

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

PRINTED: 05/26/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2011
NAME OF PROVIDER OR SUPPLIER PADUCAH CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH THIRD STREET PADUCAH, KY 42001	
(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 323	<p>Continued From page 1</p> <p>"Accidents/Incidents," dated 01/08, revealed, "It is the center's policy to provide an environment that is free from hazards over which the center has control."</p> <p>A review of the facility's "MSDS for Nail Polish Remover," dated 01/14/00, revealed "Nail polish remover had a potential to be a health hazard if swallowed or inhaled."</p> <p>A record review revealed Resident #18 was admitted to the facility on 11/24/08 with diagnoses to include Dementia with Agitation, Alzheimer's Disease and Transient Ischemic Attack (TIA).</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 03/30/11, revealed the resident was assessed to be severely cognitively impaired with disorganized thinking.</p> <p>Observations, on 05/10/11 at 11:07 AM and at 3:10 PM, revealed there was a full bottle of nail polish remover in an open storage tower in the resident's room.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 05/10/11 at 4:15 PM, revealed she was responsible for monitoring the residents' rooms during her shift. She stated potentially dangerous chemicals should be stored securely and out of the resident's sight. After discovery of the bottle of nail polish remover on 05/10/11, the LPN removed the nail polish remover from Resident #18's room and stated it should be stored in a secure location and not in the resident's room.</p> <p>Interviews with Certified Nurse Aides (CNAs) #1 and #2, on 05/12/11 at 1:50 PM and at 2:00 PM,</p>	F 323	<p>re-educated the Department Managers to include; Nurse Unit Manager, Maintenance Director, Housekeeping/Laundry Supervisor, Business Office Manager, Activity Director, Solana Program Manager, Therapy Program Manager, Clinical Case Manager, MDS Coordinator and the Dietary Manager on resident environment remaining free of hazardous chemicals. On 6/2/11 the Dietary Manager, Business Office Manager, Director of Nursing, Nurse Unit Manager, Therapy Program Manager and Housekeeping/Laundry Supervisor re-educated facility staff on resident environment remaining free of hazardous chemicals. A letter to responsible party, power of attorney or guardian will be sent on 6/3/11 to re-educate on the safe storage of personal items. A resident council meeting will be held on 6/2/11 for the education of maintaining a safe environment and storage of personal items.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Nurse Unit Manager will complete audits to ensure resident's environment is safe, hazardous chemicals are stored</p>

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F 323	<p>Continued From page 2</p> <p>respectively, revealed they were responsible for monitoring the residents' rooms for potentially dangerous chemicals during the shift. If a chemical was discovered, they were to remove the chemical and give it to the charge nurse. Resident #18's cognitive status varied throughout the day and both CNAs stated the nail polish remover should not be stored in the resident's room.</p> <p>An interview with the Director of Nursing (DON), on 05/12/11 at 11:25 AM, and at 11:45 AM, revealed potentially dangerous chemicals should be stored securely and not readily accessible to the residents. Nail polish remover was to be stored in the activity department securely and should have not been in a resident's room. Residents' families were instructed upon admission to check in all items obtained outside the facility and the nurse was expected to evaluate the items for safety and proper storage. She expected direct care staff to monitor rooms during the assigned shift and remove potentially dangerous chemicals if discovered.</p>	F 323	<p>appropriately and no hazardous chemicals are kept at bedside. The audits will be completed weekly times four (4) weeks then monthly times two (2) months. The Director of Nursing will present the results at the Performance Improvement (PI) / Committee for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings.</p>	6/9/11

