



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

PRINTED: 11/09/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/14/2012
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437	
(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 371	Continued From page 1  Findings Include:  Observations of the kitchen, on 09/11/12 at 10:25 AM and 5:12 PM, revealed:  1. Food service thermometers were not tested for accuracy and were not calibrated.  2. A 55-gallon trash can, with debris noted around the outside of the trash can, blocked pathways from the stove to the steam table. Two staff members, who were not wearing aprons, were noted to come in contact with the trash can on their way to the steam table.  3. Mops and brooms were stored on the floor in the kitchen as well as the Soiled Utility Room.  4. Three out of six refrigerators and freezers were without inside thermometers.  An observation of the tray line and interview with the Dietary Manager, on 09/11/12 at 11:23 AM, revealed the digital thermometer used for testing the temperatures of the noon meal, were not tested for accuracy, as she was not aware the digitals had to be tested. The digital thermometer tested 41 degrees Farenheit (F) in ice water and should have tested at 32 degrees F. A second non-digital thermometer, tested 46 degrees F. The temperature of the meat for the noon meal could not be assessed, as the non-digital thermometer could not register a temperature above 160 degrees F. An interview, on 09/12/12 at 3:20 PM, with the Registered Dietician revealed the thermometers should be tested and the only ones used for temperature testing should	F 371	admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.  <b>F 371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITORY</b>  1. On 9/11/2012, the Dietary Service Manager calibrated all of the food thermometers to ensure that temperatures were accurate and could be tested in ranges from 32 to 220 degrees. The 55 gallon trash can was replaced on 9/14/2012 by a 32 gallon trash can and it is on wheels and fits under the sink to prevent staff from coming into contact with the trash can. The Dietary Service Manager observed food service on 9/14/12 and noted that the staff did not touch the trash can and that proper food service	10/30/12

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F 371	Continued From page 2 be calibrated to 32 degrees F and able to test up to 220 degrees F. He was not aware the thermometers were not being tested.  An interview, on 09/11/12 at 5:12 PM, with the Dietary Manager, revealed the trash can fit under the counter near the dishwasher, when it was not placed on wheels. However, the wheels made clean-up in the kitchen as well as transport to the dumpster easier. She was not aware the staff members came in contact with the trash can and then went to the steam table. Refrigerator and freezer temperatures were recorded at approximately 6:00 AM, and the Dietary Manager was unsure why the thermometers were missing.	F 371	handling techniques were used. Wall clamps were purchased and installed on 9/14/2012 to store mops and brooms off the floor in the kitchen and Soiled Utility room floor. An observation by the Dietary Service Manager on 9/14/12 noted the brooms and mops were stored correctly off of the floor. The thermometers for the three refrigerators and freezers were replaced on 9/11/2012. An observation by the Dietary Service Manager on 9/11/12 noted that the thermometers were in place and that the staff was completing the temperature logs correctly.		
F 372 SS=E	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to dispose of garbage and refuse properly.  Findings include:  Observations, on 09/11/12 at 10:25 AM and 5:12	F 372	2. On 9/11/2012, the Dietary Service Manager calibrated all of the food thermometers to ensure that the temperatures were accurate and could be tested in ranges from 32 to 220 degrees. The 55 gallon trash can was replaced on 9/14/2012 by a 32 gallon trash can and it is on wheels		

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F 372	<p>Continued From page 3</p> <p>PM, revealed the dumpster was noted to have three of six covers opened. The closed covers were ill-fitting and displayed opened gaps of three inches and four inches wide with numerous flies throughout the area.</p> <p>An interview with the Maintenance Director and the Dietary Manager, on 09/13/12 at 2:35 PM and 3:00 PM, respectively, revealed the closing of the dumpster lids was an ongoing problem and staff members were informed about closing the lids.</p>	F 372	<p>and fits under the sink to prevent staff from coming into contact with the trash can. The Dietary Service Manager observed food service on 9/14/12 and noted that the staff did not touch the trash can and that proper food service handling techniques were used. Wall clamps were purchased and installed on 9/14/2012 to store mops and brooms off the floor in the kitchen and Soiled Utility room floor. An observation by the Dietary Service Manager on 9/14/12 noted that the brooms and mops were stored correctly off of the floor. Thermometers for the three refrigerators and freezers were replaced on 9/11/2012. An observation by the Dietary Service Manager on 9/11/12 noted that the thermometers were in place and that the staff was completing the temperature logs correctly.</p> <p>3. On 9/12/2012, the dietary staff was re-educated on the</p>	

proper method of calibrating Bi-metallic stemmed thermometer and a procedure was placed on the dietary bulletin board. The Dietary staff was re-educated by the Dietary Service Manager related to wearing aprons and changing aprons when contaminated, use of thermometers, completion of temperature logs and placement of brooms and mops off of the floor.

4. The Dietary Service Manager will conduct audits and observations weekly to include calibration of the food thermometers, storage of brooms and mops, thermometers in place, temperature log completed and accurate and wearing and changing of aprons. These audits/observations will continue weekly for twelve (12) weeks at a minimum or until the Quality Assurance Committee deems

appropriate to decrease or stop. If at any time concerns are identified, the Quality Assurance Committee will convene for review and further recommendations. Results of the audits/observations will be reviewed with the Quality Assurance Committee monthly for at least three (3) months and will consist of at a minimum of the Administrator, the Director of Nursing, Assistant Director of Nursing and the Dietary Service Manager with the Medical Director attending at least quarterly.

