

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

PRINTED: 07/18/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/07/2011
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NAME OF PROVIDER OR SUPPLIER  HAWES MEMORIAL NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1004 HOLIDAY LANE FULTON, KY 42041
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A recertification survey was conducted, on 07/05/11 through 07/07/11 and a Life Safety Code survey was conducted on 07/06/11, to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of an "F".	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure the necessary housekeeping and maintenance services were administered to provide for a sanitary environment related to a thick brown substance on the backsplash, above the kitchen stove. This was observed on entrance to the facility and existed all three days of the annual survey, 07/05/11 through 07/07/11. Findings include:  An observation on 07/05/11 at 12:55 PM, of the backsplash, over the stove, revealed an area of a thick, rust-colored substance, approximately three foot by three foot, that when wiped with a white dish cloth, left a thick rust-colored area on the cloth, yet the brown substance did not wipe off the backsplash. A label on the side of the	F 253	F 253 The corrective action was the thick goeey substance was cleaned on 7/7/11. After the goeey substance was removed, a worn brown spot remained on the galvanized metal. On July 20th the Administrator and Maintenance Supervisor met with owner of Smallman Sheet Metal regarding ordering a custom made stainless steel covering for the back splash. Stainless steel was chosen as the new covering since galvanized metal has the potential for oxidation or deterioration over time. The Administrator gave direction at that time to proceed with the custom order. All residents receiving food from the kitchen have the potential to be affected by the same deficient practice. Corrective measures and systemic changes are as follows: the stainless steel covering will ensure oxidation or deterioration will not recur, the backsplash will be cleaned twice a month and as needed, dietary and housekeeping staff will be educated regarding proper visual inspection and reporting procedure. To monitor performance and to ensure solutions are sustained, the dietary manager will visually inspect the backsplash three times a week for cleanliness and absence of greasy build up. The Registered Dietician will visually inspect the backsplash and report to the Administrator the adherence to the plan of correction monthly. The Administrator will report compliance status to the Quality Assurance (QA) committee.	8/19/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Jennifer Connell</i>	TITLE Administrator	(X6) DATE 07/26/11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253 Continued From page 1  
hood stated the contracted hood maintenance was administered on 02/11/11.

An interview with the Dietary Manager on 07/05/11 at 1:00 PM revealed the cleaning should have been completed by the contractors and the Dietary Manager failed to notify the contractors or inform the Maintenance Supervisor there was a problem.

An observation of the backsplash on 07/07/11 at 11:47 AM revealed the brown area was still visible.

An interview with the Dietary Manager, on 07/07/11 at 11:50 AM, revealed the kitchen staff had cleaned the area of a "thick, gooey" substance and the brown area, on the galvanized backsplash was a "worn area and not rust on the backsplash."

An interview with the Maintenance Supervisor on 07/07/1:50 PM revealed he replaced the air filters, in the hood, twice a month. However, he was not aware of the brown area until the Dietary Manager pointed this out on 07/06/11 and had no scheduled cleaning for the backsplash, outside what was done by the contractors every six months.

F 253

8/19/2011

F 364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, SS=F PALATABLE/PREFER TEMP

F 364

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

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F 364	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure residents received food prepared in a manner which maintained the proper temperatures. On 07/06/11 at 6:45 AM, food was held, uncovered on the steam table, prior to and throughout the breakfast meal service. A check of temperatures revealed eggs at 110 degrees Fahrenheit, (F) and milk, at 48 degrees F. A review of the Census and Condition Report, dated 07/05/11, revealed the facility census was 58, with 56 of those residents served food from the kitchen. Findings include:  1. An observation of the kitchen, on 07/06/11 at 6:45 AM, revealed the steam table was being prepared for serving a breakfast of scrambled eggs, gravy and sausage with ground sausage and gravy for mechanical soft diets and pureed sausage, bread crumbs and gravy and pureed eggs provided for the pureed diets. Temperatures for the scrambled eggs were 110 degrees F. Temperatures for the milk, laying in cartons in shallow trays of ice were 48 degrees F. The steam table remained uncovered throughout the meal. A test tray, served on an open cart on the hallway, revealed egg temperatures of 110 degrees, despite having been rewarmed on the stove. The gravy and bread crumbs were 96 degrees F., pureed gravy and sausage was 106.3 degrees F., and oatmeal was 108 degrees F.  An interview with the Dietary Manager, on 07/07/11 at 7:00 AM, revealed she had not been	F 364	Corrective action was implemented on 7/8/11. The steam table is now covered at all times when the table is turned on except at times when food is being served. Meal trays placed in the serving window have insulated bottoms and a top covering therefore insulating the entire dinner plate. Milk is prepared for serving by placing the cartons in a container using sufficient amounts of ice to cover the bottom and the top instead of a small amount of ice in the bottom of the milk tray then stored in the freezer until serving begins. Any resident served meals from the kitchen have the potential to be affected by this deficient practice. Systemic changes that will be implemented are outlined below. First, lids will cover all compartments of the steam table when the table is turned on for heating foods with the exception of when food is being served. Second, meal trays placed in the serving window have insulated bottoms as well as a top covering therefore insulating the entire dinner plate. Third, milk will be prepared prior to serving by placing the milk in insulated coolers covered with ice. Lids on the coolers will remain closed except when milk is being served. Fourth, open air carts used for transportation of meal trays served to residents out of the dining room will be replaced with enclosed double-walled polyethylene constructed carts. These insulated carts will increase quality by maintaining correct food temperatures during transport. Fifth, interruption of the serving line will be kept to a minimum by providing frequently requested amenities in a central location for nurse aide retrieval. Six, dietary staff will be educated regarding these systemic changes on 8/2/11. The dietary manager or designee will monitor two meals three times a week for compliance regarding food temperatures and dietary staffs adherence to above prescribed procedures. Monitoring will include both meals served in the dining room and meals served to residents in their rooms. Compliance reports will be presented in monthly QA meetings by the dietary manager.	8/19/2011