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 05/11/11 to determine Federal compliance with Title 42, Code of Federal Regulations, 482.41 (b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency at an E.	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Paducah Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>K025</p> <p>1. On 6/3/11 the smoke barrier wall above the protective ceiling adjacent and over the fire doors by room #116 and room #117, above the shower room and the sprinkler riser room was repaired to eliminate the open gap by the Maintenance Director.</p> <p>2. The Maintenance Director inspected the building on 5/11/11 and no other issues were identified. On 6/3/11 Administrator verified the integrity of barrier wall was not compromised and the open gap was closed.</p>	
K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This condition affected the staff, residents, and visitors. The facility had the capacity for 94 beds.</p> <p>Findings include:</p> <p>On 05/11/11 at approximately 10:00 AM, the smoke barrier wall above the protective ceiling adjacent and over the fire doors by room #116 & room #117, above the shower room and the</p>	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael Murphy</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/3/11</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patient. (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 025	Continued From page 1 sprinkler riser room, were observed detached and leaning away from its original installation past the ceiling tiles to the ceiling above, creating an open gap of approximately seventy (70) square inches. The finding was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11. Actual NFPA Standard reads: Smoke barriers shall be continuous from an outside wall to an outside wall. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces per NFPA 101, 8.3.2. When pipes, conduits, cables, wires, air ducts and similar building service equipment pass through smoke barriers, the space between the penetrating item and the smoke barrier shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or protected by an approved device that is designed for the specific purpose per NFPA 101, 8.3.6.1.	K 025	3. The Maintenance Director was re-educated on 5/31/11 by the facility Administrator regarding the need to have uncompromised barrier walls and barrier walls that are free of openings. 4. The Maintenance Director will audit smoke barriers throughout the facility monthly for three (3) months. The Maintenance Director will present the results at the Performance Improvement (PI) Committee Meeting for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings.	6/9/11	
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 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	K 029			

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K 029	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview during the survey, it was determined that the facility failed to provide hazardous areas of smoke tight construction. This condition affected the staff, residents, and visitors. The facility had the capacity for 94 beds.</p> <p>Findings include:</p> <p>On 05/11/11 at approximately 9:00 AM, it was observed that the Linen Chute Door (Standard hand operated intake, noiseless, self-closing, side hinged, 1 1/2 hour, 250", U.L. "B" labeled type-door), located at the corridor near room #124, was not smoke tight due to lack of a self-closing device.</p> <p>The finding was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11.</p> <p>Actual NFPA Standard reads: 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</p>	K 029	<p>K029</p> <ol style="list-style-type: none"> 1. On 6/1/11 a self closing device was ordered for the linen chute door by the Maintenance Director located at the corridor near room #124, expected completion date of 6/4/11 and once installed will be validated for proper functioning by the Administrator. 2. The Maintenance Director inspected the building on 5/11/11 and no other areas were identified. 3. On 5/31/11 the facility Administrator re-educated the Maintenance Director regarding the need for hazardous areas of smoke tight construction to include self-closing devices on linen chute doors. 4. The Maintenance Director will audit hazardous area doors to ensure self closing devices are installed and functioning properly. The Maintenance Director will audit the hazardous doors for four (4) weeks then monthly for two (2) months. The Maintenance Director will present the results at the Performance Improvement (PI) Committee Meeting for further recommendations and/or

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<p>K 029</p> <p>K 038 SS=F</p>	<p>Continued From page 3 restricted to, the following:</p> <ul style="list-style-type: none"> (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. <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access was so arranged that exits were readily accessible at all times in accordance with 7.1, 18.2.1, 19.2.1. This condition affected the staff, residents, and visitors. The facility had the capacity for 94 beds.</p>	<p>K 029</p> <p>K 038</p>	<p>suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings.</p> <p>K038</p> <ol style="list-style-type: none"> 1. On 5/25/11 the Maintenance Director posted the keyboard pad combination on the courtyard gate where the maintenance building is located. 2. The Maintenance Director inspected the building on 5/11/11 and not other issues were identified. 3. The Maintenance Director was re-educated on 5/31/11 by the facility Administrator related to doors within a required means of egress shall not be 	<p>6/9/11</p>
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K 038	<p>Continued From page 4</p> <p>The findings include:</p> <p>An observation on 05/11/11 at approximately 11:30 AM, revealed the exit door opposite to the Administrator's office space, toward the exterior courtyard where the maintenance building was located, was secured with a magnetic lock using a keypad combination. The combination was not posted, and the door was not equipped with a delayed egress device. The door was not near a nurse's station. Further observation and interview on 05/11/11 with the Maintenance Director, revealed the facility's outside perimeter all-around fence had an exit gate toward the public road also secured with a magnetic lock using a keypad combination, which was also not posted.</p> <p>The observation was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11.</p> <p>Actual NFPA Standard read:</p> <p>NFPA 101 (2000); 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.</p> <p>Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.)</p> <p>Exception No. 2: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is</p>	K 038	<p>equipped with a latch that requires the use of a tool or key from the egress side.</p> <p>4. The Maintenance Director will audit paths of egress to ensure exit access is arranged so that exits are readily accessible monthly for three (3) months. The Maintenance Director will present the results at the Performance Improvement (PI) Committee Meeting for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings.</p>	6/9/11

