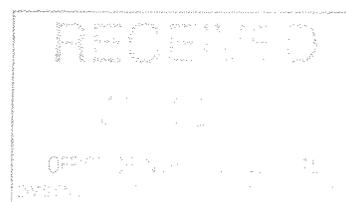


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/07/2012
NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216	
(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 490	<p>Continued From page 45</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to be administered in a manner to ensure the oversight of the nursing department staffing as detailed in the plan of correction for the abbreviated survey which concluded on 05/25/12 with a compliance date of 07/05/12 and repeat noncompliance found in F353 during the standard survey which concluded on 12/07/12.</p> <p>The findings include:</p> <p>Review of the facility's plan of correction submitted for the abbreviated survey concluded on 05/25/12 revealed by 07/05/12 the results of the nursing staff levels would be reported to the Quality Assurance Committee and the Administrator no less than quarterly to ensure compliance was achieved and maintained.</p> <p>Interview with the Director of Nursing (DON), on 12/07/12 at 5:00 PM, (in charge of the facility in the Administrator's absence) revealed monitoring of nurse staffing levels had fallen below minimum nurse staff levels since the plan of correction dated 07/05/12 and there was a plan in effect to call nurses in to ensure adequate nurse staffing. She stated it was sometimes impossible to get enough staff; however, she did not come in to the facility to work on the units to ensure resident's needs were met. In addition, she could not provide any evidence of the facility's attempts to hire additional staff. However, she stated it was difficult to get nursing staff for the facility due to it's geographic location and CNAs would apply</p>	F 490	<p>1. Director of Nursing reviewed the shower records for all residents on 12-10-12 and any resident who had not received a shower in the past 7 days was offered a shower.</p> <p>On 1-18-13 the DON and VP of Operations for Elmcroft Senior Living reviewed the facility staffing ratios to ensure staffing levels are well defined including minimum staffing levels required to ensure resident's needs are met. Staffing levels were then discussed with the staffing coordinator, staff development, and all administrative nurse staff to ensure understanding of staffing levels. DON and VP of Operations reviewed actual staffing schedules back to October 2012 to determine when the staffing ratios were not attained. Upon review it appears that staffing issues began in late November 2012. VP of Operations reviewed QA minutes from meetings held 7-24-12 and 10-30-12 and staffing was discussed during the QA meetings and at the time of the meetings the facility had maintained compliance with the POC.</p> <p style="text-align: right;">1-20-13</p>

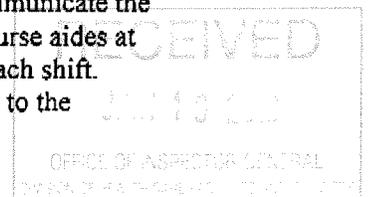


2. The shower schedule was reviewed to ensure all residents were on the schedule. Director of Nursing reviewed the shower records for all residents on 12-10-12 and any resident who had not received a shower in the past 7 days was offered a shower.

VP of Operations reviewed actual staffing schedules back to October 2012 to determine when the staffing ratios were not attained. Upon review it appears that staffing issues began in late November 2012.

DON reviewed skin assessments, reports of incidents, meal intakes, and weight records back through November 2012 to determine if there have been any negative outcomes that may be related to staffing and none were noted. Social Services reviewed all resident and family grievances and Resident Council note back through November 2012 to determine if any grievances were noted related to staffing. All this was completed by 1-19-13.

3. Director of Nursing provided written communication to nurses on 1-3-13 regarding providing showers for all residents. This was presented by way of a read and sign memo that was also reviewed verbally with the nurse by Staff Development. Nurses were responsible to communicate the procedure to the nurse aides at the beginning of each shift. Staff must provide to the



Director of Nursing each day a list of any shower scheduled but not completed. Any shower not completed must be explained. If the resident refuses, the nurse is to approach the resident to ensure it is the resident's choice to refuse the shower. An alternative bathing process will be offered, such as a bed bath, partial bath, etc. If the resident refuses any type of personal hygiene the family will be contacted and informed.

Administrator, Staffing Coordinator and Director of Nursing met on 12-10-12 to review current staffing levels and to discuss a plan to improve staffing. The following plan was developed.

1. Authorization received to utilize temporary staffing agency to improve staffing
2. Identify additional resources for recruitment of staff and place additional ads for staff.
3. Utilize Administrative nursing staff on week-ends to provide restorative services, provide assistance with dining service, and provide additional supervision to ensure resident needs are met.
4. Utilize light duty staff to provide support and assistance with resident care based on limitations.
5. Contact local CNA training programs to increase visibility.
6. Establish Staffing committee to meet weekly to review recruitment efforts, orientation process, and staffing patterns to ensure resident care needs are met.
7. Review non-essential duties assigned to aides and delegate



Rockford Manor

Jan. 18. 2013 2:45PM

No. 4401 P. 49

those non-essential duties to other staff members as needed.

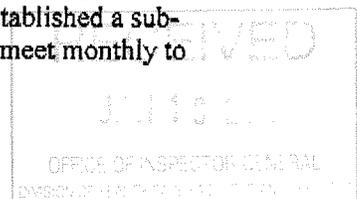
8. Establish staffing ratios and monitor staffing numbers daily.