5. Correction date: 10-26-2012

**F 372 DISPOSE GARBAGE &  
REFUSE PROPERLY**

1. A new dumpster with tighter fitting lids was ordered on 9/13/12 and delivered on 9/17/12. An observation by the Dietary Service Manager on 9/17/12

*10/30/12*

noted that the dumpster lids were closed correctly.

2. A new dumpster with tighter fitting lids was ordered on 9/13 and delivered on 9/17. An observation by the Dietary Service Manager on 9/17/12 noted that the dumpster lids closed correctly.
3. The checking of the dumpster will be part of the dietary staff's daily rounds to ensure that the lids are down and secure. Dietary staff were re-educated on this process by the Dietary Service Manager. Education on the correct placement of dumpster lids for Administrative, Nursing, Housekeeping and Laundry staff was completed on 10/17/12.
4. The Dietary Service Manager will conduct audits and observations weekly to include dumpster lid function. These audits/observations will continue weekly for twelve (12) weeks at a minimum or

until the Quality Assurance Committee deems appropriate to decrease or stop. If at any time concerns are identified, the Quality Assurance Committee will convene for review and further recommendations. Results of the audits/observations will be reviewed with the Quality Assurance Committee monthly for at least three (3) months and will consist of at a minimum of the Administrator, the Director of Nursing, Assistant Director of Nursing and the Dietary Service Manager with the Medical Director attending at least quarterly.

5. Correction date: 10-26-2012

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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: 1965.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1992 with 19 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system installed in 1966.</p> <p>GENERATOR: Type II generators installed in 2009. Fuel source is Liquid Propane.</p> <p>A standard Life Safety Code survey was conducted on 09/11/12 thru 09/12/12. Morganfield Nursing and Rehab Center 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-one (51) 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><b>NFPA 101 LIFE SAFETY CODE STANDARDS</b></p> <p>K 018</p> <ol style="list-style-type: none"> <li>On 9/21/12, a new door lock was put on room 8 by the Maintenance Director and now latches properly. On 9/27/12, a new door lock was put on room 22 by the Maintenance Director and it now latches properly as well. The hinged wooden gates on resident room # 11 and 17 were removed on 9/27/12 by the Maintenance Director and they now latch properly.</li> <li>On 9/29/12, a survey of all corridor doors was conducted by Maintenance Director. All doors were found to be in compliance and any wooden gates were removed and disposed of.</li> <li>On 10/1/12, Administrator in serviced the Maintenance Director on the requirements for NFPA 101</li> </ol>	10/26/12

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

*Avery G. Wood*

TITLE

*Administrator*

(X6) DATE

10/8/12

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	Continued From page 1	K 000			
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></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 1¾ 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 doors to resident rooms would latch properly in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, four (4) residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of</p>	K 018	<p>and door closures to include training that no impediment to the closing of the doors and door latching properly exists.</p> <p>4. The Maintenance Director will audit all corridor doors to assure that there are no impediments to door closure and that all corridor doors close and latch monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the</p>		

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K 018	<p>Continued From page 2</p> <p>the survey. The facility failed to ensure two (2) corridor doors to the resident rooms were latching properly and there were no wooden gates installed to resident rooms.</p> <p>The findings include:</p> <p>Observations, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed the corridor doors to rooms 8 and 22 would not latch properly.</p> <p>Interview, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, confirmed the observation of the doors not latching and revealed he was unaware these doors were not latching properly. The Maintenance Supervisor was aware that all resident room doors must latch in the event of an emergency.</p> <p>Observation, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed the facility had installed hinged wooden gates on resident room # 11 and 17, to prevent wandering residents from entering these rooms. Further observation revealed the gates when closed impede access to the room door to enable closure during a fire, if the resident room doors were fully opened.</p> <p>Interview, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed the facility had placed the gates on the resident room doorframes due to residents wandering into other resident rooms.</p> <p>Interview, on 09/12/12 at 11:00 AM with the</p>	K 018	<p>Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5. Competition date: 10/26/12</p> <p>K 025</p> <ol style="list-style-type: none"> <li>1. The identified penetrations in the smoke partitions and addition wall that does not extend to the roof will be repaired by 10-25-2012 by the Maintenance Director and/or a contractor.</li> <li>2. On 10/3/12, the Maintenance Director and a contractor audited the entire facility to identify any smoke barriers with penetrations. All identified areas will be repaired by 10-25-2012.</li> <li>3. The Maintenance Director was re-educated by the Administrator on the Life Safety Code for fire and smoke walls. This education will be completed by 10/8/12.</li> <li>4. The Maintenance Director will audit fire and smoke walls to assure there are no</li> </ol>	

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K 018	<p>Continued From page 3</p> <p>Administrator, revealed she was unaware of the doors not latching and wooden gates not being allowed. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</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 combustible materials.</p> <p>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.</p> <p>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</p>	K 018	<p>penetrations monthly for three (3) months then at least quarterly thereafter. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5. Completion date 10-25-2012</p> <p>K027</p> <p>1. The cross-corridor doors located at the front of hall 1</p>		

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K 018	Continued From page 4 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.  Reference: NFPA 101 (2000 Edition) 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	and hall 2 corridors will have a coordinating device installed on both doors so that they will close completely when tested. This device will be installed by 10-25-2012. 2. The cross-corridor doors located at the front of hall 1 and hall 2 corridors will have a coordinating device installed on both doors so that they will close completely when tested. This device will be installed by 10-25-2012. 3. The Administrator will re-educate the Maintenance Director on the requirement that the cross corridor doors located in a smoke barrier would resist the passage of smoke and close appropriately. 4. The Maintenance Director will audit all corridor doors to assure that doors close appropriately and resist the passage of smoke monthly for three (3) months. The results of the audits will be reviewed with the Quality		
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:	K 025			

