

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

PRINTED: 10/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/30/2013
NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078		
(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 Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance, 08/26/13 as alleged.	{F 000}			

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

TITLE

(X6) DATE

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 SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078	
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F 000	INITIAL COMMENTS	F 000	The statements contained in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken the following actions set forth with in the following corrections. The following corrections constitute the facility's compliance such that all cited will be corrected by 8/26/13.	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure it was free of medication error rates of 5% or greater involving one resident (#14), not in the selected sample. Observation of a medication pass on 08/07/13 revealed there were twenty-five (25) opportunities with seven (7) medication errors resulting in a 28% medication error rate related to timing. Findings include: A review of the facility's policy/procedure "Medication Administration Policy", undated, revealed no evidence to address timing issues related to the medication pass. An interview with the Director of Nursing (DON), on 08/08/13 at 11:30 AM, revealed this was the only policy/procedure she was able to provide related to the medication pass, which did not address timing related to administration of medications. Observation of a medication pass, on 08/07/13 at 10:05 AM through 10:25 AM, revealed Registered Nurse (RN) #1 administered Atropine 1% eye	F 332	1. Resident #14 was not harmed by the late timing of the medication administration. 2. All residents who receive medication have the potential to be affected. 3. MD was made aware of compliance issue and order was received to make all medications due on the same dosing schedule. All medication administration records reviewed for timing of medication administration. Nursing staff in- serviced on medication administration completed on 8/24/13 by pharmacy. Medication pass was monitored for time compliance daily for the next two days by DON and no issues noted with time compliance. 4. Medication Pass audit will be completed to ensure compliance daily for 5 days for two weeks then 3 times a week for two weeks then monthly. All findings will be brought to the Continuous Quality Patient Care Committee meeting monthly.	8/26/13

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F 332	<p>Continued From page 1</p> <p>drops sublingually, Meclizine 25 milligram (mg) one (1) tablet by mouth (po), Calcium Antacid 500 mg two (2) chewable tablets po, Calcium 600 Vitamin D one (1) tablet po, Carbidopa-Levodopa 25-100 mg one (1) tablet po, Natural Balance Tears Drops one (1) drop each eye, and Ropinirole HCL 0.25 mg one (1) tablet po, to Resident #14 at this time.</p> <p>A review of the physician's order, dated August 2013, revealed Atropine Sulfate Ophthalmic Solution 1% eye drops (sublingual) at 8:00 AM, 4:00 PM, and 12:00 AM; Meclizine 25 mg tablet po at 8:00 AM and 4:00 PM; Calcium Antacid Supplement 500 mg two (2) tablets po at 9:00 AM, 1:00 PM, and 7:00 PM; Calcium Carbonate with Vitamin D 600 mg tablet po at 9:00 AM and 5:00 PM; Carbidopa-Levodopa 25-100 mg tablet po at 9:00 AM, 1:00 PM, and 5:00 PM; Natural Balance Tears Drops one drop each eye at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM; and Ropinirole HCL 0.25 mg tablet po at 9:00 AM and 5:00 PM.</p> <p>Interview with RN #1, on 08/08/13 at 11:00 AM, revealed it did not usually take her that long to complete a medication pass; however, no further explanation was provided as to why medications were given late. She stated she had an understanding about the medication error rate related to timing of the medications administered to Resident #14.</p> <p>Further interview with the DON, on 08/08/13 at 11:30 AM, revealed she was made aware of a concern regarding the medication pass by RN #1, on 08/07/13. She stated RN #1 voiced that she was unable to administer medications in a timely manner to Resident #14. The DON revealed RN #1 should have requested assistance from another nurse or sought another solution if she</p>	F 332		