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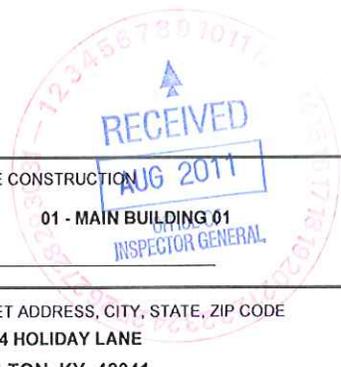
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F 364	<p>Continued From page 3</p> <p>aware the food on the steam table was not covered throughout the meal.</p> <p>2. An observation of the noon meal on 07/07/11 at 11:47 AM revealed French Fries were 129 degrees F and milk at 46.7 degrees F. Plates of food served to the residents in the dining room, were not enclosed in available plate holders and lids and there was a delay of five to six minutes, twice during the service, before the trays were taken individually to the residents at the table.</p> <p>An interview with the Dietary Manager, on 07/07/11 at 11:58 AM, revealed "There were some changes to be made."</p>	F 364		
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K 000	INITIAL COMMENTS  A Life Safety Code Survey was initiated and concluded on 07/06/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, according to NFPA standards. The deficiency	K 018	The specific measure to correct the violation occurred on 7/6/2011 when the door stop holding the dining room door open was removed. The dining room door was equipped with an automatic door closer; the automatic door closer has since been removed and the dining room door will stay open without hold-open devices. The specific measures to ensure the violation will not recur are as follows. All staff will be educated on 8/8/2011 regarding not holding doors open by furniture, doorstops, chocks, tie-backs, drop-down or plunger type devices or any other devices requiring manual unlatching or releasing for closure. The Housekeeping Supervisor makes rounds of the entire facility during scheduled hours; visual inspections will be included during these rounds to ensure no doors are blocked or propped open. The Housekeeping Supervisor will report compliance status to the QA subcommittee monthly.	8/8/2011

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

TITLE

(X6) DATE

*Jennifer Connell*

Administrator

07/26/11

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 018	Continued From page 1 had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds, with a census of fifty eight (58) the day of the survey.  The findings include:  Observation, on 07/06/2011 at 11:38 AM, with the Maintenance Supervisor revealed a door stop holding the Dining Room door open that leads to the corridor.  Interview, on 07/06/2011 at 11:38 AM, with the Maintenance Supervisor revealed he was unaware the door stop was being used to hold the Dining Room door open.  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		
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	K 025	K 025  Specific measures to correct this violation: all openings in the attic smoke barriers allowing penetration of electrical wiring, piping, or other such devices were caulked using Fire Barrier Sealant capable of 4 hour protection on 7/26/2011. Specific measures to ensure the violation will not recur are: Inspections will be made quarterly by the Maintenance Supervisor on the known penetrations to ensure adequate caulking remains. All contractors will be educated at the time of service by the Maintenance Supervisor regarding the importance of sealing all smoke barrier penetrations. Whenever a new penetration for electrical, plumbing, etc. must be made, the Maintenance Supervisor will inspect the attic to ensure adequate sealing of the new penetration.	7/26/2011

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K 025	<p>Continued From page 2</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments per NFPA standards. The deficiency had the potential to affect five (5) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/06/2011 at 12:35 PM, with the Maintenance Supervisor revealed all the smoke barriers located in the attic throughout the facility were penetrated by electrical wiring, piping, and miscellaneous openings.</p> <p>Interview, on 07/06/2011 at 12:35 PM, with the Maintenance Supervisor revealed they were unaware of the penetrations, and confirmed that the penetrations needed to be sealed.</p> <p>Reference to: NFPA 101 Life Safety Code 2000 Edition</p>	K 025		