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K 038	Continued From page 5 located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted. NFPA 101 (2000); 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.	K 038	K054 1. On 6/1/11 functionality and sensitivity testing was performed on facility smoke detectors by Premiere Fire Protection, Inc. and the detectors were certified to be operational. 2. The Maintenance Director inspected the building on 5/11/11 and no other issues were identified.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain and test smoke detectors as required. The deficient practice affected all smoke compartments, residents, staff, and visitors. The facility had the capacity for 94 beds. Findings include: During review of the facility's fire alarm testing records on 05/11/11 at approximately 2:00 PM, the facility was unable to provide documentation of completed sensitivity testing of the smoke detectors. The facility fire alarm contractor's	K 054	3. The Maintenance Director was re-educated on 5/31/11 by the facility Administrator regarding the need to have all required smoke detectors approved, maintained, inspected and tested as specified. 4. The Maintenance Director will ensure smoke detector functionality and sensitivity testing are performed at required intervals. Testing results will be discussed at the Performance Improvement (PI) Committee Meeting monthly for three (3) months for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical	

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K 054	Continued From page 6 contained the following statement: "11. SMOKE DETECTOR SENSITIVITY TEST: DATE OF (INITIAL) OR (LAST), SENSITIVITY TEST N/A." The observation was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11. Actual NFPA standard reads: NFPA 72 (1999); 7-3.2.1. Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.	K 054	Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings.	6/9/11	
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 interview and document review, the facility failed to properly maintain the automatic	K 062	K062 1. On 5/27/11 the facility automatic sprinkler system contractor Premiere Fire Protection, Inc. removed verbiage and disclosure statements off the inspection report to stay within the guidelines and maintain compliance. 2. The Maintenance Director inspected the building on 5/11/11 and no other issues were identified. 3. On 5/31/11, the facility Administrator re-educated the Maintenance Director to review inspection reports for disclosure statements nullifying system inspections. 4. The Maintenance Director will submit inspection reports to the		

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K 062	<p>Continued From page 7</p> <p>sprinkler system. The deficient practice would affect all smoke compartments, all residents, staff, and visitors. The facility had the capacity for 94 beds.</p> <p>Findings include:</p> <p>Record review on 05/11/11 at approximately 1:30 PM, revealed that the facility was not keeping satisfactory automatic sprinkler test and inspection reports in accordance with NFPA. The facility automatic sprinkler system contractor's inspection reports contained the following disclosure statement in the remarks section (# 8) of form: "We are unable to determine the level of protection from the sprinkler system without doing a full engineering review of the system design and hydraulic calculations." This statement nullified the intent of the report to document that the automatic sprinkler system was tested in accordance with the manufacturer's specifications and the appropriate NFPA requirements.</p> <p>Documentation was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11.</p> <p>Actual NFPA standard read: NFPA 101 (2000); 4.6.12.1. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by</p>	K 062	<p>Administrator to review monthly for three (3) months. The Administrator will present results to the Performance Improvement (PI) Committee Meeting for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings.</p> <p>K066</p> <ol style="list-style-type: none"> 1. Metal containers with self-closing covers into which ashtrays can be emptied were ordered on 5/24/11, with expected arrival date of 6/8/11. 2. The Maintenance Director inspected the building on 5/11/11 and no other issues were identified. 	6/9/11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185312	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2011
NAME OF PROVIDER OR SUPPLIER PADUCAH CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH THIRD STREET PADUCAH, KY 42001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 062	Continued From page 8 the authority having jurisdiction. NFPA 25 (1998); 1-10.1 All components and systems shall be tested to verify that they function as intended. The frequency of tests shall be in accordance with this standard. Following tests of components or portions of water-based fire protection systems that require valves in order to be opened or closed, the system shall be returned to service upon verification that all valves are restored to their normal operating position. Plugs or caps for auxiliary drains or test valves shall be replaced.	K 062	3. The staff were re-educated on 6/3/11 by the Staff Development Coordinator regarding the need to have available in designated smoking areas metal containers with self-closing covers into which ashtrays can be emptied.		
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	4. The Housekeeping/Laundry Supervisor will audit metal containers with self-closing covers to ensure containers are used for emptying ashtrays and cigarette butts. The audits will be completed weekly times four (4) weeks then monthly times two (2) months. The Housekeeping/Laundry Supervisor will present the results at the Performance Improvement (PI) Committee Meeting for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health		

