

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2013
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NAME OF PROVIDER OR SUPPLIER OAKLAWN NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245
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F 000	INITIAL COMMENTS	F 000		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure dignity and respect for residents by staff entering eight (8) of thirty-two (32) resident rooms on English Oaks Terrace without waiting for permission to enter after knocking. During the meal service on 03/15/13 staff were observed knocking on resident's doors as they walked into the rooms. In addition, during the Group Interview, one (1) of seven (7) residents present complained staff entered the room without knocking while the resident was being bathed.</p> <p>The findings include:</p> <p>The facility did not provide a policy on dignity and respect.</p>	F 241	<p>"The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."</p> <p>F 241</p> <p>Oaklawn promotes care for residents in a manner and environment that maintains or enhances each resident's dignity and respect. Oaklawn has a policy in effect that supports this right.</p> <p>On 3-15-13, Nursing staff involved with this deficiency was immediately educated by the Director of Nursing on the need to allow an opportunity for a resident response after knocking, and prior to entering a resident room.</p> <p>Identification of other residents potentially affected by same deficient practice:</p> <p>On 3-18-13, all residents were interviewed or observed by the</p>	3/29/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mary Burke Stephens* TITLE: *administrator* (X6) DATE: *4/4/13*

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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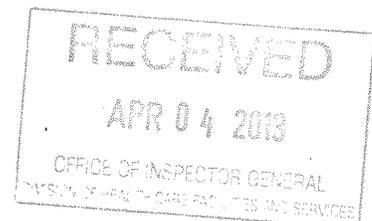
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F 241	Continued From page 1 Observation of the meal service on English Oak Terrace, on 03/13/13 at 12:35 PM, revealed staff delivered meals to residents in their rooms. Staff were noted to knock as they entered residents' rooms 205, 206, 207, 210, 211, 212, 214 and 215. There was no pause to listen for the resident's response or to allow the resident time to give permission for the staff to enter the room. Interview with Resident #8, on 03/12/13 at 3:20 PM, revealed he/she does not like it when staff enter without letting him/her know they are coming in. Interview with Resident #13, on 03/13/13 at 1:00 PM, revealed he/she does not like staff coming into his/her room without knocking and waiting for him/her to say it is ok. Interview with Resident #18, on 03/13/13 at 10:20 AM, revealed he/she preferred it if the staff would knock and let him/her know when they are coming into his/her room. Interview with Certified Nurse Aide (CNA) #3, on 03/14/13 at 9:20 AM, revealed she had received training on resident rights and knew to knock and wait for a response from the resident prior to entering the resident's room. She stated she forgot to do this and she could have embarrassed the resident by not following her training. Interview with CNA #4, on 03/14/13 at 9:55 AM, revealed knocking and waiting for permission to enter was the proper way to enter a resident's room. She stated this showed respect for the resident and this was how staff were trained. She	F 241	Unit Managers for staff knocking and allowing for a response prior to entering the room. Two additional residents were affected by the deficient practice, with staff involved immediately re-educated by the unit manager. To ensure the deficient practice does not reoccur: The Director of Nursing and Director of Education will re-educate all Oaklawn staff on following the policy and procedure regarding Dignity and Respect, including knocking on the door and waiting for a resident response prior to entering a resident room. This was completed 3/28/13. To monitor the above to ensure the solution is sustained: A sample of 20% of residents will be observed monthly by the Unit Managers to determine if residents' dignity and respect is being maintained or enhanced by staff knocking on the door and waiting for a response prior to entering a resident room.		

RECEIVED
APR 04 2013
OFFICE OF ASSISTANT CHIEF OF STAFF
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F 241	Continued From page 2 stated she did not realize she forgot to knock on the door prior to entering the resident's room. Interview with CNA #5, on 03/14/13 at 10:10 AM, revealed she was trained to knock on the door then wait for permission to enter the resident's room. She stated by not knocking and pausing for permission to enter the resident's room was disrespectfull. Interview with the Unit Manager #2, on 03/14/13 at 9:50 AM, revealed staff were trained to knock and pause prior to entering a resident's room and she did supervise staff to ensure they did so. Observation of Licensed Practical Nurse (LPN) #4, on 03/13/13 at 10:55 AM and at 10:59 AM, revealed she knocked on the door of Resident #13 and without hesitation entered the room. The resident was not provided the opportunity to respond to the knock at the door. Interview with Resident #13 during the group interview, on 03/12/13 at 1:45 PM, revealed staff came into his/her room during his/her bath and did not wait to be acknowledged before they walked into the room.	F 241	The results of the study will be reported by the Director of Nursing to the Quality Assurance committee on a quarterly basis until substantial compliance is achieved and maintained for two quarters.		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441	F 441 Oaklawn maintains an infection control program that provides a safe and sanitary environment and helps prevent the development and transmission of disease and infection.	3/30/13	