Staffing Committee met on 1-11-13 to begin the task of implementing the plan outlined above. Staffing Committee includes Director of Nursing, Staffing Coordinator, Director of Social Service, a CNA and a Staff Nurse.

Staffing Committee to report weekly to the Administrator and the VP of Operations for Elmcroft Senior Living regarding progress in recruitment, and retention of staff.

Staffing Committee will meet weekly until staffing ratios are attained and maintained for no less than 3 months and then will continue to meet monthly to monitor/review daily staffing patterns, hiring process, interviews/observation of ADL care.

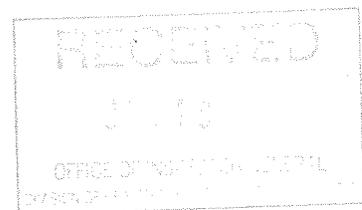
QA Meeting held on 1-16-13. Committee reviewed the survey finding from the annual survey completed on 12-7-12 and reviewed the proposed POC. Committee was educated on the QA function and responsibility, including ensuring compliance with any facility POC. Discussed the failure of committee to ensure compliance with POC developed for the 5-25-12 statement of deficiencies resulting in a repeat noncompliance with F 353. This education was provided by VP of Operations for Elmcroft Senior Living. The QA Committee established a sub-committee to meet monthly to



monitor implementation and compliance with the POC. This sub-committee includes the Administrator, DON, Staffing Coordinator, Staff Development, Maintenance Director, Safety Committee Chairman, Social Services and Activity Director. This committee will review all audits, rounds, etc. to ensure compliance with the POC. Sub-committee to review the work of the Staffing Committee to ensure progress is made in the areas of staff recruitment, retention, orientation, and staff morale.

4. QA Sub-committee to meet monthly to review all reviews, audits, completed as part of the POC. This committee will ensure that any identified issues are addressed as per the POC and that a through report is presented to the facility QA Committee no less than quarterly. This sub-committee will be in place no less than one year to ensure compliance with the implementation of the POC. Staffing Committee will report on their actions and plans to Quality Assurance Committee no less than quarterly for one year.

The facility Corporate Consultant or VP of Operations to review the actions of the QA Sub-committee monthly to monitor the implementation of the POC.



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NAME OF PROVIDER OR SUPPLIER ROCKFORD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4700 QUINN DR. LOUISVILLE, KY 40216
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F 490 Continued From page 46
but frequently they would not pass the drug screen or the criminal background check. She further stated she thought the salary's were sufficient but the facility was just having a hard time getting staff. The DON stated it was her responsibility to hire nurses and nursing assistants to maintain adequate nurse staffing levels. She stated the Administrator left the hiring of nursing staff and the staffing PAR of the building to her.

F 490

Interview with a Vice President of the corporation, on 12/07/12 at 8:55 AM, revealed she was responsible to review all of the corporation facilities' statements of deficiencies and each facility's plan of correction. She stated she had not been informed by the facility Administrator of inadequate nursing staff levels and that residents' needs were not being met.

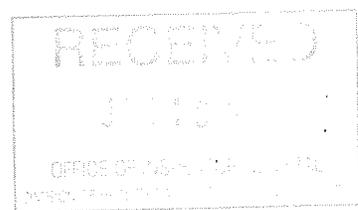
F 520
SS=F 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

F 520

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require



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F 520	<p>Continued From page 47</p> <p>disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility's Quality Assurance Committee failed to ensure the plan of correction developed for the 05/25/12 statement of deficiencies with a compliance date of 07/05/12 for cited deficiency (F353) was monitored and evaluated for compliance and/or the need for revision to ensure compliance was achieved and sustained. A repeat noncompliance was found in F353 during a standard health survey which concluded on 12/07/12.</p> <p>The findings include:</p> <p>No policy was provided regarding the Quality Assurance Committee.</p> <p>Review of the facility's plan of correction submitted for the abbreviated survey concluded on 05/25/12 revealed results of the nurse staffing level monitoring would be reported to the Quality Assurance Committee to ensure compliance was achieved and maintained to ensure residents' needs were met.</p>	F 520	<p>1. Director of Nursing reviewed the shower records for all residents on 12-10-12 and any resident who had not received a shower in the past 7 days was offered a shower.</p> <p>On 1-18-13 the DON and VP of Operations for Elmcroft Senior Living reviewed the facility staffing ratios to ensure staffing levels are well defined including minimum staffing levels required to ensure resident's needs are met. Staffing levels were then discussed with the staffing coordinator, staff development, and all administrative nurse staff to ensure understanding of staffing levels. DON and VP of Operations reviewed actual staffing schedules back to October 2012 to determine when the staffing ratios were not attained. Upon review it appears that staffing issues began in late November 2012. VP of Operations reviewed QA minutes from meetings held 7-24-12 and 10-30-12 and staffing was discussed during the QA meetings and at the time of the meetings the facility had maintained compliance with the POC.</p>	1-20-13