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K 025	<p>Continued From page 5</p> <p>Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure the smoke barriers were sealed around pipes and wires.</p> <p>The findings include:</p> <p>Observations, on 09/11/12 between 11:00 AM and 12:00 PM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located throughout the facility, were penetrated by pipe, wires and manholes through the walls. Further observation revealed the fire wall for the addition did not extend to the roof.</p> <p>Interview, on 09/11/12 between 11:00 AM and 12:00 PM with the Maintenance Supervisor, revealed he was aware of the manholes in the smoke barriers but was not aware of the penetrations by pipes and wires. Further interview revealed he was unaware the fire wall did not extend to the roof of the facility.</p> <p>Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the penetrations in the smoke barriers. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</p>	K 025	<p>Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least Quarterly.</p> <p>5. Completion date: 10/26/12</p> <p>K 029</p> <p>1. The CRC office, ADON office, DON office, Administrator office, Business office, Medical Records and Maintenance Supervisor office will have a closer added to the door by 10/25/2012.</p>	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  09/12/2012
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437		
(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 025	Continued From page 6  Reference: NFPA 101 (2000 Edition).  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: (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	2. On 10/3/2012, the contractor assessed the office doors for the need of a closer and to identify any other areas in need of closer to door. Any needed repairs will be completed by 10-25-2012.  3. The Administrator will re-educate the Maintenance Director by 10/25/2012 related to the requirement of having a closer on the door with rooms that have storage of combustible items.  4. The Maintenance Director will audit all rooms to assure that any room that stores combustible materials has a self-closer on the door monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive	K 027			

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K 027	Continued From page 7 latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure the cross corridors doors would close properly once the fire alarm released them from the magnetic locks.  The findings include:  Observation, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at the front of the hall 1 and hall 2 corridors would not close completely when tested. This was due to the doors not having a coordinating device installed on the doors.  Interview, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed he was unaware the doors needed a coordinating device to ensure the door without the astragal would always close first.  Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware the doors were not closing properly. She stated she	K 027	convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly. 5. Completion date: 10/26/12		
			K 045  1. The facility will install emergency lights with two (2) bulbs at back exits of hall 1 and 2 by 10-25-2012. 2. An audit of all exit lights will be completed by the Maintenance Supervisor by 10-25-2012 to assure all have at least two (2) bulbs. Any identified concerns will be corrected by 10-25-2012..		

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K 027	Continued From page 8 relies on the Maintenance Supervisor for Life Safety Code and she was unaware of any training he has performed on Life Safety Code. Further interview revealed the Tels program did not address the cross-corridor doors.  NFPA Standard: NFPA 101, 19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: NFPA 80 (1999 Edition)  2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.  Reference: NFPA 101 (2000 edition)  8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.	K 027	3. The Administrator will re-educated the Maintenance Director by 10-25-2012 related to requirement for all exit will be lighted with at least two (2) bulbs and will be checked monthly. 4. The Maintenance Supervisor will check all exit doors for proper lighting one (1) time per month for three (3) months for continued compliance. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When	K 029		

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K 029	Continued From page 9 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure eight (8) rooms were properly protected due to the storage in the rooms.  The findings include:  Observation, on 09/11/12 and 09/12/12 between 12:00 PM and 10:00 AM with the Maintenance Supervisor, revealed the CRC office, ADON office, DON office, Administrator office, Business office, medical records, and Maintenance Supervisor office did not have a closer added to the door. This requirement is due to the storage of combustible items inside the areas.  Interview, on 09/11/12 and 09/12/12 between 12:00 PM and 10:00 AM with the Maintenance	K 029	Maintenance Director with the Medical Director attending at least quarterly. 5. Completion date: 10/26/12  K 050  1. The Administrator will observe by 10/25/12 that fire drills were being conducted at unexpected times and under varying conditions. 2. The Administrator will observe by 10/25/12 that fire drills were being conducted at unexpected times and under varying conditions 3. On 10/1/12, the Administrator in serviced the Maintenance Supervisor on having fire drills conducted at unexpected times and under varying conditions.	

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K 029	<p>Continued From page 10</p> <p>Supervisor, revealed he was unaware the storage in a room determined whether the room was a hazardous storage area or not.</p> <p>Interview on 09/12/12 at 11:00 AM with the Administrator, revealed she relies heavily on the Maintenance Supervisor for Life Safety. The facility does use the Tels program to log various life safety checks. She was unaware of any training that the Maintenance Supervisor would have attended for Life Safety Code. The Tels program does not address hazardous storage areas.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops (4) Repair shops (5) Soiled linen rooms</p>	K 029	<p>4. The Administrator will audit fire drill times monthly for three (3) months to assure that they are conducted at unexpected times under varying conditions. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5. Completion date: 10/26/12</p>	
			K 054	

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K 029	Continued From page 11 (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	<ol style="list-style-type: none"> <li>All battery powered smoke detectors were tested on 10/8/12 by the Maintenance Director and all battery powered smoke detectors were cleaned by the Maintenance Director on 10/08/12.</li> <li>All battery powered smoke detectors were tested on 10/8/12 by the Maintenance Director and all battery powered smoke detectors were cleaned by the Maintenance Director on 10/08/12.</li> <li>The battery smoke detectors will be tested weekly and monthly cleaning was added to center's TELs program on 10/8/12. The Maintenance Director will be re-educated by the Administrator by 10-25-2012 on completing a weekly check and monthly cleaning of the battery powered smoke detectors.</li> <li>The Maintenance Director will perform testing per regulations on the TELS program. The Administrator</li> </ol>	
K 045 SS=E	<p>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</p> <p>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 three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure the emergency lights had two (2) bulbs at the back exits of halls 1 and 2.</p> <p>The findings include:</p>	K 045		

