

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185336	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 13 (c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system Reference: NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same 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: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprnklers 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 sprnklers shall be permitted to be used. NFPA 101 LIFE SAFETY CODE STANDARD	K 056		
K 062 SS=F		K 062		

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K 062	<p>Continued From page 14</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on sprinkler testing record review and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey. The facility failed to provide to complete required testing for the sprinkler system.</p> <p>The findings include:</p> <p>Sprinkler Testing Record review, on 01/10/13 at 2:15 PM, with the Maintenance Director revealed the facility did not have documentation that the gauges on the sprinkler riser had not been calibrated or replaced within the last five years.</p> <p>Interview, on 01/10/13 at 2:15 AM, with the Maintenance Director revealed he was not aware of the requirement.</p> <p>Interview, on 01/10/13 at 4:40 PM, with the Administrator revealed she was not aware of the requirement.</p>	K 062	<p>K062 SS=F NFPA Life Safety Code Standard Sprinkler Guages</p> <p>1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.</p> <p>2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.</p> <p>3) Maintenance manager contacted and scheduled for TriState Fire Protection to come and replace sprinkler gauges and provide documentation that this work has been done. TriSate Fire Protection will make regular periodic checks of the fire system as well as check and calibrate sprinkler gauges as needed.</p> <p>3) The administrator re-educated and trained the maintenance manager on 1/15/13 regarding the need for sprinkler gauges to be changed and/or calibrated every 5 years. 4) This issue will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.</p> <p>5. Date of Completion: 2/22/2013</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185338	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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K 062	Continued From page 15 Reference: NFPA 13 (1999 Edition) 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. 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. 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: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height 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.	K 062		

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K 062	<p>Continued From page 16</p> <p>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> <p>Reference: NFPA 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements</p>	K 062		

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K 062	Continued From page 17 for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3	K 062		

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K 062 Continued From page 18
 Sprinklers - fast response Test At 20 years and every 10 years thereafter
 2-3.1.1 Exception No. 2
 Sprinklers Test At 50 years and every 10 years thereafter
 2-3.1.1
 Valves (all types) Maintenance Annually or as needed Table 9-1
 Obstruction investigation Maintenance 5 years or as needed Chapter 10

K 064 SS-D
 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 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 is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure the designated smoking areas had a fire extinguisher.

The findings include:
 Observation, on 01/10/13 at 2:28 PM, with the Maintenance Director revealed there was no fire extinguisher located in the designated smoking areas.

K 062 K064 SS=() NFPA Life Safety Code Standard Fire Extinguishers
 1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.
 2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.

K 064
 3) Fire extinguishers were purchased and installed in both the resident/visitor smoking area as well as the employee smoking area. The fire extinguishers will be added to the routine fire extinguisher preventative maintenance log for regular checks.
 4) The administrator re-educated and trained the maintenance manager on 1/15/13 regarding the need for fire extinguishers to be located in all smoking areas and for these new fire extinguishers to be added to routine extinguisher preventative maintenance schedule. This requirement will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.

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K 064	Continued From page 19 Interview, on 01/10/13 at 2:28 PM, with the Maintenance Director revealed he was not aware that a fire extinguisher was required to be located in the smoking areas. Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was not aware that a fire extinguisher was required to be located in the smoking areas. 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, 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	K 064		

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K 064	Continued From page 20 In 4-3.2 (a), (b), (h), and (l), immediate corrective action shall be taken.	K 064	K064 SS=D NFPA Life Safety Code Standard Metal containers with self closing covers	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for	K 066	1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56. 2) No other residents were identified as having been affected; however on the date of this inspection the census was 56. 3) Metal containers with self-closing covers were purchased and installed in both the resident/visitor smoking area as well as the employee smoking area. Maintenance manager will check 5X/week to ensure that the metal container remains in place. 4) The administrator re-educated and trained the maintenance manager on 1/15/13 regarding the need for metal container with self closing cover to be located in all smoking areas and for these new metal containers to be added to routine daily checks to ensure they remain in place. This requirement will be discussed and reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate. 5. Date of Completion: 2/22/2013	

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(X3) DATE SURVEY
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01/10/2013

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420 EAST GRUNDY AVENUE
SPRINGFIELD, KY 40069

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(X5)
COMPLETION
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K 066: Continued From page 21
seventy (70) beds with a census of fifty six (56)
on the day of the survey. The facility failed to
ensure the smoking areas had a metal container
with a self-closing lid to dump ashtrays.

