

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

PRINTED: 09/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2012
NAME OF PROVIDER OR SUPPLIER CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1800 WESTEN AVENUE BOWLING GREEN, KY 42104		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A standard recertification survey was conducted 07/18-19/12 to determine the facility's compliance with Federal requirements. The facility was determined to be in substantial compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities.	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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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1995</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) stories, Type III (200)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/18/12. Christian Health Center of Bowling Green was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>The provider wishes this plan of correction to be considered as our allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p>

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

Melanie Eak

TITLE

Administrator

(X6) DATE

08/02/12

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

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1995</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) stories, Type III (200)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 07/18/12. Christian Health Center of Bowling Green was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Melanie Ector* TITLE *Administrator* (X8) DATE *08/07/12*

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K 000	Continued From page 1	K 000			
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>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. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty-eight (28) beds with a</p>	K 018	<p>1. Corridor doors 102, 105, 106, 107, 306, 301 were sealed with LSC recommended door foam insulation to assure gap was less than 1/8 inch around jamb, completed 07/20/12.</p> <p>2. All residents have the potential to be affected. All other corridor doors were inspected by Housing Manager and none were identified to have greater than 1/8 inch gap around jamb, assuring no other residents were affected by deficient practice as all doors will resist passage of smoke, completed 08/07/12.</p> <p>3. Corridor door gap inspections were added to the Preventative Maintenance Program for minimum of quarterly inspections, completed 08/07/12. Maintenance staff in-serviced by Housing Manager on requirements of corridor doors to resist passage of smoke, completed 07/20/12.</p>	08/07/12	

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K 018	<p>Continued From page 2</p> <p>census of twenty-eight (28) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/18/12 between 11:15 AM and 2:30 PM with the Housing Manager, revealed the corridor doors to rooms 102, 105, 106, 107, 306, and 301 had a gap larger than 1/8 of an inch around the jamb and would not resist the passage of smoke.</p> <p>Interview, on 07/18/12 between 11:15 AM and 2:30 PM with the Housing Manager, revealed he was not aware of the allowable gap in the corridor doors. Observations were confirmed with the Administrator during the exit conference.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or</p>	K 018	4. Preventative Maintenance form for corridor doors, upon completion, presented quarterly to Housing Manager for 6 months for review. Housing Manager will present to Administration quarterly for 6 months for review. Administrator will present to QA quarterly for 6 months for review and further recommendations.	
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K 018	Continued From page 3 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 NFPA standards.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was	K 025	1. Smoke partition above ceiling in 200 Hall and fire wall separating the building next to the nurse station were properly sealed, completed 07/27/12. 2. All residents have the potential to be affected. Housing Manager inspected attic space to assure all smoke compartments in attic space are properly sealed, completed 08/07/12.	08/07/12

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K 025	<p>Continued From page 4</p> <p>determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. Additionally, the facility failed to ensure the plan of correction was effective to maintain compliance with this requirement as it was cited on 8-11-11 during the recertification survey. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/18/12 between 11:15 AM and 11:50 AM with the Housing Manager, revealed the smoke partitions, extending above the ceiling located in the 200 hall portion of the building, and the fire wall separating the building next to the nurses' station were not properly sealed. The barriers failed to be properly sealed from piping and wires.</p> <p>Interview, on 07/18/12 between 11:15 AM and 11:50 AM with the Housing Manager, revealed he was not aware of the penetrations in the smoke barriers. Observations were confirmed with the Administrator during the exit conference.</p> <p>This is a repeat deficiency.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar</p>	K 025	<p>3.</p> <p>Quarterly inspections of attic space will be conducted by Maintenance staff as part of Preventative Maintenance Program, completed 07/20/12. Maintenance staff in-serviced by Housing Manager on maintaining proper seal of smoke barriers in attic quarterly for 6 months, completed 07/20/12.</p> <p>4.</p> <p>Preventative Maintenance Program inspection and copy of in-service presented by Housing Manager to Administrator quarterly for 6 months. Administrator will review and present to QA quarterly for 6 months for further review and recommendations.</p>		

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K 025	Continued From page 5 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.	K 025			
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed	K 038	1. Temporary signage placed on egress doors by Administrator at end of 100, 200, 300 Halls, completed 07/20/12. Permanent signage that meets NFPA 101 requirements ordered 07/24/12 by Administrator.	08/07/12	

