

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186467	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/01/2011
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NAME OF PROVIDER OR SUPPLIER  WINDSOR GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004
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(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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted 08/30/11 through 09/01/11 and a Life Safety Code survey was conducted on 08/31/11 with the highest scope and severity of a "F". The facility had an opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p><b>F 371 SS=F 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b></p> <p>The facility must -                  (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and                  (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:                  Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure that all staff wore hair restraints when entering the dietary department. Four non-dietary staff members were observed during tray line service entering the dietary department without the use of hair restraints. In addition, during initial tour of the kitchen, two large cartons of sour cream were observed expired.</p> <p>The findings include:                  1. Review of the facility's policy "Food Safety-Dietary Manager's Responsibility" (not</p>	F 000	<p><b>Hairnets</b></p> <p>No residents were found to have been affected by the deficient practice.</p> <p>All residents had the potential to be affected by the deficient practice.</p> <p>Signs were posted outside all kitchen doors stating, "Hairnets are required to enter the kitchen." All facility staff were inserviced by the dietary manager as they reported to duty. Documentation is on file.</p> <p>To ensure that the deficient practice will not recur, the kitchen supervisor will routinely monitor staff for compliance and correct immediately as needed. The kitchen supervisor will report documentation of the monitoring to the dietary manager.</p> <p>To monitor its performance the dietary manger will present results to the QA quarterly meeting for 6 months or longer if deemed necessary.</p>	10/1/2011
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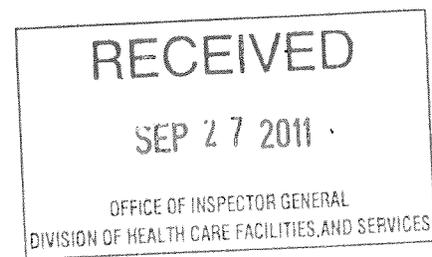
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *X Administrator* DATE: *9/27/11*

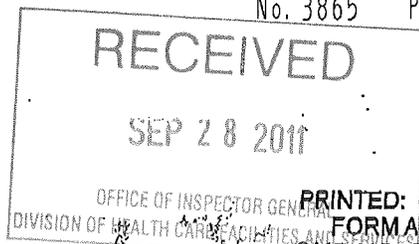
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  WINDSOR GARDENS		STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004		
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F 371	<p>Continued From page 1 dated) stated: .....6. Personnel must wear clean uniforms and clothes at all times and hair must be restrained.</p> <p>Interview with the Administrator, on 09/01/11 at 5:20 PM, revealed all staff should have hair restraints on when in the kitchen.</p> <p>Observation of the lunch tray line service, on 08/30/11 at 12:05 PM, revealed the Administrator entered the dietary department, and proceeded to the tray line to obtain silverware; then left the area without the use of a hair restraint. Observation at 12:10 PM revealed two (2) dining room staff entered the dietary department to obtain liquids, with no hair restraint. Further observation at 12:25 PM revealed the Maintenance Director entered the dietary department with no hair restraint, then turned around and left the department.</p> <p>Interview with the Dietary Manager, on 08/31/11 at 3:00 PM, revealed staff was allowed to come into the dietary department to obtain drinks for residents, as long as they were not in the food preparation area behind the food tray line.</p> <p>However, continued interview with the Administrator, on 09/01/11 at 5:20 PM, revealed the staff would be in-serviced to make sure hair nets were worn.</p> <p>2. Review of the facility's policy regarding Accepting Food Deliveries (undated) revealed: ... 2 ...Ask for a copy of the delivery slip and check off all items as they are unloaded. Count carefully the number of cases, boxes, cartons, etc. of each item.</p>	F 371	<p><b>Expired Foods</b></p> <p>No residents were found to have been affected by the deficient practice.</p> <p>All residents had the potential to be affected.</p> <p>Out-of-date cartons were found and disposed of on 8/30/2011. All other food dates were checked on that date as well with no other deficiencies found.</p> <p>The staff member accepting the order (kitchen supervisor or day cook) will check the expiration dates. They will also check items with expirations in stock on a daily basis and dispose of items as needed.</p> <p>To monitor its performance, the kitchen supervisor will report documentation of compliance measures to the dietary manager who will present results to the QA quarterly meeting for 6 months or longer if deemed necessary.</p>	8/31/2011