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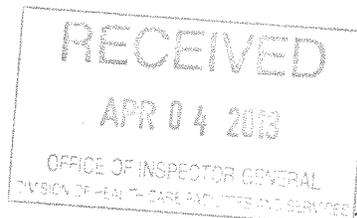
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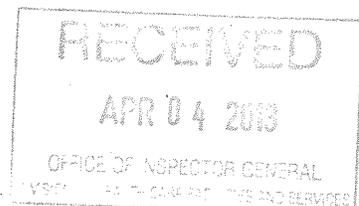
F 441	<p>Continued From page 3 to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the</p>	F 441	<p>On 3-15-13 CNA #1 was counseled and trained by the Director of Nursing on the facility policy and procedure regarding transmission-based precautions. This training included contact precaution education on the need to don gloves prior to entering a resident room, wear gloves while in the room, and remove gloves and perform hand hygiene prior to exiting the room.</p> <p>Identification of other residents potentially affected by same deficient practice:</p> <p>On 3-15-13, all residents with transmission based precautions were checked to ensure the correct precautions are being utilized, and no other residents were found to be affected by the same deficient practice. This was completed by the Unit Managers on 3-15-13.</p> <p>To ensure the deficient practice does not reoccur:</p> <p>The Director of Nursing and Director of Education will re-</p>	
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F 441	<p>Continued From page 4</p> <p>facility failed to maintain an infection control program for one (1) of six (6) unsampled and twenty-four (24) sampled residents, Unsampled Resident A. Staff were observed entering Unsampled Resident A's contact isolation room without utilizing PPE (Personal Protective Equipment).</p> <p>The findings include:</p> <p>Review of the facility's Isolation Categories of Transmission-Based Precautions policy, effective 08/01/12, revealed staff was to implement contact precautions for residents known or suspected to be infected or colonized with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The staff was to wear gloves when entering the room, remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent.</p> <p>Observation and review of the Contact Precaution Sign posted on Unsampled Resident A's door, on 03/12/13 8:06 AM, revealed the staff and visitors were to use contact precautions (with standard precautions), all staff and visitors were to apply gloves prior to entering the room, and they should be worn at all times when in the room. The staff and visitors were to remove their gloves and dispose of them in the trash can and wash their hands prior to exiting the room.</p> <p>Review of Unsampled Resident A's record revealed the facility admitted the resident on 01/29/13 and the facility placed the resident on</p>	F 441	<p>educate all Oaklawn staff on following the policy and procedure regarding transmission-based precautions. This training will include contact precaution education on donning and doffing all necessary PPE, as well as hand washing policies. This was completed March 29, 2013.</p> <p>To monitor the above to ensure the solution is sustained:</p> <p>A sample of 80% of residents in isolation with contact precautions will be observed monthly by the Unit Managers to determine if staff is following proper isolation procedures and wearing proper PPE. The results of the study will be reported to the Quality Assurance committee on a quarterly basis until substantial compliance is achieved and maintained for two quarters.</p>		



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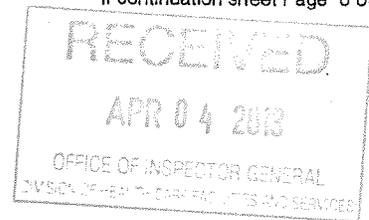
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F 441	<p>Continued From page 5</p> <p>Contact Precautions for Shingles on 03/11/13.</p> <p>Observation of a Certified Nursing Assistant (CNA), during the Breakfast meal, on 03/12/13 at 8:06 AM, revealed CNA walking in to Unsampled Resident A's room without donning gloves although the Contact Precaution sign on the door instructed her to do so. The CNA was observed to use alcohol as she left the room without washing her hands.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 03/12/13 at 8:06 AM, revealed Unsampled Resident A was on contact isolation for shingles.</p> <p>Interview with CNA #1, on 03/14/13 at 3:34 PM, revealed when she sees a sign on the Residents door that states contact precautions, she dons gloves and a gown. CNA #1 stated she would gown up when delivering a meal tray to a resident on contact precautions. CNA #1 stated it did not matter if she had had chicken pox or not.</p> <p>Interview with Registered Nurse (RN) #1, on 03/14/13 at 3:37 PM, revealed staff would not want to touch the resident without gloves and a gown on. RN #1 stated when a staff member was taking a tray in to a resident's room, who was on Contact Precautions, staff were to don gloves because you may touch the resident's bed linen. RN #1 stated because of this she would don a gown as well. RN #1 stated it did not matter if she had already had chicken pox, we could still get shingles. RN #1 stated that staff should wash their hands as they exit the room.</p> <p>Interview with the Unit Manager, on 03/13/13 at 3:55 PM, revealed she was expecting the staff to</p>	F 441		
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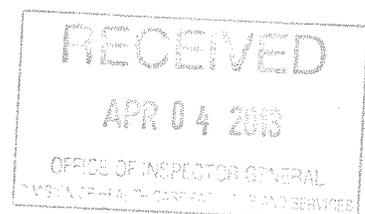
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F 441	Continued From page 6 gown and glove when entering a resident's room who was on contact precautions. She stated she was expecting the staff member to wash their hands as they left the room. Everyone should don gown and gloves when they enter the room.	F 441			
F 514 SS=D	Interview with the Director of Nursing (DON), on 03/14/13 at 4:06 PM, revealed the CNA's should wear gloves when entering a contact precaution room. The DON stated they wore gloves to protect themselves from any contact with the disease process. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain accurate clinical records to reflect the current status of two (2) of twenty-four (24) sampled residents and six (6) unsampled residents. Residents #1 and #13. The	F 514 F 514	Oaklawn maintains clinical records on each resident in accordance with professional standards and practices that are complete and accurately documented. The staff member responsible for documenting the inaccurate weights on resident #1 was immediately retrained on the importance of ensuring weights are documented on the correct resident. The DNR order for resident #13 was immediately renewed on 3-14-13. The Nurse that checked the renewal orders for resident #13 was immediately retrained on the procedure for ensuring all renewal orders are in place. The Director of Nursing completed the training on March 15, 2013. Identification of other residents potentially affected by same deficient practice:	3/30/13	