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K 045	Continued From page 12  Observation, on 09/11/12 at 12:31 PM with the Maintenance Supervisor, revealed the exterior exits at the back of building only had a single light for illumination of the outside of the exit.  Interview, on 09/11/12 at 12:31 PM with the Maintenance Supervisor, revealed he was unaware the lighting fixtures serving the exterior exits must include more than one bulb for illumination of the egress path.  Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she relies heavily on the Maintenance Supervisor for Life Safety. The facility does use the Tels program to log various life safety checks. She was unaware of any training that the Maintenance Supervisor would have attended for Life Safety Code. The Tels program does not address the requirement of two (2) exterior lights at an exit.  Reference: NFPA 101 (2000 edition) 7.B.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	will audit the TELS program for completion monthly for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.. 5. Completion date: 10/26/12	
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	K 050	K 056  1. The sprinkler heads located in the dining room, the lounge	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 050	<p>Continued From page 13</p> <p>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</p> <p>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 four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure the fire drills on second and third shift were conducted at random times.</p> <p>The findings include:</p> <p>Fire Drill review, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed the fire drills were not being conducted at random times on second and third shift. Fire drills on second shift were conducted routinely between 3:12 PM and 3:50 PM and third shift routinely between 1:30 AM and 3:00 AM.</p> <p>Interview, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed he was unaware the fire drills were not being conducted as required. The Maintenance Supervisor was unaware of the time separation on each shift to consider the times unexpected.</p>	K 050	<p>area, the front corridor and rooms 24, 25, 29, 31, 33 and 34 will be moved by 10/15/12 and will no longer be blocked by light fixtures, are not within one (1) foot of a sprinkler head and do not extend below the sprinkler head. The sprinkler head in soiled utility room on hall one has been moved and is no longer two (2) inches from the wall. This will be verified by the Maintenance Director by 10/15/12</p> <ol style="list-style-type: none"> <li>Armor Fire Protection completed a facility wide audit on 9/28/12 and located any and all sprinkler heads that were out of compliance. An order was placed on 10/1/12 for twenty two (22) sprinkler heads and will arrive in seven to ten days. All identified concerns will be corrected by 10-25-2012.</li> <li>The Administrator re-educated the Maintenance Director on 10/8/12 on the Life Safety code for clearance of sprinkler head spray and placement.</li> </ol>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 050	Continued From page 14 Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she relies heavily on the Maintenance Supervisor for Life Safety. The facility does use the Tels program to log various life safety checks. She was unaware of any training that the Maintenance Supervisor would have attended for Life Safety Code. The Tels program does log the fire drills at the facility but it did not check for time variations.  Reference: NFPA 101 (2000 edition)  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	4. <b>Armor Fire Protection</b> will complete routine audits of sprinkler heads including placement where ever needed. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure smoke detectors were inspected and tested in accordance with NFPA Standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure that the battery powered smoke detectors in each resident room were being properly tested and	K 054	5. Completion date: 10/26/12  K 062  1. The resident closets top shelves in rooms #14, 11, 21, 23, and 28 were cleaned	

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K 054	<p>Continued From page 15 cleaned.</p> <p>The findings include:</p> <p>Record review, on 09/11/12 between 12:00 PM and 1:15 PM with the Maintenance Supervisor, revealed no documentation of Smoke Detector weekly testing or monthly cleaning of the smoke detectors since June 30, 2012. Smoke detectors must be tested according to the manufacturer ' s specifications to ensure their reliability. The manufacturer of these smoke detectors recommended a weekly check of the smoke detectors and a monthly cleaning of the detector.</p> <p>Interview, on 09/11/12 between 12:00 PM and 1:15 PM with the Maintenance Supervisor, revealed he was unaware the facility did not have current checks of the smoke detectors. The company changed owners after June the 30th and the new companies ' version of the Tels program did not contain the smoke detector checks like the previous.</p> <p>Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the smoke detectors not being properly maintained. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</p> <p>Reference: NFPA 72 (1999 ed.) 7-4.1 Fire alarm system equipment shall be maintained in accordance with the manufacturer ' s instructions. The frequency of maintenance shall depend on the type of</p>	K 054	<p>by the Housekeeping Supervisor and storage items are no longer within 18 " of sprinkler head as observed by the Administrator on 9/21/12.</p> <ol style="list-style-type: none"> <li>All resident closets top shelves have been cleaned and storage items are no longer within 18" of sprinkler head will be observed by the Administrator before 10/26/12.</li> <li>The Housekeeping Supervisor was re-educated by the Administrator on 10/2/12 that all items in resident closets have to not be within 18" of sprinkler head. The housekeeping rounds sheet will include that resident top shelves will have no storage items within 18" of sprinkler head. The housekeeping staff will be re-educated by the Housekeeping Supervisor on keeping items below the eighteen inch clearance in resident closets. This education will</li> </ol>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185328	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/12/2012
NAME OF PROVIDER OR SUPPLIER  MORGANFIELD NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH CARRIER ST. MORGANFIELD, KY 42437	
(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 054	Continued From page 16 equipment and the local ambient conditions.	K 054	be completed by 10-25-2012.	
K 056 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to ensure complete sprinkler coverage in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure the sprinkler heads were not blocked by light fixtures end located at least 4 in from a wall.</p> <p>The findings include:</p> <p>Observations, on 09/11/12 and 09/12/12 between 12:00 PM and 10:00 AM with the Maintenance</p>	K 056	<p>4. The Housekeeping Supervisor will audit all closets weekly for four (4) weeks then monthly for two (2) months to ensure that there is at least eighteen inches of clearance from the sprinkler heads. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.</p>	