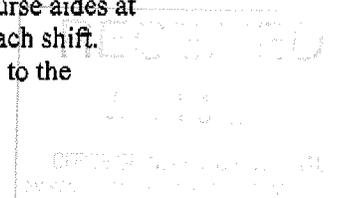


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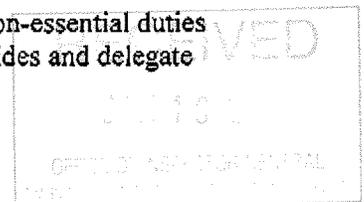
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Director of Nursing each day a list of any shower scheduled but not completed. Any shower not completed must be explained. If the resident refuses, the nurse is to approach the resident to ensure it is the resident's choice to refuse the shower. An alternative bathing process will be offered, such as a bed bath, partial bath, etc. If the resident refuses any type of personal hygiene the family will be contacted and informed.

Administrator, Staffing Coordinator and Director of Nursing met on 12-10-12 to review current staffing levels and to discuss a plan to improve staffing. The following plan was developed.

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4. Utilize light duty staff to provide support and assistance with resident care based on limitations.
5. Contact local CNA training programs to increase visibility.
6. Establish Staffing committee to meet weekly to review recruitment efforts, orientation process, and staffing patterns to ensure resident care needs are met.
7. Review non-essential duties assigned to aides and delegate



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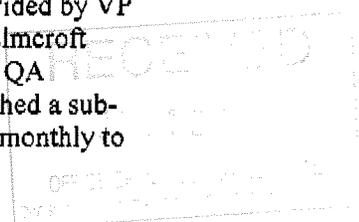
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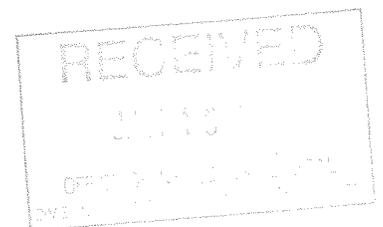
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The facility Corporate Consultant or VP of Operations to review the actions of the QA Sub-committee monthly to monitor the implementation of the POC.



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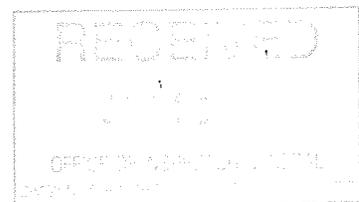
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F 520	Continued From page 48 Interview with the Director of Nursing (DON), on 12/07/12 at 5:00 PM, (in charge of the facility in the Administrator's absence) revealed the Quality Assurance Committee (QA Committee) was to review, recommend and act upon facility problems and concerns. She stated the QA Committee had been informed of the nursing department staffing level monitoring as outlined in the plan of correction for the abbreviated survey concluded on 05/25/12. The committee was aware there were days when minimum staffing was not met; however, there was no other action plan developed and in place to ensure adequate nursing department staff levels to ensure the residents' needs were met. She indicated she was not aware the residents' needs were not being met.	F 520		
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1974

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: One (1) story, Type III (111)

SMOKE COMPARTMENTS: Six (6) smoke compartments

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

SPRINKLER SYSTEM: Complete automatic dry sprinkler system.

GENERATOR: Type II generator. Fuel source is Natural Gas.

A standard Life Safety Code survey was conducted on 12/05/12. Rockford Health and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey.

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

K 000 DISCLAIMER:
The preparation of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleging or conclusions set forth in the Statement of Deficiency. This plan of Correction is prepared and executed solely because it is require by Federal and State Law.

FAXED
1-18-13

RECEIVED
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE SERVICES

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADM	(X6) DATE 1-18-13
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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 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.

No. 4404 P. 2 Rockford Manor Jan. 18, 2013 2:54PM

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K 000 Continued From page 1

K 000

K 018
SS=D
NFPA 101 LIFE SAFETY CODE STANDARD
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3

K 018
1. Resident room 2 the bed was moved immediately by the maintenance department.
2. Assistant Director of Maintenance checked all patient room doors to ensure that door closures was not blocked by bed or any other object on 1-3-13.
3. Staff will be informed via written communication from Administrator regarding bed placement and need to ensure nothing blocks closure of resident doors. This will be completed by 1-19-13. Employees will receive a copy of the communication and will sign that they "acknowledge that I have been trained and understand these safety regulations. I may keep a copy of this memo for future information." Compliance will be evaluated by review of the rounds completed for Quality Assurance. The DON will review reports of the rounds to determine the need for re-education.
4. Director of Maintenance to make rounds weekly for 4 weeks then monthly to check to see that no objects prevent resident doors from closing. These rounds will be recorded in the TELS program

1-26-13

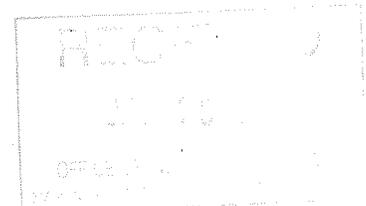
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and



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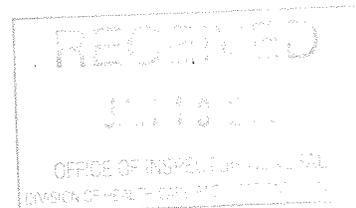
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K 018	Continued From page 2 visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observation, on 12/05/12 between 12:30 PM and 4:20 AM, with the Maintenance Director revealed the corridor door to resident room #2 was blocked from closing due to the resident's bed was located too close to the door. Interview, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director who confirmed the observation of the door not closing due to the resident's bed being located too close to the door. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms,	K 018	and reviewed by the regional Director of Facility Management no less than quarterly to ensure the rounds are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.		