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F 514	<p>Continued From page 7</p> <p>facillty documented Resident #1's weight inaccuratly and failed to renew a Do Not Resuscitate (DNR) order for Resident #13.</p> <p>The findings include:</p> <p>The facility could not provide a policy for maintaining an accurate clinical record.</p> <p>1. Observation of Resident #1, on 03/12/13 at 3:41 PM, revealed Resident #1 was lying upon the bed and his/her eyes were closed. Resident #1 was observed to have a trach and g-tube (gastro-intestinal tube) with feeding infusing at 55 cc/hr. The resident appeared clean and neat in appearance. In addition, the Resident #1 was noted to be small in stature.</p> <p>Review of Resident #1's Weight Detail Report revealed Resident #1 averaged a weight of 134.0 pounds through the dates of 09/10/12 through 01/22/13. Review then revealed on 02/01 and 02/02/13 a weight of 240 pounds. On 02/03 and 02/04/13 a weight was recorded as 244 pounds. On 02/06/13 the resident's weight was recorded as 249 pounds. On 02/08/13 a weight of 147.0 pounds was recorded and on 02/08/13 the weight was 248.5 pounds.</p> <p>Interview with the Unit Manager, on 03/13/13 at 3:55 PM, revealed Resident #1 did not weigh 200 + pounds. The Unit Manager stated she had not noticed Resident #1's weight being up and down. She stated if the weight was documented to be up and down it would be hard to distinguish a weight loss. The Unit Manager stated the nurses enter the weights in the computer and she monitored them weekly. Upon review of the</p>	F 514	<p>All current residents' medical records were checked on 3-18-13 to ensure accuracy of weights. No other residents were affected by the deficient practice.</p> <p>All current residents' renewal orders were checked on 3-15-13 to ensure the renewal order of code status is in place. No other residents were affected by the deficient practice. All renewal orders are complete effective 3-15-13.</p> <p>To ensure the deficient practice will not recur:</p> <p>All facility nursing staff will be retrained on the Policy and Procedure for weighing Residents, recording weights, and for renewal of Physician orders. The training will be conducted by the Director of Education, and will be completed by March 29, 2013.</p> <p>To monitor the above to ensure the solution is sustained:</p> <p>A sample of 20% of residents will be observed monthly by the Unit Managers for accurate documentation of weights and renewal of physician orders. Results will be reported at the quarterly QA committee meeting until compliance is achieved and sustained for two quarters.</p>		



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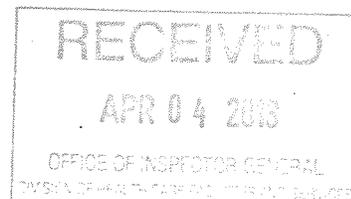
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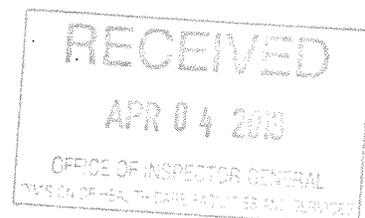
F 514	<p>Continued From page 8</p> <p>weights she reported Resident #1's family member was a resident in the facility during this particular time and it looked as if the weights were documented on the wrong patient. Both of them had the same name.</p> <p>Interview with the Director of Nursing (DON), on 03/14/13 at 4:06 PM, revealed she believed it was not an accurate account of Resident #1's weight. The DON stated the nurses and unit managers were responsible to monitor the weights and the unit managers were responsible for the NAR implementation. The DON stated Resident #1's family member was a resident in the facility and the staff should have documented by room number and not the resident's name.</p> <p>2. Review of the facility's policy for Changeover Orders at the End of the Month, dated 03/13/13, revealed a nurse was assigned to review the physician's orders for the next month for accuracy then place the orders for the physician to sign.</p> <p>Review of the clinical record for Resident #13 revealed the facility admitted the resident with diagnoses of Parkinson's Disease and Dementia. The facility completed a Quarterly Minimum Data Set (MDS) for the resident on 01/06/13 which revealed the resident was cognitively intact and required extensive assistance with all care. A Do Not Resuscitate (DNR) form had been signed by the resident. The physician orders for the months of January and February 2013 did not include the orders for a DNR.</p>	F 514		
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F 514	Continued From page 9 Interview with Unit Manager #2, on 03/14/13 at 9:50 AM, revealed the physician orders were rewritten every month and placed on the clinical record. She stated the renewed orders were reviewed by a nurse to ensure all current orders were listed and were accurate. She stated the physician would then sign those orders. She revealed this process was followed monthly; however, she was not able to locate the DNR order for Resident #13 on the orders for January and February 2013. She stated all residents requesting DNR needed a physician's order. She stated this could be confusing to staff responding to residents in cardiac arrest. Interview with the Director of Nursing, on 03/14/13 at 1:10 PM, revealed resident orders should be accurate and current.	F 514			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185455	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - OAKLAWN PLACE B. WING _____	(X3) DATE SURVEY COMPLETED 03/14/2013
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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: 2005</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type II (111)</p> <p>SMOKE COMPARTMENTS: Seven (7) per floor (story).</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Automatic (wet) sprinkler system, hydraulically designed.</p> <p>GENERATOR: Type II generator, fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 03/14/13. Oaklawn Nursing and Rehab was found to be not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the</p>	K 000	<p>"The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."</p> <p>K - 025</p> <p>1. All penetrations have been fire caulked at all locations using materials rated equal to the partition and resistive to the passage of smoke. This was completed by two maintenance assistants under the direction of the Executive Maintenance Director. Completion date 3/19/13.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Mary Burk Stephens* TITLE *administrator* (X6) DATE *4/4/13*

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.