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K 066	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide the outside smoking areas with metal containers equipped with a self-closing cover device into which ashtrays can be emptied. This deficient practice affected residents, staff, and visitors. The facility had the capacity for 94 beds. Findings Include: An observation on 05/11/11 at approximately 9:30 AM, revealed that the designated outside smoking areas for staff, visitors, and residents at the rear of the facility and at the front entrance to the facility were not equipped with metal containers with self-closing covers into which ashtrays could be emptied to permit smoking materials to be completely extinguished prior to disposal with other combustible trash. The observation was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11. Actual NFPA Standard reads: NFPA 101 (2000); 19.7.4 (3), (4). Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.	K 066	Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings. K069 1. On 6/3/11 General Fire Extinguisher and OCARRA, Inc connected the kitchen automatic fire-extinguishing system into the facility local audible alarm system so that the kitchen fire system will alarm when activated. 2. The Maintenance Director inspected the building on 5/11/11 and no other issues were identified. 3. The Maintenance Director was re-educated on 5/31/11 by the facility Administrator regarding the need to have the kitchen automatic fire-extinguishing system connected to the local audible alarm system. 4. The Maintenance Director will audit the kitchen automatic fire-extinguishing system monthly for three (3) months. The Maintenance Director will present the results at the Performance Improvement (PI) Committee Meeting for further recommendations and/or suggestions	6/9/11	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069			

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K 069	Continued From page 10 with 9.2.3, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly maintain the commercial cooking equipment. The deficient practice would affect one smoke compartment, residents, staff, and visitors. The facility had the capacity for 94 beds. Findings include: Record review on 05/11/11 at approximately 2:00 PM, revealed that the facility was not keeping satisfactory kitchen automatic fire-extinguishing system test and inspection reports in accordance with NFPA. The facility automatic fire-extinguishing system contractor's inspection reports contained the following statement in item/section # 12 of the form: "alarm when operated [marked] NO." This statement negates the intent of the report to document that the automatic fire-extinguishing system was tested to operate in accordance with the manufacturer's specifications and the appropriate NFPA requirements. The observation was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11. Actual NFPA Standard reads: NFPA 96 (1998), 7-6.1. Upon activation of an automatic fire-extinguishing system, an audible alarm or visual indicator shall be provided to show that the system has activated.	K 069	and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings. K073 1. On 5/27/11 window curtains in the staff lounge, across from the Administrator's office, were removed. 2. On 5/31/11 the Maintenance Director conducted a tour of the facility and found no other untreated combustible decorations. 3. The Maintenance Director was re-educated on 5/31/11 by the facility Administrator regarding the need to ensure furnishings and decorations	6/9/11	
K 073	NFPA 101 LIFE SAFETY CODE STANDARD	K 073			

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K 073 SS=D	Continued From page 11 No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure furnishings and decorations were non-combustible or flame retardant as required. The deficient practice would affect smoke compartments, residents, staff, and visitors. The facility had the capacity for 94 beds. The findings include: Observation on 05/11/11 at approximately 11:45 AM, revealed that the staff lounge, across the hall from the Administrator's office room, had window curtains not identified as flame-retardant material or treated to provide such properties. An interview with the Director of Maintenance revealed he did not have an active program in place for fire retardant treatments used on combustible furnishings and decorations. The observation was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11. Actual NFPA Standard read: NFPA 101 (2000): 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited	K 073	were non-combustible, flame retardant or flame-retardant treated as required. 4. The Maintenance Director will audit furnishings and decorations throughout the facility to ensure non combustible, flame retardant or flame-retardant treated. The audits will be completed weekly times four (4) weeks then monthly times two (2) months. The Maintenance Director will present the results at the Performance Improvement (PI) Committee Meeting for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings.	6/9/11	