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K 056	<p>Continued From page 17</p> <p>Supervisor, revealed the sprinkler heads located in the Dining room, the lounge area, and the front corridor were blocked by light fixtures, within 1 foot of the sprinkler head, extending below the sprinkler heads. Further observation revealed the sprinklers were blocked by light fixtures in rooms# 24, 25, 29, 31, 33, and 34.</p> <p>Interview, on 09/11/12 and 09/12/12 between 12:00 PM and 10:00 AM with the Maintenance Supervisor, revealed he was unaware that the light fixtures could block the spray pattern of the sprinkler head. The sprinkler company was contacted and confirmed the NFPA standard that any fixture cannot be within 1 foot of a sprinkler head and extend below the sprinkler head.</p> <p>Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the blocked sprinkler heads in the facility. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</p> <p>Observation, on 09/11/12 at 12:15 PM with the Maintenance Supervisor, revealed a sprinkler head in the soiled utility room on hall 1 was installed 2 inches from the wall.</p> <p>Interview, on 09/11/12 at 12:15 PM with the Maintenance Supervisor, revealed he was unaware of the requirement that a sprinkler head must be installed at a minimum of 4 inches from any wall.</p> <p>Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the</p>	K 056	<p>5. Completion date: 10/26/12</p> <p>K066</p> <ol style="list-style-type: none"> <li>1. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available at the smoker's porch and the dietary entrance door now has a smoker's urn as observed by the Administrator on 10/1/12.</li> <li>2. All smoking areas were audited by the Maintenance Director on 10/1/12. Smoking devices that do not meet standards were removed and no longer used per Maintenance Supervisor on 9/18/12.</li> <li>3. The Maintenance Director will be re-educated by the Administrator on the requirement that Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available. This re-education will be completed by 10-25-2012</li> </ol>	

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K 056	<p>Continued From page 18</p> <p>sprinkler head installed to close to the wall in the soiled utility room. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</p> <p>Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)</p> <table border="0"> <thead> <tr> <th style="text-align: right;">Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)</th> <th style="text-align: right;">Maximum Allowable Distance of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr><td>Less than 1 ft</td><td>0</td></tr> <tr><td>1 ft to less than 1 ft 6 in.</td><td>2 1/2</td></tr> <tr><td>1 ft 6 in. to less than 2 ft</td><td>3 1/2</td></tr> <tr><td>2 ft to less than 2 ft 6 in.</td><td>5 1/2</td></tr> <tr><td>2 ft 6 in. to less than 3 ft</td><td>7 1/2</td></tr> <tr><td>3 ft to less than 3 ft 6 in.</td><td>9 1/2</td></tr> <tr><td>3 ft 6 in. to less than 4 ft</td><td>12</td></tr> <tr><td>4 ft to less than 4 ft 6 in.</td><td>14</td></tr> <tr><td>4 ft 6 in. to less than 5 ft</td><td>16 1/2</td></tr> <tr><td>5 ft and greater</td><td>18</td></tr> </tbody> </table> <p>For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a).</p>	Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Maximum Allowable Distance of Deflector Obstruction (in.)	Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18	K 056	<p>4. The Maintenance Supervisor will continue to monitor smoking areas on a monthly basis for three (3) months. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5. Completion date: 10/26/12</p> <p>K 069</p> <p>1. The class k fire extinguisher in the kitchen is no longer</p>	
Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	Maximum Allowable Distance of Deflector Obstruction (in.)																									
Less than 1 ft	0																									
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K 056	Continued From page 19 Reference: NFPA 13 (1999 ed.) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.	K 056	blocked because the cart with a plugged in mixer on it was removed as observed by the Dietary Service Manager on 9/12/12.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation, interview, and sprinkler testing record review it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure no storage was within 18 " of a sprinkler head.  The findings Include:  Observation, on 09/11/12 and 09/12/12 between 12:00 PM and 10:00 AM with the Maintenance Supervisor, revealed the closets in the resident rooms had a top shelf with storage. The storage was within 18 inches of the sprinkler head in rooms# 14, 11, 21, 23, and 28.  Interview, on 09/11/12 and 09/12/12 between 12:00 PM and 10:00 AM with the Maintenance Supervisor, revealed he was aware of the	K 062	2. The kitchen was inspected by the Dietary Service Manager on 9/14/12 to make sure that the two (2) fire extinguishers in the kitchen were: 1) located in designated place; 2) No obstruction to access or visibility; 3) Operating instruction on nameplate legible and facing forward; 4) Safety seals and tamper indicators not broken or missing; 5) Fullness determined by weighing or "hefting "; 6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle; 7) Pressure gauge reading or indicator in the operable range or position, and 8) HMIS label in place. No further concerns were identified.  3. Dietary staff were re-educated on the requirement	