RW

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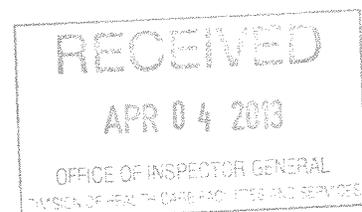
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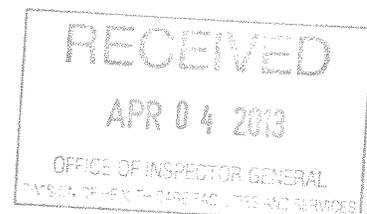
K 000	Continued From page 1 survey.	K 000		
K 025 SS=E	<p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>This STANDARD Is not met as evidenced by: 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 nine (9) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight</p>	K 025	<p>"The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."</p> <p>K 025</p> <p>1. All penetrations have been fire caulked at all locations using materials rated equal to the partition and resistive to the passage of smoke. This was completed by two maintenance assistants under the direction of the Executive Maintenance Director. Completion date 3/19/13. The two smoke barriers that were not accessible to observation will be made available for observation via hatch doors that will be installed by 4/27/13 by a contractor overseen by the Executive Maintenance Director and the Regional Maintenance Director.</p> <p>2. Executive Maintenance Director of Facility visually inspected all fire walls to ensure no other penetrations were</p>	4/18/13



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K 025	Continued From page 2 (128) beds with a census of one hundred twenty (120) on the day of the survey. The findings include: Observations, on 03/14/13 between 9:00 AM and 10:00 AM, with the Executive Maintenance Director revealed the smoke barriers, extending above the ceiling, had penetrations of pipes and two smoke barriers that were not accessible for inspection. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The locations of the penetrations were as follows: 1) The fire wall located next to room 201 was not accessible for inspection. 2) The fire wall located next to room 233 was not accessible for inspection. 3) The smoke barrier located next to room 115 had a sleeve through the wall for wires, and the inside of the sleeve was not sealed. 4) The smoke barrier located next to room 133 had a sleeve through the wall for wires, and the inside of the sleeve was not sealed. Also in the same smoke barrier were unsealed pipes penetratng the wall. 5) The smoke barrier located next to room 147 had the drywall removed around some pipes leaving a large penetration. 6) The smoke barrier located next to room 149 had a sleeve through the wall for wires, and the inside of the sleeve was not sealed. Interview, on 03/14/13 between 9:00 AM and 10:00 AM, with the Executive Maintenance Director revealed he was not aware of the	K 025	present on 3/19/13. All penetrations are sealed. 3. Regional Director of Facilities Management will develop a memorandum for the Maintenance Director to sign in/out vendors and review their final product prior to contractor departure. This will be in place by 4/27/13. The Regional Maintenance Director will educate all maintenance staff on necessity of inspecting and keeping all penetrations sealed. This will be completed by 4/27/13. The Regional Maintenance Director will verify the access doors are properly installed by 4/27/13. 4. We will add a fire/smoke penetration inspection to our TELS computer maintenance/tacking system for review. Director of Maintenance will make rounds weekly for 4 weeks then monthly to check to see that no penetrations exist in the fire walls including the walls accessible by the new hatch doors. These rounds will be recorded in the TELs program and reviewed by the Regional Director of Facility Management no less than quarterly to		



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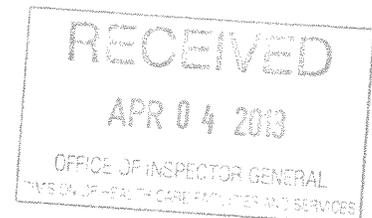
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K 025	Continued From page 3 penetrations or the inaccessible fire walls. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through 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	ensure the rounds are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (In accordance with 8.4). Doors are self-closing or automatic closing in	K 029	K 029 1. On 3/22/13 Maintenance assistants installed new door closing mechanisms to the linen room door located in laundry department, and to the MDS office located on EOT. 2. The facility Executive Maintenance Director inspected all facility doors and installed door closing devices where needed to meet NFPA standards. This was completed 3/22/13. 3. The Regional Director of Facility Management will provide education on the NFPA Standards relative to door closing devices and smoke compartments to facility maintenance staff by 4/27/13 and provide a current copy of the standard.	4/22/13



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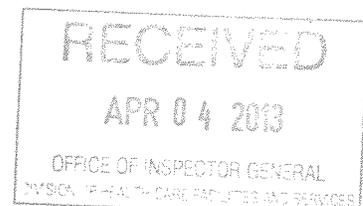
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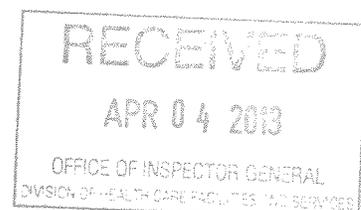
K 029	Continued From page 4 accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards In accordance with NFPA Standards. The deficiency had the potential to affect two (2) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey. The facility failed to provide self-closing devices for doors protecting hazardous areas. The findings include: Observation, on 03/14/13 between 10:00 AM and 2:30 PM, with the Executive Maintenance Director revealed rooms required being self-closing or containing a hazardous amount of combustibles did not have a self-closing device to keep the door closed. The rooms identified as hazardous requiring a self-closing device were the Clean Linen Room located in the Laundry, and the MDS Office located in the EOT Hall. Interview, on 03/14/13 between 10:00 AM and 2:30 PM, with the Executive Maintenance Director revealed he was not aware the doors to these rooms were required to be self-closing. 8.4.1.3	K 029	4. Director of Maintenance will check all doors for proper closures weekly for 4 weeks then monthly. These checks will be recorded in the TELs program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. The Executive Director of Maintenance will report any ongoing issues to the Administrator who will report to the facility QA Committee for one year.	
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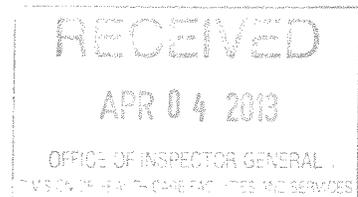
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K 029	Continued From page 5 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8. 18.3.2 Protection from Hazards. 18.3.2.1* Hazardous Areas. Any hazardous area shall be protected in accordance with Section 8.4. The areas described in Table 18.3.2.1 shall be protected as indicated. Table 18.3.2.1 Hazardous Area Protection Hazardous Area Description Separation/Protection Boiler and fuel-fired heater rooms 1 hour Central/bulk laundries larger than 100 ft2 (9.3 m2) 1 hour Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard See 18.3.6.3.4 Laboratories that use hazardous materials that would be classified as a severe hazard in accordance with NFPA 99, Standard for Health Care Facilities 1 hour Paint shops employing hazardous substances and materials in quantities less than those that would be classified as a severe hazard 1 hour Physical plant maintenance shops 1 hour Soiled linen rooms 1 hour Storage rooms larger than 50 ft2 (4.6 m2) but not exceeding 100 ft2 (9.3 m2) storing combustible material See 18.3.6.3.4	K 029			