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K 038	<p>Continued From page 6</p> <p>egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/18/12 between 11:15 AM and 2:30 PM with the Housing Manager, revealed the egress doors at the end of the 100, 200, and 300 halls did not have the proper signage for the 15 second delay, nor was the code posted. Further observation showed the two doors in the main area had the proper signage.</p> <p>Interview, on 07/18/12 between 11:15 AM and 2:30 PM with the Housing Manager, revealed he was unaware the doors were required to have delay signage or the door code posted. Observations were confirmed with the Administrator during the exit conference.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an</p>	K 038	<p>2.</p> <p>All residents have the potential to be affected. Housing Manager inspected other egress doors to assure compliance with NFPA 101 signage requirements, completed 08/07/12.</p> <p>3.</p> <p>Upon receipt of permanent signage from vendor, it will be placed on 100, 200, 300 Hall , preventing further deficient practice from recurring. Housing Manager will monthly for 3 months verify egress signage remains in place. Maintenance staff in-serviced by Housing Manager on signage requirements for egress doors, completed 07/20/12.</p> <p>4.</p> <p>Housing Manager inspections presented monthly for 3 months to Administrator for review. Administrator will review and present to QA monthly for 3 months for further review and recommendations.</p>	

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K 038	<p>Continued From page 7</p> <p>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.</p> <p>(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.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(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 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. Exception: Where approved by the authority</p>	K 038		

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K 038	<p>Continued From page 8 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 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</p>	K 038			

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K 038	Continued From page 9 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 SS=F	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 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 two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey. The findings include: Observation, on 07/18/12 between 11:15 AM and 2:30 PM with the Housing Manager, revealed the	K 045	1. Exterior exits at end of 100 and 200 Halls were illuminated with minimum double light fixtures, completed 07/20/12. 2. All residents have the potential to be affected. Housing Manager inspected other exterior exits to assure compliance with NFPA 101 illumination requirements, completed 07/20/12.	08/07/12

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K 045	Continued From page 10 exterior exit at the end of the 100 and 200 halls only had a single light for illumination. Interview, on 07/18/12 between 11:15 AM and 2:30 PM with the Housing Manager, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path. Observations were confirmed with the Administrator during the exit conference. Exit lighting must be arranged so the failure of a single bulb will not leave the exit in complete darkness. 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	3. All exterior exits with means of egress, including exit discharge, will have minimum of double light fixtures in place. Maintenance staff in-serviced by Housing Manager on requirement of double light fixtures. Minimum of quarterly inspections of exterior lights conducted by maintenance staff added to Preventative Maintenance Program, completed 08/07/12.	
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	K 050	4. Housing Manager will inspect monthly for 3 months exterior exits to confirm minimum double light fixtures in place. Inspections presented monthly for 3 months to Administrator for review. Administrator will review and present to QA monthly for 3 months for further review and recommendations. 1. Housing Manager conducted fire drill for 2 nd shift on 07/18 and for 3 rd shift on 07/19. 2. All residents have the potential to be affected by deficient practice. Housing Manager assured that all shifts had fire drill for last quarter, completed 07/19/12.	07/20/12

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K 050	Continued From page 11 This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey. The findings include: Review of the facility Fire Drill documentation, on 07/18/12 at 2:15 PM with the Housing Manager, revealed the fire drills were not being conducted on all shifts at least quarterly. The documentation revealed the facility had not conducted a fire drill on second shift in the last 4 quarters. Interview, on 07/18/12 at 2:15 PM with the Housing Manager, revealed he was unaware the fire drills were not being conducted as required. The Housing Manager looked at where 2nd shift was written on the logs and was unable to provide evidence that the facility had conducted a fire drill on 2nd shift. Observations were confirmed with the Administrator during the exit conference. Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050	3. Preventative Maintenance Program form was updated by Housing Manager to specify which shift is to be completed by month, completed 07/20/12. Fire Alarm Log created to be reviewed monthly by Housing Manager to assure all fire drills are completed per requirement. Maintenance staff in-serviced by Housing Manager on requirements for fire drills to be completed quarterly for all shifts, completed 07/20/12. 4. Housing Manager will review and present Fire Alarm Log monthly for 3 months to Administrator for review. After review for compliance and completion, Administrator will present to QA monthly for 3 months for further review and recommendations.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	1. Insulation fallen on sprinkler heads after annual inspection conducted by maintenance staff. Insulation fallen on sprinkler heads in attic above nurses' station area removed, completed 07/27/12.	08/07/12