K 066

The findings include:

Observation, on 01/10/13 at 2:27 PM, with the
Maintenance Director revealed the facility failed to
provide a metal container with a self-closing lid to
dump the ashtrays, located in the designated
smoking areas.

Interview, on 01/10/13 at 2:27 PM, with the
Maintenance Director revealed he was not aware
of the requirement for metal containers with a
self-closing lid for dumping ashtrays.

Interview, on 01/10/13 at 4:00 PM, with the
Administrator revealed she was not aware of the
requirement for metal containers with a
self-closing lid for dumping ashtrays.

Reference: NFPA Standard 101 (2000 Edition).

19.7.4 Smoking (4)
Metal containers with self-closing cover devices
into which ashtrays can be emptied shall be
readily available to all areas where smoking is
permitted.

K 070

K 070
SS=D
NFPA 101 LIFE SAFETY CODE STANDARD

Portable space heating devices are prohibited in
all health care occupancies, except in
non-sleeping staff and employee areas where the
heating elements of such devices do not exceed
212 degrees F. (100 degrees C) 19.7.8

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K 070 Continued From page 22

This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure, portable space heaters used in the facility were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey.

The findings include:

Observation, on 01/10/13 at 3:15 PM, with the Maintenance Director revealed a portable space heater located in the Social Services Office. The facility did not have a policy for portable heaters or documentation that the heaters did not exceed 212 degrees.

Interview, on 01/10/13 at 3:15 PM, with the Maintenance Director revealed he was not aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas, they thought this requirement was only for patient care areas.

Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was aware the heaters could not exceed 212°F in non-sleeping, staff, and employee areas.

K 070 K070
SS=D
NFPA Life Safety Code Standard
Space Heaters

1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.

2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.

3) All portable space heaters were removed from the center on 2/10/13. Maintenance manager will add to his regular center checks to check for space heaters. All space heaters found will be immediately taken from the area from which it is found, and removed from the center.

4) The administrator re-educated and trained the maintenance manager on 1/15/13 regarding the need to add space heaters to his regular center checks and to remove any that he finds immediately. This requirement will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.

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SPRINGFIELD, KY 40068

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(X5)
COMPLETION
DATE

K 070 Continued From page 23
Reference: NFPA 101 (2000 edition)
19.7.8 Portable Space-Heating Devices. Portable
space-heating
devices shall be prohibited in all health care
occupancies.
Exception: Portable space-heating devices shall
be permitted to be used
in non-sleeping staff and employee areas where
the heating elements of
such devices do not exceed 212°F (100°C).
NFPA 101 LIFE SAFETY CODE STANDARD

K 072
SS=D

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 one (1) of
three (3) smoke compartments, residents, staff
and visitors. The facility is certified for seventy
(70) beds with a census of fifty six (56) on the day
of the survey. The facility failed to ensure the
means of egress was free of all obstructions or
impediments.

The findings include:

Observations, on 01/10/13 between 12:00 PM
and 4:00 PM, with the Maintenance Director

K 070

K072
SS=D

K 072

NFPA Life Safety Code Standard
Exit Access

1) No specific residents were cited in the
statement of deficiency as having been affected;
however, on the date of this inspection the
census was 56.

2) No other residents were identified as having
been affected; however on the date of this
inspection the census was 56.

3) Ice machine will be relocated to adjacent
copy room to allow for this area to be used for
east hall medication cart storage. Electrical
quote obtained to wire the new room for the ice
machine in order to free up the old area for cart
storage. This work will be completed by
2/21/13. West hall medication carts will be
stored behind the nurses station when not in use;
underneath the chart cabinet. Wheelchairs will
be parked in the resident room to which it
belongs. Lifts will be stored in the common
shower room when not in use. The management
team will make daily rounds of routes of egress
to ensure these remain free of obstructions.

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 072 Continued From page 24 revealed the storage of medication carts, two (2) wheel chairs, and a lift were being stored in the East Hall.