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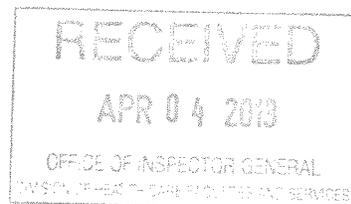
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K 029	Continued From page 6 Storage rooms larger than 100 ft ² (9.3 m ²) storing combustible material 1 hour Trash collection rooms 1 hour	K 029		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with lighting in accordance with NFPA standards. The deficiency had the potential to affect four (4) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey. The findings Include: Observation, on 03/14/13 between 10:00 AM and 2:30 PM, with the Executive Maintenance Director revealed the exit doors located in the end of the TOG Hall, the end of the COG Hall, exit by activities, and exit across from activities did not have a light installed outside to provide the required illumination for exit discharge. The exits were equipped with a light fixture; however, the light fixture only had one (1) bulb. Interview, on 03/14/13 between 10:00 AM and	K 045	K 045 1. Maintenance Director upgraded all fixtures incorporating 2 light bulbs at all exits on 3/20/13. This includes the TOG (EOG), COG, and all exits in and around the Activities area, (OT gym). This was completed 3/20/13. 2. The facility Executive Director of Maintenance checked all facility exits for adequate lighting with 2 bulbs. All exits are correctly illuminated with lighting consisting of a minimum of two bulbs. 3. The Facility Regional Maintenance Director will provide education on the NFPA Standards to facility maintenance staff by 4/27/13 and provide a current copy of the standard.	4/28/13



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K 045	Continued From page 7 2:30 PM, with the Executive Maintenance Director revealed he was not aware the exits did not have the required illumination for egress lighting. 7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. 7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. 7.8.1.3*	K 045	4. These exterior lights will be reviewed on the TELS maintenance schedule to be conducted and repaired on a monthly basis. These checks will be recorded in the TELS program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year.		



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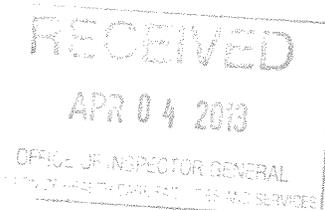
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K 045	Continued From page 8 The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 This STANDARD is not met as evidenced by: Based on observation, and interview it was determined the facility failed to test emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey. The facility failed to provide documentation of emergency battery light ninety minute yearly testing.	K 046		



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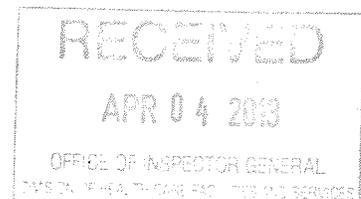
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NAME OF PROVIDER OR SUPPLIER OAKLAWN NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245
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K 046	<p>Continued From page 9 The findings include:</p> <p>Observation, on 03/14/13 at 10:38 AM, with the Executive Maintenance Director revealed the facility did not have documentation for the annual testing of emergency battery lighting located in the facility.</p> <p>Interview, on 03/14/13 at 10:38 AM, with the Executive Maintenance Director revealed he was not aware documentation was to be kept on emergency battery light testing.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than</p>	K 046	<p>K 046</p> <ol style="list-style-type: none"> On 3/17/13 the Executive Maintenance Director completed the yearly ninety minute test on the facility emergency battery light on the generator and documented the results in the LSC binder. The Executive Maintenance Director and maintenance staff will be trained on this ongoing yearly process by the Regional Director of Facility Management by 4/27/13 The documentation of the 3/17/13 test, and yearly hereafter, will be inserted into the Life-Safety Code Documentation (TELS program) and maintained in the Executive Maintenance Director's office. These tests as documented in the TELS system will be reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. The Executive Director of Maintenance will report any ongoing issues to the Administrator who will report to the facility QA Committee for one year. 	4/28/13
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K 046	Continued From page 10 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		
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. 18.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty	K 050	K 050 1. Beginning in March 2013 Monthly Fire Drills will be conducted at varying times on all shifts. 2. The Executive Maintenance Director provided a 2013 schedule for the monthly fire drills to the Administrator on 3/29/13. 3. We will modify the TELS program to stipulate variable times, one shift per month on a quarterly basis. Regional Director of Facility Management will provide education on the NFPA Standards to facility maintenance staff by 4/27/13 and provide a current copy of the standard.	4/28/13