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F 332	Continued From page 2 was getting behind during the medication pass. The DON revealed the goal should be to administer medications one hour before or after the scheduled time.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure food was served under sanitary conditions related to multiple observations of flies in the kitchen and dining area. Findings include: Review of the policy/procedure for Dietary Sanitary Procedures for Infection Control, revised 12/09, revealed staff would provide a safe food service for residents, employees, and guests. Observation in the kitchen, on 08/06/13 at 11:10 AM, revealed approximately eight (8) flies swarming the steam table, landing on clean plates and plastic lids used to cover drinking	F 371	1. Staff assisted in eradicating flies that were present in the building. 2. All residents have the potential to be affected. 3. Current pest control company was contacted and proposed a pest control program to include a fly control program. Program was implemented 8/26/13. Kitchen staff will keep doors closed as much as possible. All staff encouraged to limit the use of the kitchen exterior door as well as the exterior door in the service area by the kitchen. Air curtains will remain in good working order as well as bug lights. 4. Administrator or designee will round daily to monitor for flies. Pest control company will continue with the fly control program as agreed. All findings will be reported to the Continuous Quality Improvement committee monthly.	8/26/13

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F 371	<p>Continued From page 3</p> <p>cups. At 11:30 AM, the food on the steam table was uncovered. One (1) fly was observed to land on the mashed potatoes just prior to the food service. Multiple flies were noted on the surfaces around the food, on the ceiling above the steam table, and on the kitchen door leading to outside.</p> <p>Observation, on 08/07/13 at 10:50 AM, revealed approximately ten (10) flies swarming the steam table. Flies were noted on clean saucers, bowls, plastic lids for drinking cups, and sippy cup lids. Food items were covered at the time; however, there was one (1) fly noted coming from under a partially closed lid on the steam table. The food items under the lid were chicken, gravy, cauliflower, chopped chicken, pureed chicken, and pureed vegetables.</p> <p>On 08/06/13 at 12:15 PM, and on 08/07/13 at 12:15 PM, during lunch observations in the dining room, numerous flies were observed landing on residents' plates of food, table, or his/her person at various times. No complaints were voiced during the lunch meal.</p> <p>Observation of a meal service, on 08/07/13 at 12:17 PM, revealed twenty-seven (27) residents were sitting in the dining room. Approximately sixteen (16) flies were observed with residents fanning flies from their food on seven (7) different occasions.</p> <p>Interview with the Dietary Manager, on 08/08/13 at 9:50 AM, revealed the delivery company staff were bringing in supplies from the kitchen door that lead to outside; however, they have stopped using the door a couple of weeks ago. This was an effort to reduce the flies in the kitchen. She revealed there had been a noticeable decrease of</p>	F 371		

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F 371	Continued From page 4 flies in the kitchen.	F 371		
F 469 SS=F	<p>Interview with the Director of Nursing (DON), on 08/08/13 at 12:55 PM, revealed she was aware of the increased flies in the facility. She revealed the issue had been worse the last few days.</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's pest control agreement, it was determined the facility failed to maintain an effective pest control program so that the facility was free of pests.</p> <p>Findings include:</p> <p>Review of the facility's contracted pest control agreement, dated 11/23/98, revealed pests not to be controlled included flying insects.</p> <p>Observation in the kitchen, on 08/06/13 at 11:10 AM, revealed approximately eight (8) flies swarming the steam table, landing on clean plates and plastic lids used to cover drinking cups. At 11:30 AM, the food on the steam table was uncovered. One (1) fly was observed to land on the mashed potatoes just prior to the food service. Multiple flies were noted on the surfaces</p>	F 469	<ol style="list-style-type: none"> 1. Staff assisted in eradicating flies that were present in the building. 2. All residents have the potential to be affected. 3. Current pest control company was contacted and proposed a pest control program to include a fly control program. Program was implemented 8/26/13. Kitchen staff will keep doors closed as much as possible. All staff encouraged to limit the use of the kitchen exterior door as well as the exterior door in the service area by the kitchen. Air curtains will remain in good working order as well as bug lights. 4. Administrator or designee will round daily to monitor for flies. Pest control company will continue with the fly control program as agreed. All findings will be reported to the Continuous Quality Improvement committee monthly. 	8/26/13

