

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

PRINTED: 06/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185271</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/14/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GLENVIEW HEALTH CARE FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1002 GLENVIEW DR. GLASGOW, KY 42141</b>		
(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 recertification survey was conducted 06/12/13 through 06/14/13 to determine the facility's compliance with Federal requirements. The facility met the minimum requirements for recertification with no regulatory violations identified.	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: 1961.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1963, upgraded in 2003 with 4 smoke detectors and 2 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1961 and upgraded in 1986.</p> <p>GENERATOR: Type II generator installed in 2008. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 06-13-13. Glenview Health Care Facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Sixty (60) beds with a census of Fifty-Eight (58) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000	<p>The submission of this plan of correction does constitute an admission of guilt by the facility of the cited deficiencies or any violation of a regulation or a standard of care. Also, we reserve the right to take further action, including any and all legal means necessary, to resolve any dispute about the accuracy of this information.</p> 	

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

*[Handwritten Signature]*

Administrator

TITLE

07-25-2013

(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	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000			
K 038 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. 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 the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, twenty-eight (28) residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Eight (58) on the day of the survey. The facility failed to ensure the exit at the end of the short hall had a durable surface to the public way.  The findings include:  Observation, on 06/13/13 at 12:10 PM with the Maintenance Supervisor, revealed the exit at the back of the short hall does not have a 4' wide durable surface to a public way.	K 038	NFPA 101 life Safety Code Standard 7.1 19.2.1 1. Kenneth Cowles Concrete will be installing a 4 foot concrete walkway from the steps of the deck at the end of short hall to the existing concrete walkway that is connecting the back of nursing facility to the back that houses several offices. Installation will begin on 07-29-2013. 2. The Maintenance Director will check all surfaces from exits to ensure that are are of durable surface 4 feet wide. 3. The Maintenance Director will check all surfaces yearly and report to the Administrator. 4. The Administrator will report the findings from the Maintenance Director yearly to the QA committee for a period of 12 months.	08-07-2013	

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K 038	<p>Continued From page 2</p> <p>Interview, on 06/13/13 at 12:10 PM with the Maintenance Supervisor, revealed he was unaware exits require a durable path to the public way.</p> <p>Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1.</p> <p>Reference: NFPA 101 (2000 edition) 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. 7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times. 7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22</p>	K 038		

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K 038	Continued From page 3 and 23.	K 038		
K 047 SS=E	<p>CMS S&amp;C letter 5-38</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with section 7.10 with continuous 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. The deficiency had the potential to affect four (4) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Eight (58) on the day of the survey. The facility failed to ensure the exit paths were clearly marked in the facility.</p> <p>The findings include:</p> <p>Observation, on 06/13/13 at 10:10 AM with the Maintenance Supervisor, revealed egress paths were not properly marked above the cross-corridor doors in the long and short halls.</p> <p>Interview, on 06/13/13 at 10:10 AM with the Maintenance Supervisor, revealed he was unaware of the signage missing for the exits.</p> <p>Reference: NFPA 101 (2000 edition)</p>	K 047	<p>1.NFPA 101 Life Safety Code Standard 19.2.10.1</p> <ol style="list-style-type: none"> <li>1. The Maintenance Director installed missing signage for exits on 07-09-2013.</li> <li>2. The Maintenance Director checked all halls throughout the building to ensure that exit paths are marked throughout the facility.</li> <li>3. The Maintenance Director will check all exit signs monthly to ensure exit paths are clearly marked and report findings to the Administrator.</li> <li>4. The Administrator will submit findings to the QA committee monthly for a period of 12 months.</li> </ol>	08-07-2013

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K 047	Continued From page 4	K 047		
K 062 SS=F	<p>7.10.1.2* Exits. Exits, other than main exterior 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.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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 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 five (5) of five (5) smoke compartments, all residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Eight (58) on the day of the survey. The facility failed to ensure the interior of the pipe in the sprinkler system was maintained free of rust and silt and to ensure a partial trip test was conducted annually.</p> <p>The findings Include:</p> <p>Sprinkler report review, on 06/13/13 at 10:30 AM with the Maintenance Supervisor, revealed the facility failed flush the interior of the sprinkler</p>	K 062	<p>NFPA 101 Life Safety Code Standard 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <ol style="list-style-type: none"> <li>1. Kelley Fire Protection, Inc. will perform a flush of the interior of the sprinkler piping and the required trip test by August 7, 2013.</li> <li>2. The Maintenance Director will ensure the interior of the pipe in the sprinkler system is maintained free of rust and silt and will ensure a partial trip test is conducted annually.</li> <li>3. The Maintenance Director will check the pipes of the sprinkler system yearly and ensure that the trip test is completed yearly and will report the findings to the Administrator.</li> <li>4. The Administrator will submit the findings to the QA committee yearly.</li> </ol>	08-07-2013

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K 062	<p>Continued From page 5</p> <p>pipng. After the interior pipe was inspected in June 2012 a buildup of rust and silt were noted and a recommendation was made to flush the system.</p> <p>Interview, on 06/13/13 at 10:30 AM with the Maintenance Supervisor, revealed he was aware the system had not been flushed but was unaware that is was a requirement to follow the notes on the sprinkler system.</p> <p>Record review, on 06/13/13 at 10:45 AM with the Maintenance Supervisor, revealed the facility failed to provide documentation that the dry sprinkler system had a partial flow trip test performed since 6-6-12.</p> <p>Interview, on 06/13/13 at 10:45 AM with the Maintenance Supervisor, revealed the sprinkler company was due to come back in September for the next quarter inspection and he thought it would meet code as long as it was performed in the year at any time.</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p>	K 062			