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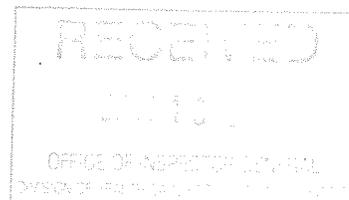
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/05/2012
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K 018	Continued From page 3 bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in	K 025	1. Penetration has been fire caulked 1-3-13 at both locations. This was completed by the Assistant Director of Maintenance.	1-20-13



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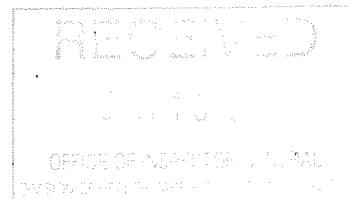
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K 025	Continued From page 4 accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds, with a census of one hundred nine (109) on the day of the survey. The facility failed to ensure penetrations in the smoke partition were sealed with a material capable of maintaining the smoke resistance of the smoke barrier. The findings include: Observation, on 12/05/12 between 12:50 PM and 4:20 PM, with the Maintenance Director revealed the smoke partition, extending above the ceiling located at the cross corridor doors across from the dining room, had a penetration by a pipe sleeve with data lines and was not sealed inside the sleeve. Further observation revealed another	K 025	2. Regional Director of Facility Management visually inspected all fire walls to ensure no other penetrations were present on 1-3-13. 3. Regional Director of Facilities Management (RDFM) will develop a memorandum for the Maintenance Director (MD) to sign in/out vendors and review their final product prior to contractor departure. This will be in place by 1-19-13. 4. We will add a fire/smoke penetration inspection to our TELS computer maintenance/tracking system for review. Director of Maintenance to make rounds weekly for 4 weeks then monthly to check to see that no penetrations in the fire walls. These rounds will be recorded in the TELS program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the rounds are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the Facility QA Committee for one year.		



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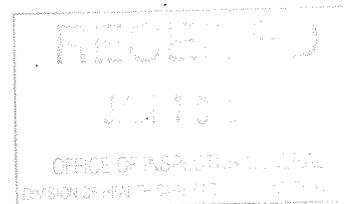
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K 025	Continued From page 5 penetration above the cross corridor doors located on the west side of the east/west cross corridor doors. The penetration was around a data line pipe sleeve. The penetrations were not filled with a material rated to maintain the smoke resistance rating of the wall. Interview, on 12/05/12 between 12:50 PM and 4:20 PM, with the Maintenance Director revealed they were aware of the requirements for sealing penetrations in smoke barriers but not aware of the unsealed penetrations found above the ceiling. Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires,	K 025		



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K 025	Continued From page 6 air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 19.3.7.4 Not less than 30 net ft ² (2.8 net m ²) per patient in a hospital or nursing home, or not less than 15 net ft ² (1.4 net m ²) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litterborne patients, not less than 6 net ft ² (0.56 net m ²) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments. 19.3.7.5	K 025	



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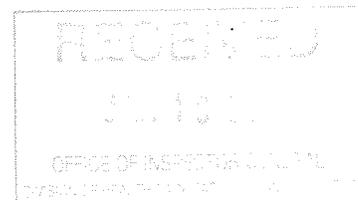
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K 025	Continued From page 7 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.	K 025			
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 3/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility has one hundred ten (110)	K 027	1. Astragal to be removed, Regional Director of Facility Management will add "siliconseal" (UL approved) to the space between the doors that will eliminate the overlap issue permanently. This will be completed by 1-19-13. 2. Entire building to be reviewed for like issues related to door overlapping. This will be completed by 1-19-13 by the Maintenance Director. 3. Regional Director of Facility Management to provide education to the NFPA Standards to the Facility Maintenance staff by 1-19-13 and provide a current copy of the standard. 4. Director of Maintenance to check all doors for proper closure weekly for 4 weeks then monthly. These checks will be recorded in the TELS program and reviewed by the Regional Director of Facility.	1-20-13	



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K 027	Continued From page 8 certified beds with a census of one hundred nine (109) on the day of the survey. The findings include: Observation, on 12/05/12 at 12:54 PM, with the Maintenance Director revealed the cross-corridor doors, located across from the dining room would not close completely when tested. This was due to the doors not having a coordinator to ensure the door without the t-astragal would close first after the initial close. Interview, on 12/05/12 at 12:54 PM, with the Maintenance Director revealed he was unaware the doors needed a coordinator to ensure the doors would close properly in the event of an emergency. NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027	Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report on same to the Facility QA Committee for one year.		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029	1. Door closure to be added to the		



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K 029 Continued From page 9
SS=D

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

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas.