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K 062	<p>Continued From page 20</p> <p>distance requirement from sprinkler heads but was not aware the closet shelves in the resident rooms had storage within 18 " of sprinkler heads.</p> <p>Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the storage in the resident closets was too close to the sprinkler heads. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</p> <p>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</p>	K 062	<p>that fire extinguishers in the kitchen are not to be blocked by cart or any other item. This re-education was completed by Administrator on 10/2/12.</p> <p>4. The Dietary Service Manager will complete weekly "Quick Kitchen Sanitation Rounds" to ensure that the fire extinguishers are not blocked weekly for twelve (12) weeks. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the</p>	

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K 062	Continued From page 21 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.  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.	K 062	Maintenance Director with the Medical Director attending at least quarterly. 5. Completion date:10/26/12	
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	K 066	K 072  1. Wheelchairs and lifts are properly stored out of the corridor when not in use as observed by the Administrator on 10/17/12. 2. An observation by the Administrator on 10/17/12 noted that the means of egress are free of obstructions and impediments. 3. Nursing staff were re-educated on proper storage of lifts and wheel chairs and the requirement to keep the means of egress clear of obstacles and impediments. This re-education was completed by Administrator and will be completed by 10-25-2012. 4. The Administrator, Housekeeping Supervisor or Maintenance Director will conduct audits of all	

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K 066	<p>Continued From page 22 design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure they had a self-closing metal container to dump ashtrays into.</p> <p>The findings include:</p> <p>Observation, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed the ashtrays located at the smokers porch and the dietary entrance door did not have a metal container with a self-closing lid to dispose of the cigarette butts.</p> <p>Interview, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed he was not aware of the requirement for self-closing metal bucket to empty the ashtrays</p>	K 066	<p>means of egress five (5) times per week for four (4) weeks then weekly for eight (8) weeks to assure that all means of egress are clear of obstacles or impediments. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5. Completion date: 10/26/12</p> <p>K 074</p>	

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K 066	Continued From page 23 into.  Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the requirement of a metal bucket with a self-closing lid to dump ashtrays into. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.  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 066	1. Privacy curtains in facility's shower room on hall one and hall two will be corrected by 10/25/12 and replaced with ½ in (1.3 cm) diagonal mesh with design to have a horizontal and minimum vertical distance that meets the requirement of NFPA 13 and will be observed by the Administrator by 10/25/12. 2. The Maintenance Director completed a complete facility audit of privacy curtains on 10/2/12 to ensure all privacy curtains meet the NFPA standard any identified concerns were immediately corrected.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the installation of portable fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, no residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure the class k fire extinguisher in the kitchen was not blocked.  The findings include:	K 069	3. The Maintenance Director was re-educated by the Administrator on 10/2/12 on the NFPA standards for privacy curtains. 4. The Maintenance Director will complete monthly audits of all privacy curtains for three (3) months to assure they meet the standards for clearance.	

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K 069	<p>Continued From page 24</p> <p>Observations, on 09/11/12 at 12:04 PM with the Maintenance Supervisor, revealed the wall mounted, Class K portable fire extinguisher in the Kitchen was blocked by a cart with a plugged in mixer on it.</p> <p>Interview, on 09/11/12 at 12:04 PM with the Maintenance Supervisor, revealed he was unaware the fire extinguisher was blocked. Further interview revealed he was under the impression if the object was on wheels it could be placed in front of the fire extinguisher.</p> <p>Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the blocked fire extinguisher in the kitchen. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</p> <p>Reference: NFPA 10 6.2.1* Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected, manually or by electronic monitoring, at more frequent intervals when circumstances require. 6.2.2* Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Operating instructions on nameplate legible and facing outward (4)* Safety seals and tamper indicators not broken or missing (5) Fullness determined by weighing or " hefting</p>	K 069	<p>The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly.</p> <p>5. Completion date: 10/26/12</p>	
		K 147		

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

PRINTED: 09/28/2012  
FORM APPROVED  
OMB NO. 0938-0391

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K 069	Continued From page 25	K 069		
K 072 SS=E	<p>(6) Examination for obvious physical damage, corrosion, leakage, or clogged nozzle</p> <p>(7) Pressure gauge reading or indicator in the operable range or position</p> <p>(8) Condition of tires, wheels, carriage, hose, and nozzle checked (for wheeled units)</p> <p>(9) HMIS label in place</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure wheelchairs and lifts were properly stored out of the corridor when not in use.</p> <p>The findings include:</p> <p>Observation, on 09/11/12 between 11:00 AM and 12:15 PM with the Maintenance Supervisor, revealed a lift was stored in the exit corridor of</p>	K 072	<ol style="list-style-type: none"> <li>The laundry area will be cleared within three (3) feet of the electrical panel as observed by the Maintenance Director by 10/25/12. The twenty three (23) electrical items listed on the 2567 page 31 will be corrected as observed by the Maintenance Director by 10/25/12.</li> <li>An audit of all electrical panels as well as a complete facility audit to identify any blocked electrical panels without a three (3) foot clearance and any power strips used inappropriately or broken missing receptacle covers. Any identified areas will be corrected by 10-25-2012.</li> <li>The Administrator re-educated the Maintenance Director on 10/8/12 on the requirement for NFPA 70 to include clearance of electrical panels as well as repair of receptacle covers and use of power strips.</li> <li>The Maintenance Director will audit all rooms in the</li> </ol>	