Interview, on 01/10/13 between 12:00 PM and 4:00 PM, with the Maintenance Director revealed the items were routinely stored in these areas.

Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed the items were routinely stored in these areas.

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 073 SS=F
NFPA 101 LIFE SAFETY CODE STANDARD
No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey.

The findings include:

K 072 3) The administrator re-educated and trained the maintenance manager on 1/15/13 regarding the need maintaining our means of egress and keeping all hallways cleared of clutter. This requirement will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.

5. Date of Completion: 2/22/2013

K 073
K073
SS=F
NFPA Life Safety Code Standard
Fire Retardant

1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.

2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.

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NAME OF PROVIDER OR SUPPLIER SPRINGFIELD NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 420 EAST GRUNDY AVENUE SPRINGFIELD, KY 40069
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K 073	Continued From page 25 Observation, on 01/10/13 at 2:14 PM, with the Maintenance Director revealed the facility did not have a flame retardant policy or documentation that newly introduced personal decorations for residents had been treated with a flame retardant. Interview, on 01/10/13 at 2:14 PM, with the Maintenance Director revealed they were not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated. Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was not aware decorations were required to be treated with flame retardant and the items were required to be documented. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1.	K 073	3) Administrator directed the Activities Director to start doing an inventory list of all resident seasonal decorative items that need to be treated with flame retardant and to maintain this documentation. Resident inventory list was completed on 2/20/13. Maintenance manager will treat all the inventoried items with an approved fire retardant spray. This work will be completed by 2/21/13. 3) Administrator re-educated and trained the Activity Director, Maintenance Manager, Dietary Supervisor, and Housekeeping Supervisor regarding the need for all facility seasonal decorations to be treated with flame retardant (each time) prior to being displayed. This needs to be coordinated with the Maintenance Manager so he can ensure all items have flame retardant protection before use. This requirement will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate. 5. Date of Completion: 2/22/2013	
K 074 SS=D		K 074		

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K 074 Continued From page 26
NFPA 13

Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4, 19.7.5.3

This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the privacy curtains, located within the shower rooms, were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey.

The findings include:

Observation, on 00/10/13 at 3:32 PM, with the Maintenance Director revealed the privacy curtain to the toilet within the shower room located in the East Shower Room, did not have mesh of 1/2 inch at the top.

Interview, on 01/10/13 at 3:32 PM, with the Maintenance Director revealed he was not sure why the old shower curtain was still in the building and he was aware of the requirements for shower curtains.

Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was aware of the

K 074

K0 74
SS=F
NFPA Life Safety Code Standard
Shower Curtain Standard

- 1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.
- 2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.
- 3) Administrator directed the Housekeeping Manager to check all shower curtains and cubicle curtains to ensure there is 1/2 inch mesh at top as to not obstruct sprinkler system. Housekeeping manager completed this task on 1/25/13 and no further curtains with less than 1/2 inch mesh was found. Clean inventory of shower and cubicle curtains were also checked with no unapproved curtains found. All shower curtains and cubicle curtain in use and in inventory have 1/2 inch mesh as required at the top as to not obstruct sprinkler operation
- 3) Administrator re-educated and trained the Housekeeping Manager regarding the need for all shower curtains and cubicle curtains to have 1/2 inch mesh at top of curtains in order to not impede the operation of the fire sprinkler system. Housekeeping Manager will educate all housekeeping staff

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K 074 Continued From page 27
requirements for curtains located within a shower room.

K 074 regarding this standard. This education will be completed by 2/1/13. The housekeeping manager and staff will continue to monitor curtains and linen inventory to assure that no shower or cubicle curtains are used in the center that do not have the 1/2 inch mesh at the top. This requirement will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.

5. Date of Completion: 2/22/2013

NFPA 13
Cubicle curtains;
Reference to:
NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition
19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler deflector; using a 1/2-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.
NFPA 101 LIFE SAFETY CODE STANDARD

K 104 SS=F Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.