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K 025	<p>Continued From page 3</p> <p>8-2.4.4 Penetrations and Miscellaneous Openings in Smoke Partitions.</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protective 's shall be as follows:</p> <p>(3) 1/2-hour fire barrier - 20-minute fire protection rating</p> <p>(1) 2-hour fire barrier - 1 1/2-hour fire protection rating</p> <p>(2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42</p> <p>8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke</p>	K 025		

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K 025	Continued From page 4 barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.	K 025		
K 038 SS=D	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 exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. The deficiency had the potential to affect one (1) smoke compartment, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observation, on 07/06/2011 at 11:36 AM, with the Maintenance Supervisor revealed mini-blinds mounted on the exit door located in the dining room.	K 038	Specific measures to correct the violation were completed on 7/6/11 at which time the Maintenance Supervisor removed the mini blinds from the door. The specific measures to ensure the violation will not recur: at no time will any window treatments such as curtains, blinds, etc. be applied to any exit door. The Housekeeping Supervisor will include in weekly rounds visual inspection of exit doors to ensure no curtains or blinds have been installed.	7/7/11

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K 038	Continued From page 5 Interview, on 07/06/2011 at 11:36 AM, with the Maintenance Supervisor revealed they were unaware that mini-blinds were prohibited to be mounted on exit doors.  Reference: NFPA 101 (2000 Edition)  7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit.	K 038			
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure fire drills were conducted at unexpected times under varied conditions. The deficiency had the potential to affect 5 of 5 smoke compartments, staff and residents. The facility is licensed for sixty (60) beds with a census of fifty eight (58) residents on the day of the survey.	K 050	Specific measures to correct the deficient practice: the Maintenance Supervisor will conduct fire drills for all three shifts at varied times and varied conditions. Specific measures to ensure this deficient practice does not recur will be for the Administrator to review the fire drill log monthly for proof that fire drills are occurring for each shift at varied times and conditions.	8/8/11	

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K 050	Continued From page 6  The findings include:  Record review of the fire drill log on 07/06/2011 at 1:00 PM, with the Maintenance Supervisor revealed the fire drills were not being conducted quarterly and at unexpected times under varied conditions.  Interview, on 07/06/2011 at 1:00 PM, with the Maintenance Supervisor revealed that he was unaware that fire drills were not being conducted as required.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050			
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  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	K 056	The roof over the walk in freezer was added to the building in 1995. Subsequent inspections since that time have not cited this area as deficient. The specific measures to correct this deficiency as it now stands is: a sprinkler connected to our existing sprinkler and alarm system will be installed to this small awning/overhead covering by Key Fire Protection, Inc. To ensure the deficiency does not recur, the Administrator will ensure any future construction adding awnings, coverings, porches, etc. will include the addition of a sprinkler connected to the current fire and alarm system.	8/12/11	

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K 056	Continued From page 7  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments and kitchen staff. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observation, on 07/06/2011 at 12:25 PM, with the Maintenance Supervisor revealed one (1) overhang with no sprinkler protection. The overhang is located at the rear of the kitchen and provided access to an outside walk in cooler.  Interview, on 07/06/2011 at 12:25 PM, with the Maintenance Supervisor confirmed the observation.  Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056		
K 062 SS=D	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	K 062		

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K 062	Continued From page 8  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) the day of the survey.  The Findings Include:  Observation, on 07/06/2011 at 10:55 AM, with the Maintenance Supervisor revealed items stored on a shelf within 18 inches of the sprinkler head located in the East Hall Dressing Closet.  Interview, on 07/06/2011 at 10:55 AM, with the Maintenance Supervisor revealed that he was unaware someone had placed the items within 18 inches of the sprinkler head.  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	K 062 Specific measures to correct the deficiency were completed 7/6/11 when the Maintenance Supervisor removed the box of nonskid socks from the top shelf of the closet. Staff members on duty were educated regarding not putting any item within 18 inches of a sprinkler. Specific measures to ensure the deficiency does not recur include: the East Hall Dressing Closet and other applicable storage space where the potential to obstruct the sprinkler head from reliably operating will be modified to include permanent indicators marking the height limit for storage. Employees will be educated on 8/8/11 regarding not putting any item within 18 inches of a sprinkler head. The Housekeeping Supervisor will perform weekly visual inspections of the applicable storage closets to ensure compliance. Results of these inspections will be reported to the QA committee.	8/12/2011
K 072	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		