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K 062	<p>Continued From page 6</p> <p>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 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</p>	K 062		

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K 062	Continued From page 7  Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps	K 062		

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K 062	Continued From page 8 Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually	K 062		

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K 062	Continued From page 9 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2  Reference: NFPA 25 (1998 Edition).  9-4.4.2.2.1* Every 3 years and whenever the system is altered, the dry pipe valve shall be trip tested with the control valve fully open and the quick-opening device, if provided, in service.  9-4.4.2.2.2* During those years when full flow testing in accordance with 9-4.4.2.2.1 is not required, each dry pipe valve shall be trip tested with the control valve partially open.	K 062		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure kitchen hood extinguishing system would activate the fire alarm. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Eight (58) on the day of the survey. The facility failed to ensure the kitchen hood suppression system was connected to the fire alarm.	K 069	NFPA 101 Life Safety Code Standard 9.2.3, 19.3.2.6, NFPA 96 1. Comstar Systems connected the range hood system to the fire alarm system on 07-22-2013. 2. The Maintenance Director will ensure the kitchen range hood suppression system will remain connected to the fire alarm system. 3. The Maintenance Director will check the range hood suppression system yearly to ensure that it is working properly and will report findings to the Administrator. 4. The Administrator will report findings to the QA committee yearly for a period of 12 months.	08-07-2013

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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
K 069	Continued From page 10  The findings include:  Kitchen Hood Inspection, on 06/13/13 at 9:00 AM with the Maintenance Supervisor, revealed the kitchen hood suppression system was not connected to the facilities fire alarm.  Interview, on 06/13/13 at 9:00 AM with the Maintenance Supervisor, revealed he was unaware of the requirement for the hood suppression system to be connected to the fire alarm. He also felt that when the fire alarm was updated in 2003 that they would have connected it properly when they were completing that work.  NFPA 1996 (1998 ed.) 7-6.2 Where a fire alarm signaling system is serving the occupancy where the extinguishing system is located, the activation shall activate the fire alarm signaling system.	K 069		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	NFPA 101 Life Safety Code Standard NFPA 99 4.3.1.1.2, 19.3.2.4  1. The facility purchased a separate storage building on 07-10-2013 and placed it on facility grounds for the storage of oxygen cylinders.  2. The Maintenance Director will ensure that Oxygen storage locations are kept in accordance with regulations.  3. The Maintenance Director will check oxygen storage monthly and report findings to the Administrator.  4. The Administrator will report findings to QA committee monthly for a period of 12 months.	08-07-2013

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

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FORM APPROVED  
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K 076	Continued From page 11  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for sixty (60) beds and the census was fifty eight (58) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored 5 feet away from any combustibles and ignition sources were located five (5) feet from the floor.  The findings include:  Observation, on 06/13/13 at 10:24 AM with the Maintenance Supervisor, revealed four (4) trans-filling oxygen tanks in the medical records room. The oxygen tanks were being stored within five (5) feet of combustible items, i.e. boxes, papers and files.  Interview, on 06/13/13 at 10:24 AM with the Maintenance Supervisor, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials once the storage equals over 300 cubic feet in a smoke compartment.  Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3)	K 076			

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K 076	<p>Continued From page 12</p> <p>(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.</p> <p>(e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations.</p> <p>(f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d.</p> <p>(g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13.</p> <p>(h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27.</p> <p>(i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations.</p>	K 076		

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K 076	Continued From page 13 (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076			
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;  (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2  This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect three (3) of five (5) smoke compartments, twenty-six (26) residents, staff and visitors. The facility is certified for Sixty (60) beds with a census of Fifty-Eight (58) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire	K 143	NFPA 101 Life Safety Code Standard 8.6.2.5.2 1. The Maintenance Director placed an order from Western Kentucky Door & Specialities Co. for a 1 hour fire rated door and frame for the oxygen trans-filling room. The Maintenance Director will install the door by 08-07-2013. 2. The Maintenance Director will ensure that the oxygen transferring room will have a fire rated door and frame. 3. The Maintenance Director will check the fire rated door and frame yearly to ensure they are in good working order and will submit findings to the Administrator. 4. The Administrator will submit findings to the QA committee yearly for a period of 12 months.	08-07-2013	

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K 143	<p>Continued From page 14</p> <p>rated door frame that had a 1 hour fire resistive rating.</p> <p>The findings include:</p> <p>Observation, on 06/13/13 at 10:15 AM with the Maintenance Supervisor, revealed the oxygen trans-filling room did not have a fire rated door or frame installed.</p> <p>Interview, on 06/13/13 at 10:15 AM with the Maintenance Supervisor, revealed he was unaware the door on the trans-filling oxygen room was required to be 1-hour fire rated.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and</p> <p>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</p> <p>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</p> <p>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and</p>	K 143		

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K 143	Continued From page 15 adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143			