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K 073	Continued From page 12 quantities that a hazard of fire development or spread is not present. 10.3.5* Furnishings or decorations of an explosive or highly flammable character shall not be used. A.10.3.5 Christmas trees not effectively flame-retardant treated, ordinary crepe paper decorations, and pyroxylin plastic decorations might be classified as highly flammable. 10.3.6 Fire-retardant coatings shall be maintained to retain the effectiveness of the treatment under service conditions encountered in actual use.	K 073	K144 1. On 5/11/11 the facility Maintenance Director verified that the generator starting battery unit charger is electrically continuously monitored and recharged. On 6/3/11 the facility Administrator verified that the generator is equipped to electrically monitor the battery status and to recharge the battery when necessary. On 5/11/11 the facility Maintenance Director established a written weekly generator log to record weekly inspections of the emergency generator.		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and staff interviews conducted on 05/11/11, the facility failed to ensure compliance with NFPA 99 (Standard for Health Care Facilities) and NFPA 110 (Standard for Emergency and Standby Power Systems), related to emergency power generator maintenance, inspection, and operational testing. The deficient practice would affect all smoke compartments, all residents, staff, and visitors.	K 144	2. The Maintenance Director inspected the building on 5/11/11 and no other issues were identified. 3. The Maintenance Director was re-educated on 5/31/11 by the facility Administrator regarding the need to maintain a written weekly generator log to record weekly inspections of the emergency generator and maintaining battery charge requirement. 4. The Administrator will review audits weekly to ensure generator logs are being maintained. The audits will		

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K 144	Continued From page 13 The facility had the capacity for 94 beds. Findings include: Record review on 05/11/11 at approximately 2:15 PM, revealed that the facility was not keeping a written weekly log of inspections of the emergency generator. Observation of the generator on 05/11/11 at 2:20 PM, revealed the engine was missing the required starting battery unit charger, which must be connected to the annunciator panel. An interview with the facility Maintenance Director on 05/11/11 at 2:20 PM, revealed the facility assumed this requirement could be satisfied with the availability of records kept electronically along with current facility's computer automated data and record keeping programs. Observed practice did not account for field acquired maintenance and inspection information transfer to the electronic application. The Maintenance Director stated he was unaware of the battery charger requirement. The observation was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11 Actual NFPA standard reads: NFPA 110 (1999): 6-3.4 A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. The written record shall include the following: (a) The date of the maintenance report (b) Identification of the servicing personnel	K 144	be completed weekly times four (4) weeks then monthly times two (2) months. The Administrator will present the results at the Performance Improvement (PI) Committee Meeting for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings. K147 1. On 6/1/11 the Maintenance Director installed metal plate covers on junction and metal boxes located above the drop down ceiling, in the laundry room and at the facility's outside perimeter all-around fence exit gate toward the public road.	6/9/11	

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K 144	Continued From page 14 (c) Notation of any unsatisfactory condition and the corrective action taken, including parts replaced (d) Testing of any repair for the appropriate time as recommended by the manufacturer Actual NFPA standard reads: NFPA 110 (1999); 5-12.6. The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer's recommendations and accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 144	2. On 6/1/11 the facility Maintenance Director inspected the facility and installed metal plate covers on all metal and junction boxes that lacked adequate covers. 3. The Maintenance Director was re-educated on 5/31/11 by the facility Administrator regarding the need to ensure compliance as it relates to wire chases, junction boxes, and protection of electrical wiring.		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interviews conducted on 05/11/11, the facility failed to ensure compliance with NFPA 70, National Electric Code, related to wire chases, junction boxes, and protection of electrical wiring. The deficient practice would affect all smoke compartments, all residents, staff, and visitors. The facility had the capacity for 94 beds. Findings include: Observations on 05/11/11, revealed a metal box serving as a wire chase and junction box for	K 147	4. The Maintenance Director will audit junction boxes, wire chases and protection of electrical wiring to ensure compliance monthly for three (3) months. The Maintenance Director will present the results at the Performance Improvement (PI) Committee Meeting for further recommendations and/or suggestions and follow-up as needed. The Performance Improvement (PI) Committee consists of the facility Administrator, Director of Nursing, Assistant Director of Nursing, Maintenance Director, Medical Director, Social Services Director, Activities Director, Solana Program Director, Admission/Marketing		

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K 147	<p>Continued From page 15</p> <p>electrical wiring in the attic, in the laundry room, and at the facility's outside perimeter all-around fence exit gate toward the public road were missing covers. The purpose of the wire chase was to protect the wires from damage.</p> <p>The observation was verified by the Maintenance Director and acknowledge by the Administrator at the exit interview on 05/11/11.</p> <p>Actual NFPA Standard: NFPA 101 (2000); 9.1.2. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code.</p>	K 147	<p>Director, Housekeeping/Laundry Supervisor, Dietary Manager, Clinical Case Manager and the Health Information Manager. All members are invited to attend monthly Performance Improvement Committee Meetings.</p>	6/9/11
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