The findings include:

Observation, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed the door to the Medical Records Office did not



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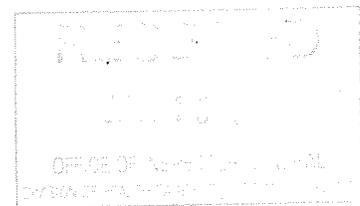
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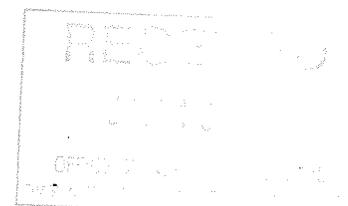
K 029	<p>Continued From page 10 have a self-closing device installed and the door and was protecting a hazardous storage area.</p> <p>Interview, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed he was not aware the door to this room was required to be self-closing.</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms</p>	K 029	<p>1. Door closer to be added to the Medical records office by 1-8-13. This will be completed by the Assistant Maintenance Director</p> <p>2. Assistant Maintenance Director inspect all facility doors to identify any other doors requiring door closures. This will be completed on 1-8-13.</p> <p>3. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 1-19-13 and provide a current copy of the standard .</p> <p>4. . Director of Maintenance to check all doors for proper closures weekly for 4 weeks then monthly. These checks will be recorded in the TELs program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.</p>	1-20-2013
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K 038	<p>Continued From page 12</p> <p>requirement. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility has one hundred ten (110) certified beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed the exits at the end of the East and West Halls to have hanging shades mounted to the doors making the path of egress not clearly recognizable. Further observation revealed the exit door located at the end of the West Hall had a dead bolt lock installed at approximately five (5) feet from the finished floor. The dead bolt lock could not release upon activation of the facilities fire alarm system or power failure.</p> <p>Interview, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed he was unaware the doors were not allowed to have dead bolt locks installed on the exit door. Further interview with the Administrator revealed the door was locked only at night due to the employees using the exit to come and go and the facility was not in a good neighborhood.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved,</p>	K 038	<p>1 Shades to be removed permanently and we will affix a frosted film to the door glass and side-light and the dead bolt will be removed. This will be completed by 1-19-13, by the Maintenance Director</p> <p>2. Regional Director of Facility Management made rounds on 1-3-13 to identify any other doors with shades and/or deadbolts and no others were noted.</p> <p>3. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 1-19-13 and provide a current copy of the standard .</p> <p>4. . Director of Maintenance to check all doors for deadbolts monthly. These checks will be recorded in the TELs program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.</p>	1-20-2013



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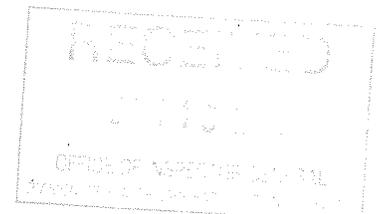
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K 038	Continued From page 13 listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release	K 038			



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K 038	<p>Continued From page 14</p> <p>process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.</p> <p>Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>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.</p> <p>7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to</p>	K 038	



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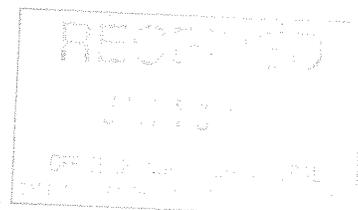
K 038 Continued From page 15
conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met:
(a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress.
(b) They are installed across an opening that is at least 6 ft (1.8 m) in width.
(c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.

K 038

K 045 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E 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

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 and failed to ensure the staff was knowledgeable of the requirement. The deficiency



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K 045	<p>Continued From page 16</p> <p>had the potential to affect five (5) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed the exterior exit located in the A, B, C, and D Hall only had one light bulb outside to light the egress path. Further observation revealed the West Wing Exit did not have a light outside to light the egress path.</p> <p>Interview, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed they were not aware the exits did not have the required illumination for egress lighting.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and</p>	K 045	<p>1. Maintenance Director or Assistant will repair or replace fixtures to incorporate 2 light bulbs at each exit by 1-19-13, and add a light on the West Wing Exit. This will be completed on 1-21-13 due to the work is to be performed by an outside contractor and we cannot get on his schedule until 1-21-13. This work is being completed by J&J Design and Construction.</p> <p>2- On 1-3-13 the Regional Director of Facility Management made rounds and observed all exits for this type of upgrade</p> <p>3- This upgrade will resolve all exterior light requirements. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 1-19-13 and provide a current copy of the standard .</p> <p>4. These exterior lights will be reviewed on the TELS maintenance schedule to be conducted and repaired on a monthly basis. . These checks will be recorded in the TELS program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.</p> <p>1-22-2013 1-20-13 per Mary Campbell by P/B 1-22-13</p>



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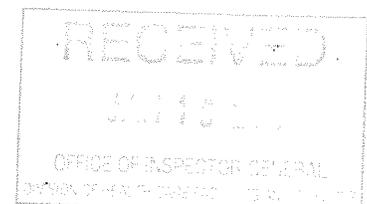
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K 045	Continued From page 17 passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not	K 045			