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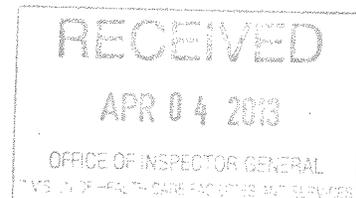
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K 050	<p>Continued From page 11 (120) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times on all shifts.</p> <p>The findings include:</p> <p>Fire Drill review, on 03/14/13 at 10:01 AM, with the Executive Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on third shift. All fire drills conducted in the last four quarters on third shift were conducted within fifteen (15) minutes of 5:30 AM.</p> <p>Interview, on 03/14/13 at 10:01 AM, with the Executive Maintenance Director revealed he was not aware the fire drills were not being conducted as required.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 18.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.</p>	K 050	<p>4. Director of Maintenance will record all fire drills in the TELs program and log accordingly into the Life Safety Binder. Fire drill records will be reviewed by the Regional Director of Facility Management no less than quarterly to ensure the drills are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report to the facility QA Committee for one year.</p>	
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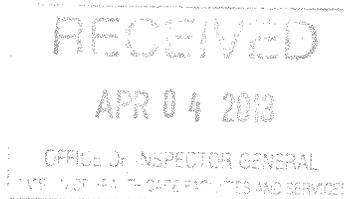
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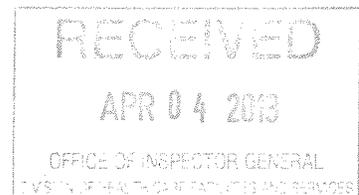
K 052 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on interview and fire alarm inspection review, the facility failed to test the fire alarm system quarterly per NFPA standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, residents, staff, and visitors. The facility has one hundred twenty eight (128) certified beds with a census of one hundred twenty (120) on the day of the survey.</p> <p>Findings include:</p> <p>Fire alarm inspection review, on 03/14/13 at 10:22 AM, with the Executive Maintenance Director revealed the facility failed to conduct a fire alarm inspection in the 3rd quarter of 2012. However a fire alarm inspection was conducted on 10/03/12.</p> <p>Interview, on 03/14/13 at 10:22 AM, with the Executive Maintenance Director revealed the facility had a contract with a company to complete the fire alarm tests as required, but did not have a system in place to monitor the fire alarm testing company to ensure they were conducting the</p>	K 052	<p>1. The 3rd quarter fire alarm safety test was completed 3 days late on 10/3/012. Subsequent quarterly testing has been done on time.</p> <p>2. To ensure all fire alarm tests are completed quarterly, and on time, by the contract company the Executive Maintenance Director will schedule all tests on a yearly basis with the testing company. The dates for the test will be noted in writing to the Administrator. The Executive Maintenance Director will call the testing company 1 week in advance when the quarterly test is due, and will ensure the testing is completed within the regulatory time frame.</p> <p>3. The Executive Maintenance Director and the Regional Maintenance Director will ensure that the quarterly fire alarm testing is entered into the TELS program for further prompting and tracking of testing dates. The maintenance department staff will be trained by the Regional maintenance director on the NFPA standards regarding fire alarm testing, and this will be completed 4/27/13.</p>	4/28/13
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NAME OF PROVIDER OR SUPPLIER OAKLAWN NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245		
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K 052	Continued From page 13 tests in accordance with NFPA standards.	K 052	4. Quarterly fire alarm safety tests documented in the TELS system will be reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report to the facility QA Committee for one year.		
K 056 SS=D	Actual NFPA Standard: NFPA 101, 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. 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, installed in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of	K 056	K- 056 1. The three sprinkler heads in the kitchen with temperature response ratings of 286 degrees have been replaced with sprinkler heads with a temperature response rating of 155 degrees which makes all sprinkler heads in the kitchen of the same temperature response type. Completed 4/3/13 2. The executive maintenance director and regional maintenance director reviewed all sprinkler heads in the building and found no other mixed	4/28/13	