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

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K 072	Continued From page 26 hall 1 from 11:00 AM to 12:15 PM. Further observation revealed several wheelchairs stored from 11:00 AM to 12:15 PM in the front corridor by the dining room.  Interview, on 09/11/12 between 11:00 AM and 12:15 PM with the Maintenance Supervisor, revealed the facility routinely stored the wheelchairs at the dining area during meal times. Further interview revealed he was aware the lift should not be stored in the corridor and it had a usual storage spot in a shower room.  Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was aware of the wheelchairs routinely being stored in the corridor during meal times. She stated it was part of their walk to dine program. The wheelchairs are generally stored in the corridor for an hour to an hour and a half. She was unaware the maximum allowed time for corridor storage is thirty (30) minutes. She was unaware of the lift stored in the corridor was unaware of why it was not stored in the shower room.  This is a repeat deficiency.  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 072	center for broken receptacle covers, inappropriate use of power strips and blocked electrical panels monthly on an ongoing basis. The results of the audits will be reviewed with the Quality Assurance Committee monthly for at least three (3) months or until the committee deems appropriate to decrease. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a least the Administrator, Director of Nursing, Assistant Director of Nursing and the Maintenance Director with the Medical Director attending at least quarterly. 5. Completion date: 10/26/12		
K 074 SS=E	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	K 074			

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

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K 074	<p>Continued From page 27</p> <p>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.</p> <p>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, NFPA 13</p> <p>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</p> <p>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 four (4) smoke compartments, thirty-six (36) residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure shower curtains were at proper heights for sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed the one of privacy curtains within the</p>	K 074			

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

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K 074	<p>Continued From page 28</p> <p>shower room located on hall 1, was of a solid fabric with no mesh for sprinkler coverage. Further observation revealed the other shower curtain to have 10 inches of mesh at the top of the shower curtain.</p> <p>Interview, on 09/11/12 between 12:00 PM and 4:45 PM with the Maintenance Supervisor, revealed he was unaware the shower curtains must contain 18 " of mesh or be hung 18 " below the sprinkler head so that the top of the curtain does not obstruct the spray pattern of the sprinkler heads.</p> <p>Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the improper shower curtains located in the shower room of hall 1. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</p> <p>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 ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler</p>	K 074			

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

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K 074	Continued From page 29 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.	K 074			
K 147 SS=F	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 four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for sixty (60) beds with a census of fifty-one (51) on the day of the survey. The facility failed to ensure electrical panels maintained three (3) feet of clearance around them and power strips were being used properly.  The findings include:  Observations, on 09/11/12 at 12:44 PM with the Maintenance Supervisor, revealed the electrical panels in the laundry area had storage of paper, clean linen, a folding table, a clean linen cart, a labeling machine, and cardboard within 3 feet of the electrical panels.	K 147			

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

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K 147	<p>Continued From page 30</p> <p>Interview, on 09/11/12 at 12:44 PM with the Maintenance Supervisor, revealed he was unaware there could not be storage within 3 feet of electrical panels.</p> <p>Observations, on 09/11/12 and 09/12/12 between 12:00 PM and 10:00 AM with the Maintenance Supervisor, revealed:</p> <ol style="list-style-type: none"> <li>1) Two (2) power strips were plugged into a multi-plug adapter located in the CRC office.</li> <li>2) An oxygen concentrator was plugged into a power strip located in room# 9.</li> <li>3) A bed was plugged into a multi-plug adapter located in room# 8.</li> <li>4) A tube feeder was plugged into a power strip located in room# 5.</li> <li>5) A bed was plugged into a power strip located in room# 15.</li> <li>6) An oxygen concentrator was plugged into a multi-plug adapter located in room# 14.</li> <li>7) A bed was plugged into a multi-plug adapter located in room# 12.</li> <li>8) A power strip was plugged into a multi-plug adapter located in the Business Office.</li> <li>9) Two (2) beds were plugged into a multi-plug adapter located in room# 20.</li> <li>10) A power strip was plugged into a multi-plug adapter located in the medical records office.</li> <li>11) A receptacle cover was missing on an outlet located in room# 4.</li> <li>12) A receptacle cover was broken on an outlet located in room# 17.</li> <li>13) A receptacle cover was broken on an outlet located in the administrator 's closet.</li> <li>14) A receptacle cover was missing on an outlet located in room# 26.</li> <li>15) An air purifier was plugged into a multi-plug</li> </ol>	K 147		

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

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FORM APPROVED  
OMB NO. 0938-0391

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K 147	<p>Continued From page 31</p> <p>adapter located in room# 21.</p> <p>16) A bed was plugged into a multi-plug adapter located in room# 23.</p> <p>17) A bed was plugged into a multi-plug adapter located in room# 25.</p> <p>18) A refrigerator was plugged into a multi-plug adapter located in the Activities Office.</p> <p>19) A bed was plugged into a multi-plug adapter located in room# 29.</p> <p>20) Two (2) beds were plugged into a multi-plug adapter located in room# 30.</p> <p>21) An oxygen concentrator and a feeding tube were plugged into a power strip located in room# 33.</p> <p>22) Two (2) beds and a mini nebulizer were plugged into a multi-plug adapter located in room# 34.</p> <p>23) A power strip was plugged into a multi-plug adapter located in the front lounge next to the fish tank.</p> <p>Interview, on 09/11/12 and 09/12/12 between 12:00 PM and 10:00 AM with the Maintenance Supervisor, revealed he was unaware the multi-plug adapters being used throughout the facility could not be used like a hard wired multi-plug. Further interview revealed he was unaware of the broken outlet covers in the facility.</p> <p>Interview, on 09/12/12 at 11:00 AM with the Administrator, revealed she was unaware of the blocked electrical panels in the laundry area and the improper electrical use throughout the facility. She stated she relies on the Maintenance Supervisor for Life Safety and she was unaware of any training provided to the Maintenance Supervisor for Life Safety Code.</p>	K 147			