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K 062	<p>Continued From page 12</p> <p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system according to NFPA standards. Additionally, the facility failed to ensure the plan of correction was effective to maintain compliance with this requirement as it was cited on 8-11-11 during the recertification survey. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/18/12 at 11:35 AM with the Housing Manager, revealed insulation had fallen on the sprinkler heads located in the attic above the nurses' station area.</p> <p>Interview, on 07/18/12 at 11:35 AM with the Housing Manager, revealed he was unaware of the fallen insulation lying on the sprinkler heads. They are conducting annual inspections of the insulation but missed it. Observations were confirmed with the Administrator during the exit conference.</p> <p>This is a repeat deficiency.</p>	K 062	<p>2. All residents have the potential to be affected by deficient practice. Housing Manager inspected attic space to assure no other areas had fallen insulation on sprinkler heads, completed 08/07/12.</p> <p>3. Preventative Maintenance Program updated to include quarterly inspections by maintenance staff of attic space to assure no fallen insulation on sprinkler heads, completed 08/07/12. Maintenance staff in-serviced by Housing Manager on requirements to keep sprinkler heads free from fallen insulation, completed 07/20/12. In-service will be completed quarterly for 6 months.</p> <p>4. Housing Manager will review and present inspections and in-services quarterly for 6 months and present to Administrator for review. After review for compliance and completion, Administrator will present to QA quarterly for 6 months for further review and recommendations.</p>	

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K 062	<p>Continued From page 13 Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p>	K 062		

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K 062	Continued From page 14 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062			
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey. The findings include: Observation, on 07/18/12 at 2:35 PM with the Housing Manager, revealed no documentation for fire damper testing. Interview, on 07/18/12 at 2:35 PM with the Housing Manager, revealed that no maintenance documentation was kept on the fire/smoke dampers. The dampers had not been checked in the 16 years the building has been in service. Observations were confirmed with the	K 104	1. One damper in the health center required inspection, completed 07/24/12. 2. All residents have the potential to be affected by deficient practice. Housing Manager reviewed damper inspection report to assure completion, completed 08/07/12. 3. Preventative Maintenance Program updated to include required damper inspection every 4 years, completed 08/07/12. Maintenance staff in-serviced by Housing Manager on requirements to complete damper inspections every 4 years to ensure fire/smoke dampers are maintained in accordance to NFPA standards, completed 07/20/12.	08/07/12	

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K 104	Continued From page 15 Administrator during the exit conference. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104	4. Housing Manager will submit copy of damper inspection and updated Preventative Maintenance Program damper inspection form to Administrator for review After review for compliance and completion, Administrator will present to QA for further review and recommendations.		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the emergency generator according to NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is licensed for twenty-eight (28) beds with a census of twenty-eight (28) on the day of the survey. The findings include:	K 144	1. Battery- powered lighting installed by maintenance staff in the room where the transfer switch for the emergency generator was located on 07/20/12. 2. All residents have the potential to be affected by deficient practice. Housing Manager checked for proper installation of battery-powered lighting, completed 08/07/12.	08/07/12	

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K 144	<p>Continued From page 16</p> <p>Observation, on 07/18/12 at 3:18 PM with the Housing Manager, revealed the facility did not have any battery-powered lighting installed in the room where the transfer switch for the emergency generator was located. The room where the transfer switch for the emergency generator is located must have battery-powered lighting in case there is a failure of the emergency generator and staff must operate the transfer switch manually.</p> <p>Interview, on 07/18/12 at 3:18 PM with the Housing Manager, revealed he was not aware of the requirement for the battery backup lighting. Observations were confirmed with the Administrator during the exit conference.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p>	K 144	<p>3. Maintenance staff in-serviced by Housing Manager on requirement to have working battery-powered lighting in transfer switch room for emergency generator, completed 07/20/12. Preventative Maintenance Program updated to include quarterly inspections by maintenance staff to assure battery operational for batter-powered light, completed 08/07/12.</p> <p>4. Evidence of battery powered lighting installed and added to Preventative Maintenance Program presented to by Housing Manager to Administrator for review. Administrator, after review and verification of complete, will present to QA quarterly for 3 months for further review and recommendations.</p>		