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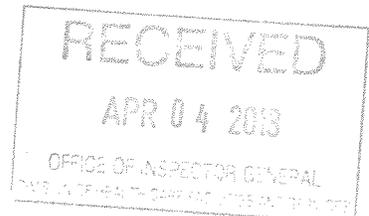
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K 056	<p>Continued From page 14</p> <p>one hundred twenty (120) on the day of the survey. The facility failed to ensure sprinkler heads installed in a compartment were of the same temperature response type.</p> <p>The findings include:</p> <p>Observations, on 03/14/13 at 11:47 AM, with the Executive Maintenance Director revealed mixed response sprinkler heads located in the Kitchen.</p> <p>Interview, on 03/14/13 at 11:47 AM, with the Executive Maintenance Director revealed he was not aware of the requirement for sprinkler heads being of the same response rating in a compartment.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</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</p>	K 056	<p>response sprinkler heads in the building. 4/1/13</p> <p>3.To ensure all sprinkler heads remain the same temperature response rating according to the NFPA 13 standard all maintenance personnel will be educated about the NFPA standard and compliance with the standard. This will be completed by the Regional Maintenance Director by 4/27/13.</p> <p>4. The Executive Maintenance Director will inspect sprinkler heads according to our TELS program and the results will be reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report to the facility QA Committee for one year.</p>	
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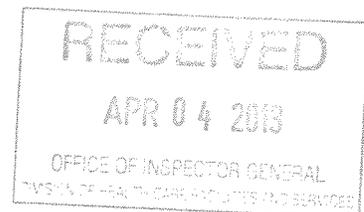
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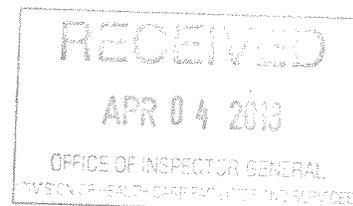
K 056	<p>Continued From page 15 are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed</p>	K 056		
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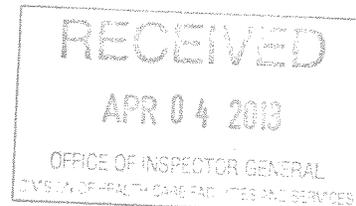
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K 056	<p>Continued From page 16 maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 edition)</p> <p>5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</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 colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)</th> <th>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> </tbody> </table>	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A) (B)	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	K 056		
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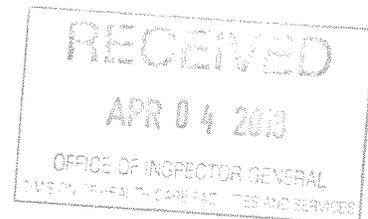
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K 056	Continued From page 17 4 ft 6 in. to less than 5 ft 161/2 5 ft and greater 18	K 056			
K 064 SS=D	For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire extinguishers were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey. The facility failed to provide required signage for fire extinguishers. The findings include: Observation, on 03/14/13 at 11:44 AM, with the Executive Maintenance Director revealed there was no placard stating that the hood suppression system must be used before the class K fire extinguisher. This type of extinguisher is used as a secondary measure to the range hood extinguishing system.	K 064	K 064 1. Oaklawn ensures that all necessary fire extinguishers are present and in proper working condition. The Class K extinguisher in the kitchen that was lacking a sign stating the hood suppression system must be used before the Class K fire extinguisher now has the sign in place. This was completed on March 20, 2013 by the Executive Maintenance Director. 2. Inspection by the Executive Maintenance Director and Regional Maintenance Director revealed there are no other Class K extinguishers in the building. Completed March 20, 2013. 3. To ensure the sign remains in place the executive Maintenance Director will inspect for presence of the sign during monthly TELS reviews, and document same. 4. The regional maintenance director will review the monthly inspection reports and notify the administrator of any ongoing issues which will be	3/21/13	



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NAME OF PROVIDER OR SUPPLIER OAKLAWN NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SHELBY STATION DRIVE LOUISVILLE, KY 40245	
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K 064	Continued From page 18 Interview, on 03/14/13 at 11:44 AM, with the Executive Maintenance Director revealed he was not aware of the signage requirement. Reference: NFPA 10 (1998 Edition). 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. Reference NFPA 10 (1998 Edition). 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lb (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb (18.14 kg) (except wheeled types) shall be so installed that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 in. (10.2 cm).	K 064	reported in the facility QA Committee for one year. K 066 1. The housekeeping director has purchased and provided metal containers with self-closing lids into which ashtrays can be emptied. The new containers are readily available to all smoking areas. This was completed 3/25/13 2. All housekeeping employees have been educated on the use of the new self-closing containers for the collection of residue from ashtrays. This was completed 4/2/13. In addition all newly hired housekeeping staff will be trained on the proper disposal of waste from ash trays. This will be ongoing. 3. The Housekeeping Director will make weekly rounds for four weeks and monthly thereafter to ensure the containers are in place and used appropriately. 4. Results of monthly inspections, and any ongoing issues, will be reported by the Housekeeping Director to the Administrator who shall report to the quarterly QA committee for one year.	4/3/13
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.	K 066		



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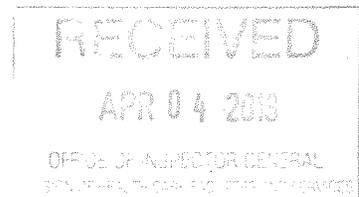
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K 066	<p>Continued From page 19</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking 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. 18.7.4</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 smokers, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays.</p> <p>The findings include:</p> <p>Observation, on 03/14/13 at 10:41 AM, with the Executive Maintenance Director revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking areas.</p> <p>Interview, on 03/14/13 at 10:41 AM, with the</p>	K 066		
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K 066	Continued From page 20 Executive Maintenance Director revealed he was not aware of the requirement for metal containers with a self-closing lid for dumping ashtrays. Reference: NFPA Standard 101 (2000 Edition). 19.7.4 Smoking (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect three (3) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments. The findings include:	K 072	1. Medication carts that were not in use were removed from the corridors and placed in the hall behind the nurses' station on COG by the Director of Nursing on 3/14/13. 2. The Director of Nursing and the Facility Executive Maintenance Director reviewed placement of medication/treatment carts throughout the building. Additional electrical outlets will be installed for the storage of all carts in alternative areas when not in use. The work is scheduled to be completed by 4/27/13 by the electrical contractor as verified by the Executive Maintenance Director. 3. All nurses and CMTs will be trained on the need to keep the hallways free of obstruction with medication and	4/28/13	

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K 072	Continued From page 21 Observations, on 03/14/13 between 10:00 AM and 2:30 PM, with the Executive Maintenance Director revealed the storage of med carts, at the cross corridor doors located in the COG Hall A and B. Interview, on 03/14/13 between 10:00 AM and 2:30 PM, with the Executive Maintenance Director revealed the med carts were routinely stored in these areas. Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	treatment carts when they are not in use. The training will be conducted by the Director of Education and it will be completed by 4/27/13. 4. Charge Nurses will monitor the hallways daily for one week, weekly for four weeks and monthly thereafter. Reports will be submitted to the DON upon completion and will be reviewed with staff on duty at the time of the observations so any issues may be addressed with staff responsible. DON will report on observations to the facility QA Committee for one year.		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on fire damper testing record review, and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect fourteen (14) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey. The facility failed to provide documentation that the smoke/fire dampers were	K 104	K 104 1. Fire/smoke damper testing will be initiated and completed by 4/27/13. This will be completed by a contract service with verification of the work by the Executive Maintenance Director 2. Fire Damper testing has been added to the TELS preventive maintenance program for testing every 4 years. This	4/29/13	