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

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K 147	<p>Continued From page 32</p> <p>Reference: NFPA 99 (1999 edition) 110.26. Spaces</p> <p>10.26 Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>(A) Working Space. Working space for equipment operating at 600 volts, nominal, or less to ground and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2), and (3) or as required or permitted elsewhere in this Code.</p> <p>(1) Depth of Working Space. The depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) unless the requirements of 110.26(A)(1)(a), (b), or (c) are met. Distances shall be measured from the exposed live parts or from the enclosure or opening if the live parts are enclosed.</p> <p>Table 110.26(A)(1) Working Spaces</p> <table border="1"> <thead> <tr> <th>Nominal Voltage to Ground</th> <th colspan="3">Minimum Clear Distance</th> </tr> <tr> <th>Condition 1</th> <th>Condition 2</th> <th colspan="2">Condition 3</th> </tr> </thead> <tbody> <tr> <td>0-150 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> <td>900 mm (3 ft)</td> </tr> <tr> <td>151-600</td> <td>900 mm (3 ft)</td> <td colspan="2">1 m (3½ ft)</td> </tr> <tr> <td></td> <td></td> <td colspan="2">1.2 m (4 ft)</td> </tr> </tbody> </table> <p>Note: Where the conditions are as follows: Condition 1 - Exposed live parts on one side and no live or grounded parts on the other side of the working space, or exposed live parts on both sides effectively guarded by suitable wood or</p>	Nominal Voltage to Ground	Minimum Clear Distance			Condition 1	Condition 2	Condition 3		0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	151-600	900 mm (3 ft)	1 m (3½ ft)				1.2 m (4 ft)		K 147		
Nominal Voltage to Ground	Minimum Clear Distance																							
Condition 1	Condition 2	Condition 3																						
0-150 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)	900 mm (3 ft)																					
151-600	900 mm (3 ft)	1 m (3½ ft)																						
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K 147	Continued From page 33 other insulating materials. Insulated wire or insulated busbars operating at not over 300 volts to ground shall not be considered live parts. Condition 2 - Exposed live parts on one side and grounded parts on the other side. Concrete, brick, or tile walls shall be considered as grounded. Condition 3 - Exposed live parts on both sides of the work space (not guarded as provided in Condition 1) with the operator between.  (a) Dead-Front Assemblies. Working space shall not be required in the back or sides of assemblies, such as dead-front switchboards or motor control centers, where all connections and all renewable or adjustable parts, such as fuses or switches, are accessible from locations other than the back or sides. Where rear access is required to work on nonelectrical parts on the back of enclosed equipment, a minimum horizontal working space of 762 mm (30 in.) shall be provided. (b) Low Voltage. By special permission, smaller working spaces shall be permitted where all uninsulated parts operate at not greater than 30 volts rms, 42 volts peak, or 60 volts dc. (c) Existing Buildings. In existing buildings where electrical equipment is being replaced, Condition 2 working clearance shall be permitted between dead-front switchboards, panelboards, or motor control centers located across the aisle from each other where conditions of maintenance and supervision ensure that written procedures have been adopted to prohibit equipment on both sides of the aisle from being open at the same time and qualified persons who are authorized will service the installation. (2) Width of Working Space. The width of the working space in front of the electric equipment	K 147		

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

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K 147	Continued From page 34 shall be the width of the equipment or 750 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. (3) Height of Working Space. The work space shall be clear and extend from the grade, floor, or platform to the height required by 110.26(E). Within the height requirements of this section, other equipment that is associated with the electrical installation and is located above or below the electrical equipment shall be permitted to extend not more than 150 mm (6 in.) beyond the front of the electrical equipment. (B) Clear Spaces. Working space required by this section shall not be used for storage. When normally enclosed live parts are exposed for inspection or servicing, the working space, if in a passageway or general open space, shall be suitably guarded. (C) Entrance to Working Space. (1) Minimum Required. At least one entrance of sufficient area shall be provided to give access to working space about electrical equipment. (2) Large Equipment. For equipment rated 1200 amperes or more and over 1.8 m (6 ft) wide that contains overcurrent devices, switching devices, or control devices, there shall be one entrance to the required working space not less than 610 mm (24 in.) wide and 2.0 m (6½ ft) high at each end of the working space. Where the entrance has a personnel door(s), the door(s) shall open in the direction of egress and be equipped with panic bars, pressure plates, or other devices that are normally latched but open under simple pressure. A single entrance to the required working space shall be permitted where either of the conditions in 110.26(C)(2)(a) or (b) is met. (a) Unobstructed Exit. Where the location permits	K 147			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185329	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/12/2012
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K 147	Continued From page 35 a continuous and unobstructed way of exit travel, a single entrance to the working space shall be permitted. (b) Extra Working Space. Where the depth of the working space is twice that required by 110.26(A)(1), a single entrance shall be permitted. It shall be located so that the distance from the equipment to the nearest edge of the entrance is not less than the minimum clear distance specified in Table 110.26(A)(1) for equipment operating at that voltage and in that condition. (D) Illumination. Illumination shall be provided for all working spaces about service equipment, switchboards, panelboards, or motor control centers installed indoors. Additional lighting outlets shall not be required where the work space is illuminated by an adjacent light source or as permitted by 210.70(A)(1), Exception No. 1, for switched receptacles. In electrical equipment rooms, the illumination shall not be controlled by automatic means only.  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		