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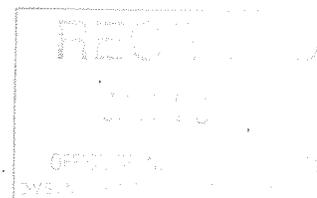
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K 045	Continued From page 18 result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045	<ol style="list-style-type: none"> Maintenance Director will be trained on this process by the Regional Director of Facility Management by 1-19-13. The battery emergency lighting will be tested per the requirement for 1 ½ hours by the maintenance Director by 1-19-13 Maintenance Director will be trained on this process by the Regional Director of Facility Management by 1-19-13. The battery emergency lighting will be tested per the requirement for 1 ½ hours by the maintenance Director by 1-19-13 The documentation of this test will be inserted into the Life-Safety binder on the premises. It is located in the Administrators office. These tests will be recorded in the TELs program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year. 	1-20-2013	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on interview and record review of emergency lighting testing, it was determined the facility failed to test emergency lighting in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility has one hundred ten (110) certified beds with a census of one hundred nine (109) on the day of the survey. The findings include: Record review fo the emergency lighting testing, on 12/05/12 at 1:56 PM, with the Maintenance Director revealed they did not have documentation that the battery emergency lighting in the facility was tested for 1-1/2 hours within the last year. Interview, on 12/05/12 at 1:56 PM, with the Maintenance Director revealed they were not aware the annual test for the battery emergency light for 1-1/2 hours had to be documented. Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided	K 046			



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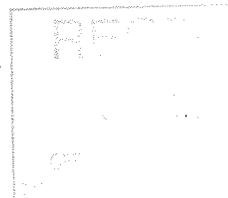
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K 046	Continued From page 19 for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals. NFPA 101 LIFE SAFETY CODE STANDARD SS=D Exit and directional signs are displayed in accordance with section 7.10 with continuous	K 046		
K 047		K 047		



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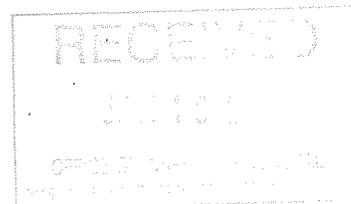
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K 047	<p>Continued From page 20</p> <p>illumination also served by the emergency lighting system. 19.2.10.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage.</p> <p>The findings include:</p> <p>Observation, on 12/05/12 at 3:17 PM, with the Maintenance Director revealed the exit doors located in the Kitchen did not have an exit sign above the door making the path of egress clearly recognizable.</p> <p>Interview, on 12/05/12 at 3:17 PM, with the Maintenance Director revealed he was not aware the exits did not have proper signage.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.10.1.2* Exits. Exits, other than main exterior</p>	K 047	<p>1. We will modify the existing exit sign to add a directional arrow leading to the exterior parking lot by 1-4-13. This will be completed by the Maintenance Director or Assistant</p> <p>2. 3- On 1-3-13 the Regional Director of Facility Management made rounds and observed all exits for appropriate signage.</p> <p>3. . Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 1-19-13 and provide a current copy of the standard .</p> <p>4. Director of Maintenance to check all exit signs monthly. These checks will be recorded in the TELs program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.</p> <p>1-20-2013</p>



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K 047	Continued From page 21 exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.	K 047		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect six (6) of six (6) smoke compartments, one hundred ten (110) residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times. The findings include:	K 050		



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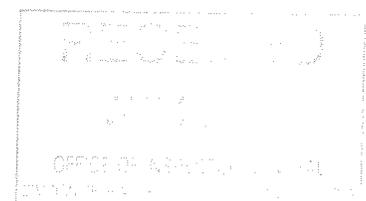
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K 050	Continued From page 22 Fire Drill review, on 12/05/12 at 1:45 PM, with the Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on all shifts. Interview, on 12/05/12 at 1:45 PM, with the Maintenance Director revealed they were not aware the fire drills were not being conducted as required. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. 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 building. NFPA 101 LIFE SAFETY CODE STANDARD	K 050	1-20-2013 1 Beginning in January Fire Drills will be conducted at varying times on all shifts. 2. Maintenance Director was provided a schedule for the monthly fire drills by the Administrator on 1-17-13. 3- We will modify the TELS program to stipulate variable times, one shift per month on a quarterly basis. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 1-19-13 and provide a current copy of the standard . 4. Director of Maintenance to record all fire drills in the TELs program and log accordingly into the Life Safety Binder. Fire drill records will reviewed by the Regional Director of Facility Management no less than quarterly to ensure the drills are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.
K 056 SS=F		K 056	