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K 072 SS=E	<p>Continued From page 9</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 according to NFPA standards. The deficiency had the potential to affect three (3) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 07/06/2011 at 10:55 AM, with the Maintenance Supervisor revealed wheelchairs, cleaning carts, and med carts were being stored in the Back Hall and the East Wing longer than thirty (30) minutes.</p> <p>Interview, on 07/06/2011 at 10:55 AM, with the Maintenance Director revealed the facility lacked storage space.</p> <p>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</p>	K 072	<p>Specific measures utilized to correct the violation began 7/6/11 when the equipment not in use was removed from the corridors. The same day a storage area measuring 16 feet by 11 feet was designated as a specified area for equipment storage. This new storage area will be used in addition to current areas used for equipment storage. The employees present on 7/6/11 were educated on the storage area and the importance of maintaining corridors obstacle-free. Specific measures to ensure the deficient practice does not recur includes continued education with current employees 8/8/11 and new employees during the orientation process regarding the proper storage of equipment when not in use. The charge nurse(s) on duty will be responsible for ensuring the corridors remain free of obstacles or impediments and for implementing ongoing education necessary to ensure the deficient practice does not recur.</p>	8/8/11

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K 072	Continued From page 10 impediments to full instant use in the case of fire or other emergency.	K 072		
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 according to NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, including residents, staff, and visitors. The facility is licensed for sixty (60) beds with a census of fifty eight (58) on the day of the survey.  The findings include:  Observation, on 07/06/2011 at 10:45 AM, with the Administrator revealed an extension cord plugged into a television located in the Employee Conference Room.  Interview, on 07/06/2011 at 10:45 AM, with the Administrator revealed she was aware of the extension cord but thought it was acceptable as long as it was for temporary use.  Observation, on 07/06/2011 at 11:40 AM, with the Maintenance Supervisor revealed piggy backed power strips in the Business Office.  Interview, on 07/06/2011 at 11:40 AM, with the	K 147	The specific measure to correct the deficiencies: 1) The extension cords plugged into the televisions in both the employee conference room and the dining room were replaced with power strips on 7/6/2011. 2) On 7/6/2011 the piggy backed power strips in the business office were separated and the Business Manager was educated by the Maintenance Supervisor to not repeat this practice. On 7/23/2011 the electrician hard wired additional receptacles to manage the equipment demand in the business office and the power strips were removed. 3) On 7/6/2011 the oxygen concentrator was unplugged from the power strip and plugged into a regular receptacle. Staff education was provided by the Maintenance Supervisor to the employee who utilized the power strip for the concentrator. 4) On 7/25/2011 the Administrator approved a bid from an electrician to cover the junction box on or before 8/12/2011. In addition to the junction box the electrician will also install additional receptacles in patient care areas to met the patient medical equipment demands. 5) The extension cord in the laundry room was removed. On or before 8/12/2011 a receptacle will be installed in the laundry room. Specific measures to ensure the violation will not recur is to place all power strips under the control of the maintenance and housekeeping supervisors. These supervisors will only release a power strip for nonmedical equipment. The supervisors will keep a list of those power strips released indicating the purpose of each strip. The housekeeping supervisor makes rounds of the entire facility during scheduled hours; visual inspections will be included during these rounds to ensure power strips are being used for nonmedical equipment only. The housekeeping supervisor will report compliance status to the QA subcommittee monthly.	8/12/2011

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K 147	<p>Continued From page 11</p> <p>Maintenance Supervisor revealed he was unaware of the power strips being plugged into each other in the office.</p> <p>Observation, on 07/06/2011 at 11:40 AM, with the Maintenance Supervisor revealed an Oxygen Concentrator plugged into a power strip, and an extension cord plugged into a television located in the Dining Room.</p> <p>Interview, on 07/06/2011 at 11:40 AM, with the Maintenance Supervisor revealed the Dining Room needed more plugs to accommodate the needs of residents when used for Activities such as Bingo.</p> <p>Observation, on 07/06/2011 at 11:45 AM, with the Maintenance Supervisor revealed an extension cord located in the Laundry Room.</p> <p>Interview, on 07/06/2011 at 11:40 AM, with the Maintenance Supervisor revealed he was unaware an employee had brought in the extension cord to power a small radio.</p> <p>Observation, on 07/06/2011 at 12:35 PM, with the Maintenance Supervisor revealed an open junction box located in the attic, above the West Hall Lobby.</p> <p>Interview, on 07/06/2011 at 12:35 PM, with the Maintenance Supervisor revealed he was unaware of the open electrical junction in the attic.</p>	K 147	All extension cords were removed from the building on 7/7/2011. On 8/8/2011 staff education will be provided regarding the proper utilization of electrical receptacles and power strips as well as the importance of not using extension cords for any purpose. Education will also include the use of wall receptacles as the only appropriate power source for medical equipment.		

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K 147	Continued From page 12  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.  Reference: NFPA 70 (1999 edition)  370.28(c) Covers.  All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147			