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K 104	Continued From page 22 tested within the last four (4) years. The findings include: Fire damper testing record review, on 03/14/13 at 10:40 AM with the Executive Maintenance Director revealed the facility did not have documentation that fire/smoke dampers had been tested within the last four (4) years. Interview, on 03/14/13 at 10:40 AM, with the Executive Maintenance Director revealed he was not aware of the requirements for fire/smoke damper testing. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104	was added by the Executive maintenance Director on 4/2/13. 3. The documentation of the fire/smoke damper testing for 2013 will be maintained in the Life-Safety Code Documentation (TELS program) and maintained in the Executive Maintenance Director's office. 4. The fire/smoke damper tests as documented in the TELS system will be reviewed by the Regional Director of Facility Management annually to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report to the facility QA Committee for one year.		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to protect direct vent fireplaces to ensure safe operation in accordance with CMS. The deficiency had the potential to affect one (1) of fourteen (14) smoke compartments, residents, staff and visitors. The facility is certified for one hundred twenty eight	K 130	K 130 1. A protective screen has been added in front of the gas fireplace to ensure the glass is not touched by residents, staff or visitors. This was done by the Director of Housekeeping on 4/1/13. 2. There are no other fire places in the building.	4/2/13	



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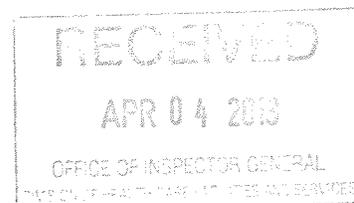
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K 130	Continued From page 23 (128) beds, with a census of one hundred twenty (120) on the day of the survey. The facility failed to provide a protective screen to protect residents from burns. The findings include: Observation, on 03/14/13 at 8:28 AM, with the Executive Maintenance Director revealed a gas fireplace located in the Main Lobby. The fireplace was a direct-vent natural gas fireplace with a solid glass front. The glass did not have a protective screen provided to ensure residents, staff, or visitors could not touch the glass. Interview, on 03/14/13 at 8:28 AM, with the Executive Maintenance Director revealed he was not aware the facility had failed to provide the required protection for direct-vent fireplaces.	K 130	3. The Housekeeping Director will ensure the new screen remains in place at all times by making visual inspection weekly for 4 weeks and monthly for one year. 4. The Administrator will ensure the checks are being completed, and will report any ongoing issues to the facility QA Committee for one year.	
K 147 SS=D	Ref: S&C-12-21-LSC 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 fourteen (14) smoke compartments, residents, staff, and visitors. The facility is certified for one hundred twenty eight (128) beds with a census of one hundred twenty (120) on the day of the survey. The facility failed	K 147	K 147 1. All power strips and multi plug adaptors have been removed and ground fault receptacles have been added to the Therapy gym for the hydrocollator units. The refrigerators, and coffee grinder have been removed and all equipment including the housekeeping department coffee maker have been plugged directly into wall outlets. This work was completed by the Executive Maintenance Director on 3/25/13. 2. On 3/25/13 the Executive Maintenance Director and the Maintenance Assistant made rounds to identify any other improper use of power strips, or multi-plug adaptors,	4/22/13



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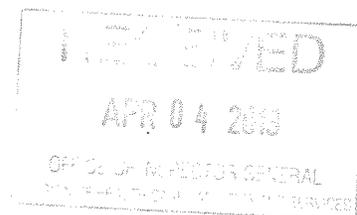
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K 147	<p>Continued From page 24 to maintain proper use of power strips, extension cords, and GFCI receptacles.</p> <p>The findings include:</p> <p>Observations, on 03/14/13 between 10:00 AM and 2:30 PM, with the Executive Maintenance Director revealed:</p> <ol style="list-style-type: none"> 1) A coffee maker and refrigerator were plugged into a power strip located in the Housekeeping Office. 2) Two (2) hydrocollators located in the Therapy Gym were not plugged into a ground fault (GFCI) receptacle. 3) A refrigerator was plugged into a multi-plug adaptor located in room #127. 4) A refrigerator and coffee grinder were plugged into a power strip located in the Copy Room. <p>Interview, on 03/14/13 between 10:00 AM and 2:30 PM, with the Executive Maintenance Director revealed he was not aware the misuse of power strips and extension cords. Further interview revealed he was not aware the hydrocollators were not plugged into a GFCI receptacle.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>3-3.2.1.2 D</p> <p>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</p>	K 147	<p>as well as presence and proper use of GFCI receptacles.</p> <p>3. All maintenance staff will receive training on the use of power strips, multi-plug adaptors and GFCI receptacles by the Regional Maintenance Director by 4/27/13</p> <p>All staff, families, and residents will be informed about this regulation via written communication from the Administrator in the next facility newsletter.</p> <p>4. Executive Maintenance Director will make rounds daily for one week, weekly for four weeks and monthly thereafter to check all areas of the facility for the proper use electrical receptacles without the use of power strips, GFCI, and/or multi plug adaptors. Reports will be submitted to the Administrator upon completion. Any ongoing issues will be reported by the Administrator to the facility QA Committee for one year.</p>		



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K 147	<p>Continued From page 25 adapters.</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around 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>Reference: NFPA 70 (1999 edition)</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>370.28(c) Covers.</p> <p>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.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p>	K 147			



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K 147	Continued From page 26 Reference: NFPA 70 400-8 (Extensions Cords) Uses Not Permltted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147			