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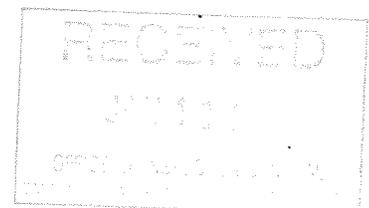
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K 056	<p>Continued From page 23</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</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, installed in accordance with NFPA Standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey. The facility failed to ensure sprinkler heads were not blocked by light fixtures on the ceiling, and the facility had complete sprinkler coverage.</p> <p>The findings include:</p> <p>Observations, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed the sprinkler heads located in resident</p>	K 056	<p>1. We will be replacing the light fixtures in all the areas identified as having the sprinkler head blocked by the light fixture. We are adding sprinkler heads to the areas identified as not having them.</p> <p>2. On 1-3-13 the Regional Director of Facility Management made rounds and observed all areas for any lights that blocked sprinkler heads and to observe for any areas requiring sprinkler heads that did not have them.</p> <p>3. Lights are approved and contracted to be supplied by AM Electric Company. Per the quote that was received 1-16-13 the lights will be delivered in two weeks. Installation will be completed by corporate maintenance staff and will begin the day the lights are delivered. It is estimated that installation will take approximately 2 weeks. This project will be under the oversight of the Regional Director of Facility Management. The Sprinkler Heads are approved and per the quote received 1-16-13 and returned as approved 1-17-13 this work will begin within a week of the approval. It is estimated that the installation will be completed within 3 days. This project is under the oversight of the Regional Director of Facility Management.</p> <p>Projected date of completion 2-15-13</p>



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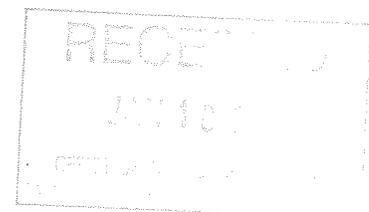
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2012
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K 056	<p>Continued From page 24</p> <p>bathrooms, Therapy Bathroom, Admissions Office, Dish Room, Medical Records, Staffing Office, and the Laundry Room were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed a ceiling compartment located at the A, B, C, and D Hall cross corridor doors that did not have sprinkler coverage. Further observation revealed a porch roof off of the Kitchen back door, and the Dining Room exit did not have sprinkler coverage and the porch roof extended out greater than forty eight (48) inches.</p> <p>Interview, on 12/05/12 between 12:30 PM and 4:20 PM with the Maintenance Director revealed they were unaware sprinkler heads could have no obstructions below the deflector within 12 inches of the head. Further interview revealed they were not aware the building did not have complete sprinkler coverage.</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</p>	K 056	<p>4. . Director of Maintenance to check all sprinkler heads quarterly. These checks will be recorded in the TELs program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year. The Regional Director of Facility Maintenance will be responsible for the oversight of the installation of the lights and sprinkler heads, and will notify the VP of Operations for Elmcroft Senior Living if the project will not be completed as indicated in this POC so notification can be made to the Central Office if the project will exceed the projected date of compliance.</p>		



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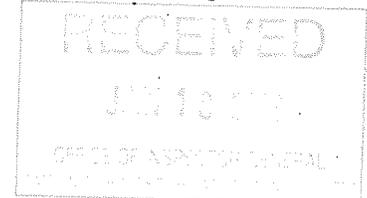
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K 056	<p>Continued From page 25</p> <p>section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(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>Reference: NFPA 13 (1999 edition)</p> <p>5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Maximum Allowable Distance</td> <td></td> </tr> <tr> <td style="text-align: center;">Distance from Sprinklers to</td> <td style="text-align: center;">of Deflector</td> </tr> <tr> <td style="text-align: center;">above Bottom of</td> <td></td> </tr> <tr> <td style="text-align: center;">Side of Obstruction (A)</td> <td style="text-align: center;">Obstruction (in.)</td> </tr> </table>	Maximum Allowable Distance		Distance from Sprinklers to	of Deflector	above Bottom of		Side of Obstruction (A)	Obstruction (in.)	K 056		
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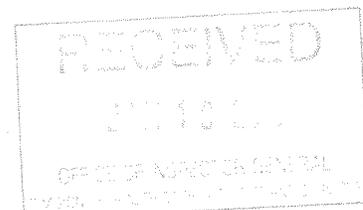
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K 056	Continued From page 26 (B) Less than 1 ft 0 1 ft to less than 1 ft 6 in. 21/2 1 ft 6 in. to less than 2 ft 31/2 2 ft to less than 2 ft 6 in. 51/2 2 ft 6 in. to less than 3 ft 71/2 3 ft to less than 3 ft 6 in. 91/2 3 ft 6 in. to less than 4 ft 12 4 ft to less than 4 ft 6 in. 14 4 ft 6 in. to less than 5 ft 161/2 5 ft and greater 18 For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 edition) 5-13.8.1. Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056			
K 064 SS=0	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview it was	K 064			



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K 064	Continued From page 27 determined the facility failed to ensure that fire extinguishers were maintained in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff, and visitors. The facility has one hundred ten (110) certified beds with a census of one hundred nine (109) on the day of the survey. The facility failed to have fire extinguishers in smoking areas and failed to ensure the staff was knowledgeable of the requirement. The findings include: Observation, on 12/05/12 at 3:35 PM, with the Maintenance Director revealed there was no fire extinguisher located in the designated smoking area. Interview, on 12/05/12 at 3:35 PM, with the Maintenance Director revealed he was not aware that a fire extinguisher was required to be located in the smoking area. Reference: NFPA 10 1999 4-3.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (a) Location in designated place (b) No obstruction to access or visibility (c) Operating instructions on nameplate legible and facing outward (d)* Safety seals and tamper indicators not broken or missing (e) Fullness determined by weighing or "hefting" (f) Examination for obvious physical damage,	K 064	1. Fire extinguisher added to the designated smoking area 1-4-13. This was completed by the Maintenance Assistant. 2. On 1-3-13 the Regional Director of Facility Management made rounds and observed all areas for required fire extinguishers. 3. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 1-19-13 and provide a current copy of the standard . 4. Director of Maintenance to check all fire extinguishers monthly. These checks will be recorded in the TELs program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.	1-20-2013



