment Assurance Committee. If any areas of concern are identified, the frequency and or duration of the audit may be increased.	February 18, 2012