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F 469	<p>Continued From page 5</p> <p>around the food, on the ceiling above the steam table, and on the kitchen door leading to outside.</p> <p>On 08/06/13 at 12:15 PM, and on 08/07/13 at 12:15 PM, during lunch observations in the dining room, numerous flies were observed landing on residents' plates of food, table, or his/her person at various times. No complaints were voiced during the lunch meal.</p> <p>Observation, on 08/07/13 at 10:50 AM, revealed approximately ten (10) flies swarming the steam table. Flies were noted on clean saucers, bowls, plastic lids for drinking cups, and sippy cup lids. Food items were covered at the time; however, there was one (1) fly noted coming from under a partially closed lid on the steam table. The food items under the lid were chicken, gravy, cauliflower, chopped chicken, pureed chicken, and pureed vegetables.</p> <p>On 08/07/13 from 9:25 AM through 10:25 AM, during observation of a medication pass with Registered Nurse (RN) #1, there were two (2) flies present. One of the flies landed on top of the medication cart while RN #1 was passing medications. She would "shoe it away"; however, it kept returning and landing on the medication cart. RN #1 summoned another staff member on the hallway to bring a fly swatter to resolve the issue. The staff member brought the fly swatter and swatted the fly while it was on the medication cart. RN #1 then cleaned the cart with a disinfectant. Additionally, RN #1 went into a resident's room to administer medications. While in there, a fly was flying around the resident's head. The resident swatted at the fly a couple of times with his/her hand; however, RN #1 did not address it at that time.</p>	F 469			

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F 469	<p>Continued From page 6</p> <p>On 08/08/13 at 9:45 AM, flies were noted around the nurses' desk near the 100, 200, and 300 halls.</p> <p>Interview with Certified Nurse Aide (CNA) #1, on 08/08/13 at 10:15 AM, revealed there had been a problem with flies for about two weeks on both halls of the facility. She stated she noticed it more so in the halls than in anyone's room, and had not heard complaints from residents or other co-workers. She revealed it was reported; however, she did not recall who she reported the flies to, and also stated they kept fly swatters at the nurses' desk.</p> <p>Interview with RN #1, on 08/08/13 at 10:53 AM, revealed she had not noticed a problem with flies until recently. She stated it had been a problem for approximately a week or so, and there were fly swatters available for the problem. She revealed no residents have complained to her; however, some of the staff have voiced complaints, although she did not recall who voiced them. She stated "we need to pay attention to what residents have in their rooms as far as food, as well as the condition of the food, which could be a possible source of the flies."</p> <p>Interview with the Dietary Manager, on 08/08/13 at 9:50 AM, revealed the delivery company staff were bringing in supplies from the kitchen door that lead to outside; however, they have stopped using the door a couple of weeks ago. This was an effort to reduce the flies in the kitchen. She revealed there had been a noticeable decrease of flies in the kitchen.</p> <p>Interview with an employee from the facility's</p>	F 469			

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F 469	<p>Continued From page 7</p> <p>contracted pest control company, on 08/08/13 at 12:20 PM, revealed flying insects were not included in the facility's basic pest control service contract as it was difficult to keep them under control.</p> <p>Interview with the Maintenance Director, on 08/08/13 at 12:45 PM, revealed the facility had "air curtains" at three entrance doors in the facility and a "bug light" near two entrances. There was a repellent sprayer outside two of the entrance doors. He revealed these interventions were in place to reduce the flies in the facility.</p> <p>Interview with the Director of Nursing (DON), on 08/08/13 at 12:55 PM, revealed she was aware of the increased flies in the facility; however, indicated there were interventions in place. She revealed the issue had been worse the last few days.</p>	F 469			

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{K 000}	INITIAL COMMENTS	{K 000}		
{K 069}	Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/06/13 as alleged.	{K 069}		
SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96			
	This STANDARD is not met as evidenced by: A waiver was requested and granted for this deficiency			

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1996 Survey under: NFPA 101 (2000 edition) Chapter 19 Facility type: SNF/NF Type of structure: Type II (000) Smoke Compartment: 4 Fire Alarm: Complete fire alarm installed 1996. Smoke detectors 46 located in corridors and heat detectors 3 located in Kitchen and Main Mechanical Room. Sprinkler System: Complete automatic sprinkler system (wet) installed in 1996. An antifreeze loop was installed for the front canopy in 2008. Generator: Type II, Diesel, installed in 1996. A standard Life Safety Code survey was conducted on 08/06/2013. Salem Springlake Health and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was forty-nine (49). The facility is certified for seventy five (75) The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	The statements contained in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken the following actions set forth with in the following corrections. The following corrections constitute the facility's compliance such that all cited will be corrected by 11/08/13.	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045	1. A new light was installed on 8/26/13 to satisfy the cited illumination of means of egress noted outside the kitchen corridor exit. 2. New light to meet standard installed 8/26/13. 3. The Maintenance Director was in-serviced by the Administrator on 8/8/13 on the standard regarding illumination of the egress cited. The Maintenance director will ensure the lighting remains in good working order.	8/26/13