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F 371	Continued From page 2  Observation during the initial tour, on 08/30/11 at 9:05 AM, revealed two (2) large cartons of sour cream with expired dates of 08/27/11.  Interview with the Dietary Supervisor, on 08/31/11 at 3:10 PM, revealed she was responsible for checking for expired foods during the four (4) days she worked. The main cook was responsible for checking the remaining three (3) days a week. The supervisor stated when the dietary department accepts food from vendors, they should be checking the dates.  Interview with the Dietary Manager, on 08/31/11 at 3:15 PM, revealed the vendor delivered the sour cream with expired dates; however, the dietary department was responsible for checking the food for expired dates.	F 371		
F 502 SS=E	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to monitor expired laboratory tubes used for drawing blood for monitoring blood thinning medication. Review of sixteen (16) blue top tubes revealed expired dates.  The findings include:	F 502	No resident was affected by this cited deficiency. 5 residents were found to be potentially affected by this cited deficiency. All expired laboratory tubes were removed from the lab room immediately on 8/30/2011. The policy was created on 9/1/2011 to ensure that all laboratory tubes were inspected at least once monthly by the ADON or DON. Laboratory tubes with expiration dates within the next 30-day period will be removed and disposed of in a sharps container. The laboratory tubes will be re-ordered from the visiting laboratory agency by the ADON or DON. Monthly audits of the lab room supplies will be kept and submitted by the DON to the quarterly QA committee for a period of 6 months	9/2/2011

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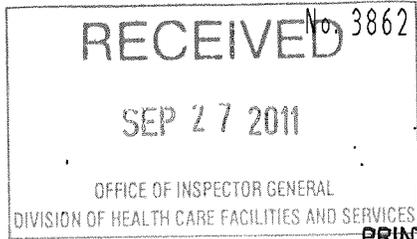
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 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185487</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/01/2011</b>
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F 502	<p>Continued From page 3</p> <p>Review of the facility policy relating to Expired Medications or supplies, dated 09/01/11 (last day of survey), revealed: ...5 ...Any medical supplies that will expire within the next 30 days will be removed and disposed of accordingly. The supply will be re-ordered according to the supplies.</p> <p>Observation of the laboratory room, on 08/30/11 at 11:35 AM, revealed sixteen (16) blue top laboratory tubes with expiration dates of June 2011.</p> <p>Interview with LPN #1, on 08/30/11 at 11:35 AM, revealed laboratory testing is completed by an outside agency five (5) days a week; however, the LPN stated there was a potential that staff would be required to obtain lab testing with the current lab tubes, when the outside lab service was not available.</p> <p>Interview with the Director of Nursing (DON), on 08/30/11 at 12:00 PM, revealed there were four resident's in the facility, who required laboratory testing to monitor for regulation of Coumadin (blood thinning medication). The DON also stated that all laboratory supplies should be checked monthly for any expired dates, and reordered.</p> <p>Interview with the Administrator, on 09/01/11 at 5:20 PM, revealed she was unaware of the expired lab supplies, and stated the supplies should be monitored.</p>	F 502	<p>Continued From page 3</p> <p>or longer if deemed necessary by the QA committee.</p>	
F 514 SS=E	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p>	F 514	<p>One resident was affected by the cited deficiency with no adverse outcome.. All residents were found to be potentially</p>	9/14/2011



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F 514	<p>Continued From page 4</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies on Self Determination Protocol on Advance Directives and Admissions, it was determined the facility failed to ensure one (1) of the eleven (11) sampled resident's (#9) medical record was complete and accurate in relation to the resident's and family's wishes for advance directives.</p> <p>The finding's include: Review of the facility's policy titled Self Determination Protocol on Advance Directives, dated 07/07/06, revealed upon admission/readmission the facility will provide family members or guardians information regarding advance directives when the patient is comatose or otherwise incapacitated and unable to receive the information. Once he/she is no longer incapacitated, the information must be provided directly to the adult patient. Each individual will be provided with information of</p>	F 514	<p>Continued From page 4</p> <p>affected by this cited deficiency. The POA for resident # 9 was contacted immediately on 9/1/2011 and verification of a full code status was obtained. The physician for resident # 9 was contacted immediately on 9/1/2011 and orders for a full code status were obtained. The order was faxed to pharmacy on 9/1/2011 and checked against all flow sheets and the care plan. Social services conducted a 100% audit of the medical records on 9/8/2011 to ensure the advanced directives and physician's orders were the same and no further deficiencies were found. The DON conducted a 100% audit on 9/13/2011 of the advanced directives, physician's orders and the care plans to ensure that they all were correct and no further deficiencies were found. Social Services or DON will complete a 100% audit monthly to ensure that all advanced directives, physician's orders and care plans are correct. Social Services will also complete a Readmission Advanced</p>	