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K 064 Continued From page 28
corrosion, leakage, or clogged nozzle
(g) Pressure gauge reading or indicator in the operable range or position
(h) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units)
(i) HMIS label in place
4-3.3 Corrective Action.
When an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.

K 072 NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
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

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 six (6) smoke compartments, residents, staff and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments and failed to ensure the staff was knowledgeable of the requirement.

The findings include:

~~K 064~~
K 072

K 072

1. Linen Carts will no longer be utilized. Trash carts and lifts will be relocated to appropriate area (shower rooms) for storage when not in use.
2. Trash carts and lifts will be relocated to appropriate areas for storage when not in use.
3. Staff will be informed via written communication from Administrator regarding storage of linen carts, trash carts and lifts when not in use and the need to keep the hallways clear of obstructions. This will be completed by 1-19-13.. Employees will receive a copy of the communication and will sign that they " acknowledge that I have been trained and understand these safety regulations. I may keep a copy of this memo for future information. " This will also be addressed in a nursing in-service scheduled for 1-10-13. This in-service to be repeated monthly for 3 months. Compliance will be evaluated by review of the rounds completed for Quality Assurance. The DON will review reports of the rounds to determine the need for re-education.
4. Charge Nurse will monitor the hallways daily for one week, weekly for four weeks and monthly thereafter. Reports will be submitted to the DON upon completion and will be reviewed with staff on duty at the time of the observations so any issues may be addressed with staff responsible. DON will report on observations to the facility QA Committee for one year.

1-20-2013



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K 072 Continued From page 29
Observation, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed the storage of linen carts, trash carts, and lifts located in the B, C, and D Halls.

K 072

Interview, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed the items were routinely stored in the B, C, and D Halls.

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.

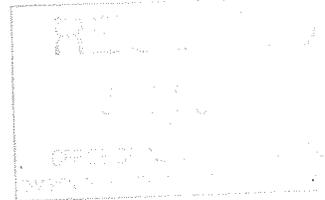
K 147 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 147

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards and failed to ensure the staff was knowledgeable of the requirement. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred ten (110) beds with a census of one hundred nine (109) on the day of the survey.

The findings include:



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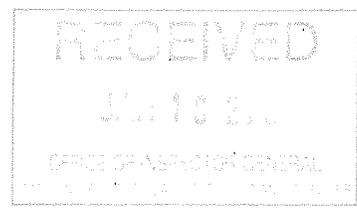
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K 147	<p>Continued From page 30</p> <p>Observations, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) A refrigerator, toaster, and microwave plugged into a power strip located in the Front Office Copy Room. 2) A refrigerator and coffee maker were plugged into a power strip located in the Admissions Office. 3) An extension cord was plugged into the wall located in the Administrators Office. 4) An extension cord was plugged into a power strip and running up through the ceiling to service phone equipment located in a closet in the Laundry. 5) An oxygen concentrator was plugged into a power strip located in room #4. <p>Interview, on 12/05/12 between 12:30 PM and 4:20 PM, with the Maintenance Director revealed they were aware of the proper use of power strips and extension cords but not aware any had been installed and misused.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to</p>	K 147	<ol style="list-style-type: none"> 1. All power strips and extension cords to this equipment. (Refrigerator, microwave and coffee maker) have been removed and all equipment plugged directly into the wall outlet. The toaster was removed. The extension cord was removed from the Administrators office. The extension cord in the laundry room was removed. The oxygen concentrator has been plugged directly into the wall outlet. This will all be completed by 1-19-13 2. On 1-3-13 the Regional Director of Facility Management and the Maintenance Assistant made rounds to identify any other improper use of power strips or extension cord. 3. Staff will be informed via written communication from Administrator regarding use of power strips and extension cords. This will be completed by 1-19-13 Employees will receive a copy of the communication and will sign that they "acknowledge that I have been trained and understand these safety regulations. I may keep a copy of this memo for future information." This will also be addressed in a nursing in-service scheduled for 1-10-13. This in-service to be repeated monthly for 3 months. Compliance will be evaluated by review of the rounds completed for Quality Assurance. The DON will review reports of the rounds to determine the need for re-education. 4. Maintenance Director will make rounds daily for one week, weekly for four weeks and monthly thereafter to check all areas of the facility for the improper use of power strips and extension cords. Reports will be submitted to the Administrator 	1-20-2013
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upon completion, Administrator will report on rounds to QA Committee for one year.



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K 147	<p>Continued From page 31 approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p>	K 147		
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