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Wayne Karcewski* TITLE: _____ (X5) DATE: 10/1/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 : MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2013
NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078	
(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 045	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for Seventy-Five (75) beds with a census of Forty-Nine (49) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at one (1) exit. The findings include: Observation, on 08/06/13 at 3:14 PM with the Maintenance Supervisor, revealed the exterior exit at the kitchen corridor exit only had a single light for illumination of the outside of the exit. Interview, on 08/06/13 at 3:14 PM with the Maintenance Supervisor, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Reference: NFPA 101 (2000 edition) 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is	K 056		

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K 056	<p>Continued From page 2</p> <p>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</p> <p>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 three (3) of four (4) smoke compartments, all residents, staff, and visitors. The facility is certified for Seventy-Five (75) beds with a census of Forty-Nine (49) on the day of the survey. The facility failed to ensure resident wardrobes across from the door had proper sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 08/06/13 between 2:45 PM and 4:00 PM with the Maintenance Supervisor, revealed the wardrobes located in room #602, 604, 501, 502, 506, 505, 509, 510, 403, 404, 304, 302, 207, 211, 212, 208, 204, 103, and 101 did not have proper sprinkler coverage. The rooms were equipped with a sprinkler on the side of the wall and the wardrobes were twelve (12) feet</p>	K 056	<p>1. The sprinkler system company (Tri-state) entered the building for inspection of the sprinkler system to bring sprinkler system up to code on 8/29/13. Tri-state determined that the sprinkler system gave proper coverage of the wardrobes and that the building was in compliance with the NFPA Standards</p> <p>2. A spec sheet was submitted by Tri-state to ensure that the sprinkler system meet the standard and no renovation is required.</p>	09/06/13

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K 056	<p>Continued From page 3 away from the sprinkler head.</p> <p>Interview, on 08/06/13 between 2:45 PM and 4:00 PM with the Maintenance Supervisor, revealed he was not aware that the wardrobes listed did not have proper sprinkler protection.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>S&C letter stating all facilities must be fully sprinkler protected by August 2013</p>	K 056		

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K 062 K 062 SS=F	Continued From page 4 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 record review and interview, it was determined the facility failed to have quarterly inspections performed of the fire sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff, and visitors. The facility is certified for Seventy-Five (75) beds with a census of Forty-Nine (49) on the day of the survey. The facility failed to ensure a first quarter sprinkler inspection was conducted during 2013 and an internal obstruction conducted within the last five (5) years. The findings include: Record review, on 08/06/13 at 11:15 AM with the Maintenance Supervisor, revealed the facility did not have documentation for a first quarter inspection of the fire sprinkler system. Interview, on 08/06/13 at 11:15 AM with the Maintenance Supervisor, revealed the facility had switched sprinkler vendors and the first quarter of 2013 must have been missed. Record review, on 08/06/13 at 11:45 AM with the Maintenance Supervisor, revealed the facility	K 062 K 062	1. Tri-state Fire Protection Inc. company was contacted on 8/8/13 and notified of the need for internal pipe inspection. 2. The inspector for Tri-state Fire Protection Inc. entered the building on 8/30/13 and the internal pipe inspection will be completed on 9/3/13 and will be inspected every 5 years to maintain the standard. 3. Internal pipe inspection will be completed every 5 years as per the standard and will be monitored by the Administrator and maintenance director to ensure compliance.	9/6/13

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K 062	<p>Continued From page 5</p> <p>failed to provide documentation that the obstruction investigation had been completed within the last 5 years.</p> <p>Interview, on 08/06/13 at 11:45 AM with the Maintenance Supervisor, revealed he was unaware the work had not been completed. He was new to the facility and had not been in his position when the obstruction investigation was recommended.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <p>Item Activity Frequency Reference</p> <p>Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2</p> <p>Control valves Inspection Weekly/monthly Table 9-1</p> <p>Alarm devices Inspection Quarterly 2-2.6</p> <p>Gauges (wet pipe systems) Inspection Monthly 2-2.4.1</p> <p>Hydraulic nameplate Inspection Quarterly 2-2.7</p>	K 062		