No. 3862 P. 7

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F 614	<p>Continued From page 5</p> <p>living wills and durable power of attorney prior to, or on admission. Social Services will maintain a dated listing of residents and their code status.</p> <p>Review of the facility's policy titled Admissions, dated 03/18/08, revealed copies of advance directive, surrogate forms, power of attorney forms are required for admission. Nursing would transcribe and verify physician orders, complete admission order sheets and call the order to the pharmacy. The Social Services Director will complete the admission record, add the resident to the census and place copies of the advanced directives in the resident's chart.</p> <p>Review of Resident #9's clinical record revealed an original admission date of 01/10/10 and a readmission date of 02/14/11. The facility readmitted Resident #9 from the hospital with the following diagnoses: Hypertension; Anorexia; Failure to Thrive; Depression; Anxiety; Dementia; Atrial Fibrillation; and a Blood Clot. The Physician orders for 02/2011 prior to discharge to hospital revealed the resident was a Full Code, upon readmission physician orders dated 02/14/11 revealed the resident was a Do Not Resuscitate (DNR).</p> <p>Further review of Resident #9's clinical record revealed an Advance Directive as a Full Code. The hospital discharge summary revealed the resident was a DNR. Review of the Comprehensive Plan of Care dated 09/01/11 revealed a nursing care plan to honor the code status of a Full Code. However, current physician orders for July, 2011 revealed a code status of a DNR.</p>	F 614	<p>Continued From page 5</p> <p>Directives Verification form on all residents that are readmitted to the facility. The form will be completed within 24 hours of the resident's return to the facility. Any discrepancies found during the audits or changes made on the advanced directives during readmission will be reported to the charge nurse. The charge nurse will clarify any discrepancies and obtain new orders for changes. The new orders will be faxed to the pharmacy and placed on the resident's care plan. The audits will be kept and submitted to the quarterly QA committee for a period of 6 months or longer if deemed necessary by the QA committee.</p>	
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F 514	<p>Continued From page 6</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 09/01/11 at 10:30 AM, revealed she was not aware of the resident's code status and not aware of a policy.</p> <p>Interview with CNA #2, on 09/01/11 at 10:35 AM, revealed the resident's code status information was located on the nurse report sheet which was given at the beginning of each shift.</p> <p>Interview with Registered Nurse #1, on 09/01/11 at 10:38 AM, revealed the resident's code status information was located on the chart and on the nurse report sheet.</p> <p>Review of the Nursing Report form, dated 08/29/11, revealed Resident #9 was listed as a full code.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 09/01/11 at 1:10 PM, revealed admission orders are filled out and completed using the hospital discharge orders. The ADON stated she had noted the discrepancy back in February while completing the admission checklist. The ADON revealed the Director of Nursing (DON) and social services was notified at that time. However, the ADON stated she did not follow up with either the DON or Social Services to ensure the discrepancy in code status was corrected. The ADON stated a potential problem with not clarifying the code status of the resident would be the resident would not be resuscitated if something would have happened. The ADON revealed she was not aware who was responsible to ensure medical records are correct and accurate. She further revealed there was a system problem with communication between</p>	F 514		
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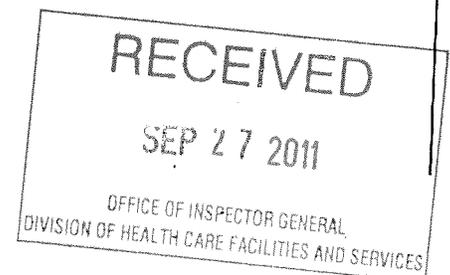
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F 514	<p>Continued From page 7 Social Services and the nurses.</p> <p>Interview with the Social Services Director, on 09/01/11 at 1:30 PM, revealed she was not aware of a discrepancy in the resident's clinical record regarding advance directives. She stated she was not aware of a physician order from the resident's readmission to change the code status to a DNR.</p> <p>Further interview with the Social Service Director, on 09/01/11 at 1:50 PM revealed the code status audits were completed. The last audit was completed in April, 2011. The Social Service Director revealed the audit consisted of comparing advance directive forms with the Emergency Medical Service form, and the out of hospital form. She did not compare the advance directive form with the physician orders during the audit or during a readmission.</p> <p>Interview with the DON, on 09/01/11 at 1:35 PM, revealed admission orders were based on the discharge summary from the hospital. The physician was called to verify orders. If there was a discrepancy noted in the advance directives, social services should have been notified. The DON revealed social services was not notified of Resident #9's change in code status upon readmission. The DON stated she could not say definitely that all nurses check the code status with the advance directives. The DON revealed potentially the resident may not have been resuscitated. The DON stated she was ultimately responsible for the accuracy of the clinical record.</p>	F 514		
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2005</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Two (2)</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Automatic (dry) sprinkler system, hydraulically designed</p> <p>GENERATOR: Type II generator, fuel source is diesel</p> <p>A standard Life Safety Code survey was conducted on 08/31/2011. Windsor Gardens was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for thirty (30) beds and the census was twenty-four (24) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		