This STANDARD is not met as evidenced by:
Based on fire damper testing record review and

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K 104	<p>Continued From page 28</p> <p>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 three (3) of three (3) smoke compartments, residents, staff and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey.</p> <p>The findings include:</p> <p>Fire Damper Testing Record review, on 01/10/13 at 2:14 PM with the Maintenance Director, revealed the facility did not have documentation that fire/smoke dampers had been tested within the last four (4) years</p> <p>Interview, on 01/10/13 at 2:14 PM, with the Maintenance Director revealed they were not aware of the requirements for fire/smoke damper testing.</p> <p>Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed they were not aware of the requirements for fire/smoke damper testing.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and</p>	K 104	<p>NFPA Life Safety Code Standard Fire Dampers</p> <p>1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56.</p> <p>2) No other residents were identified as having been affected; however on the date of this inspection the census was 56.</p> <p>3) Maintenance manager contacted Springfield Heating and Cooling, Inc. to come to the facility check all fire dampers; map the location of all fire dampers, and test the dampers. All fire dampers were checked and tested on 1/30/13 by contractor. No problems were identified with dampers. Documentation was obtained from the contractor regarding dampers being tested. This documentation is on file in the maintenance managers office.</p> <p>4) Administrator re-educated and trained the Maintenance Manager, regarding the need for all facility fire dampers to be checked and tested at least every 4 years. Next required damper check will be scheduled for 1/2017. This requirement will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for fire damper checks every 4 years. If at any time concerns are identified the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate.</p> <p>5. Date of Completion: 2/22/2013</p>	

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K 104 Continued From page 29
the smoke barrier shall meet one of the following conditions:
a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.
b. It shall be protected by an approved device that is designed for the specific purpose.
(2) 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 meet one of the following conditions:
a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier.
b. It shall be protected by an approved device that is designed for the specific purpose.
(3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:
a. It shall be made on either side of the smoke barrier.
b. It shall be made by an approved device that is designed for the specific purpose.
8.3.6.2
Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions:
(1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier.
(2) It shall be protected by an approved device that is designed for the specific purpose.

Reference: NFPA 90A (1999 edition)

K 104

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K 104	Continued From page 30 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		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff, and visitors. The facility is certified for seventy (70) beds with a census of fifty six (56) on the day of the survey. The facility failed to ensure the proper use of power strips and multi-plug adapters. The findings include: Observations, on 01/10/13 between 12:00 PM and 4:00 PM, with the Maintenance Director revealed: 1) Three (3) battery chargers were plugged into a power strip located in the employee lounge. 2) A power strip was plugged into a multi-plug	K 147	K147 SS=E NFPA Life Safety Code Standard Electrical Wiring 1) No specific residents were cited in the statement of deficiency as having been affected; however, on the date of this inspection the census was 56. 2) No other residents were identified as having been affected; however on the date of this inspection the ccnsus was 56. 3) AM Electrical provided Administrator with a quote to provide the needed upgrade to electrical wiring in the employee break room where 3 battery charges are located. The multi-plug adaptor that was found in the dietary office was removed on 1/11/13. The refrigerator that was plugged into a power strip has been also quoted in the electrical contractor bid. This work will be completed by 2/18/13. The maintenance manager did a survey of all outlets to report any other areas or outlets found to be out of compliance. All items were immediately corrected when found. No issues identified.	

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K 147	Continued From page 31 adapter located in the Dietary Office. 3) A refrigerator was plugged into a power strip located in the MDS Office. Interview, on 01/10/13 between 12:00 PM and 4:00 PM, with the Maintenance Director revealed they were aware of the proper use of power strips and multi-plug adapters but it was hard to monitor. Interview, on 01/10/13 at 4:00 PM, with the Administrator revealed she was aware of the proper use of power strips and multi-plug adapters. Reference: NFPA 101 (2000 Edition) 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 approval by the authority having jurisdiction. 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	K 147	3) Administrator re-educated and trained the Maintenance Manager, Dietary Supervisor, and Housekeeping Supervisor regarding the standard for electrical wiring and the proper use of power strips and multi-plug adaptors. 4) This requirement will be reported to the quality improvement committee where results will be reviewed and monitored by the quality improvement committee for ensuring on-going compliance for the next 3 months. If at any time concerns are identified during this monitoring process, the Quality Improvement committee will be convened to analyze and recommend any further interventions and actions as deemed appropriate. 5. Date of Completion: 2/22/2013		

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K 147	Continued From page 32 Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D 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.	K 147		