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K 062	Continued From page 6 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		
K 066 SS=D	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.	K 066	1. The proper metal receptacle was placed in the smoking area to meet the standard on 9/3/13. 2. A metal receptacle was place in the smoking area to meet the standard on 9/3/13. The maintenance director was educated by the Administrator on 8/8/13 of the standard for the smoking area. 3. The receptacle will remain in the smoking area at all times and will be monitored for its presence upon daily rounds by the maintenance director or designee.	9/3/13

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K 066	<p>Continued From page 7</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for Seventy-Five (75) beds with a census of Forty-Nine (49) on the day of the survey. The facility failed to ensure they had a self-closing metal container to dump ashtrays into at the smoking area.</p> <p>The findings include:</p> <p>Observation, on 08/06/13 at 3:25 PM with the Maintenance Supervisor, revealed the smoking area did not have a metal container with a self-closing lid to dispose of the cigarette butts.</p> <p>Interview, on 08/06/13 at 3:25 PM with the</p>	K 066			

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K 066	<p>Continued From page 8</p> <p>Maintenance Supervisor, revealed he was unaware the facility was required to have a metal bucket to dispose of cigarette butts.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be 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 areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into</p>	K 066		
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K 066	Continued From page 9 which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on records review and interview, the facility failed to upgrade their kitchen range hood automatic fire suppression system in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for Seventy-Five (75) beds with a census of Forty-Nine (49) on the day of the survey. The facility failed to upgrade the kitchen range hood suppression system in 2009 when the hydrostatic test was performed. The findings include: Record review, on 08/06/13 at 11:15 AM with the Maintenance Supervisor, revealed a range hood inspection form revealed that the range hood automatic suppression system was hydrostatically tested in the year 2009. The system was not converted to UL 300 at the time of the hydrostatic test. Interview, on 08/06/13 at 11:15 AM with the Maintenance Supervisor, revealed that he was not aware of the requirement to upgrade the kitchen hood suppression system when the hydrostatic test was performed..	K 069	1. An inspection of the range hood was completed by an electrician on 8/26/13 and by Tristate on 9/4/13 and it was determined that the system would require work to bring up to standard. 2. Work will be completed on the range hood and will be brought up to code by 11/08/13. 3. The Administrator educated the maintenance director on the regulation regarding the range hood on 8/8/13. The Administrator and maintenance director will ensure that the range hood remains up to code by review of Life Safety Code Standards.	11/08/13

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K 069	Continued From page 10 Reference: NFPA 101 2000 Edition 19.3.2.6 Cooking Facilities. Cooking facilities shall be protected in accordance with 9.2.3. Exception*: Where domestic cooking equipment is used for food-warming or limited cooking, protection or segregation of food preparation facilities shall not be required. 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. Reference: NFPA 96 1998 Edition	K 069			
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	1. All items were removed from the corridors and no means of egress was impeded on 8/8/13. 2. All exit hallways in the center have been inspected and alternate locations was found for all items when not in use. 3. Education was provided to the maintenance director on the regulation by the Administrator on 8/8/13. The maintenance director will inspect the corridors daily to ensure the standard is met.	8/26/13	

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K 072	<p>Continued From page 11</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff, and visitors. The facility is certified for Seventy-Five (75) beds with a census of Forty-Nine (49) on the day of the survey. The facility failed to ensure carts, a chair, and O2 tank, and a dolly were properly stored out of the corridor when not in use.</p> <p>The findings include:</p> <p>Observation, on 08/06/13 at 3:17 PM with the Maintenance Supervisor, revealed five (5) carts, a chair, an O2 tank, and a dolly were stored in the kitchen corridor for over 30 minutes.</p> <p>Interview, on 08/06/13 at 3:17 PM with the Maintenance Supervisor, revealed the facility routinely stored items in this corridor because the residents did not use it</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 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.</p>	K 072			