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

TITLE

(X6) DATE

X *[Signature]*

X Administrator X

9/22/2011

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

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K 000	Continued From page 1	K 000		
K 050 SS=F	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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. 18.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to conduct fire drills according to NFPA standards. The deficiency had the potential to affect each of the two (2) smoke compartments, residents, staff and visitors. The facility is licensed for thirty (30) beds and the census was twenty-four (24) on the day of the survey.</p> <p>The findings include:</p> <p>Record review, on 08/31/11 at 1:15 PM, with the Maintenance Director revealed fire drills were not being conducted quarterly, at unexpected times under varied conditions. The facility's records had no written reports for fire drills conducted during the second quarter of the past year.</p> <p>Interview, on 08/31/2011 at 1:15 PM, with the</p>	K 050	<p>No resident was affected by the deficiency.</p> <p>All residents, staff and visitors had the potential to be affected by the deficiency. Further fire drills will be conducted at varying times and under varying conditions. Fire drills will be documented and per regulation, one per shift per quarter. To ensure compliance, fire drills will be conducted by the Maintenance Director or designee and logged in the fire log binder and brought to the QA meeting for six months or longer as deemed necessary by the QA committee.</p>	10/1/2011

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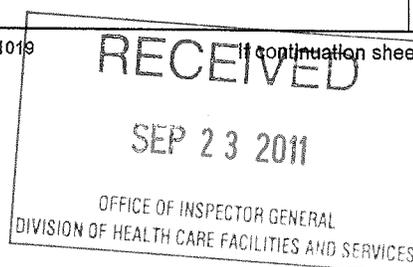
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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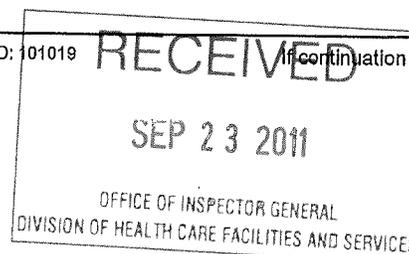
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185457	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - WINDSOR GARDENS B. WING _____	(X3) DATE SURVEY COMPLETED  08/31/2011
NAME OF PROVIDER OR SUPPLIER  WINDSOR GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004	
(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 050	Continued From page 2 Maintenance Director, the Administrator, and the Director of Nursing revealed their records had incomplete documentation of fire drills being conducted quarterly, at unexpected times under varied conditions.  Reference: NFPA 101 Life Safety Code (2000 Edition).  18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the buil	K 050		
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, it was	K 054		



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NAME OF PROVIDER OR SUPPLIER  WINDSOR GARDENS			STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004	
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K 054	Continued From page 3 determined the facility failed to maintain the fire alarm system according to NFPA standards. The deficiency had the potential to affect each of the two (2) smoke compartments, residents, staff and visitors. The facility is licensed for thirty (30) beds and the census was twenty-four (24) on the day of the survey.  The findings include:  Record review, on 08/31/11 at 1:20 PM, with the Maintenance Director revealed no documentation regarding the requirement for sensitivity testing of the smoke detectors in the fire alarm system.  Interview, on 08/31/11 at 1:20 PM, with the Maintenance Director revealed he was not aware the test had not been performed by the fire alarm inspection contractor.  Reference: NFPA 72 1999 edition  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	K 054	No resident was affected by the deficiency. All residents, staff and visitors had the potential to be affected by the deficiency. Smoke detector sensitivity tests will be performed during the next quarterly inspection due in September, 2011 by the contracted agency, QSI and according to regulation thereafter. Documentation will be on file. The maintenance director will bring documentation to the quarterly QA meeting and followed for twelve months or longer as deemed necessary.	10/1/2011



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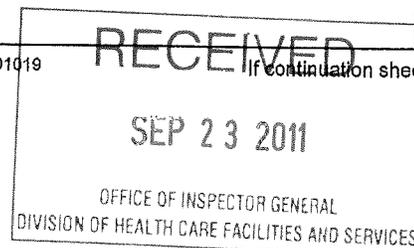
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NAME OF PROVIDER OR SUPPLIER  WINDSOR GARDENS	STREET ADDRESS, CITY, STATE, ZIP CODE 101 ISAAC GREER COURT BARDSTOWN, KY 40004
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K 054	<p>Continued From page 4</p> <p>alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer ' s calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</li> </ol> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced.</p> <p>Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p> <p>7-3.2.2</p> <p>Test frequency of interfaced equipment shall be the same as specified by the applicable NFPA standards for the equipment being supervised.</p> <p>7-3.2.3</p> <p>For restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested</p>	K 054		
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K 054	Continued From page 5 on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested.	K 054		

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