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

PRINTED: 07/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185355		06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER VALLEY NURSING HOME	305 TAYLOR STREET #402 BUTLER, KY 41006

(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)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	SEE Attachments	
	A Recertification survey was initiated on 06/19/12 and concluded on 06/21/12. Deficiencies were cited at the highest scope and severity of an "E".			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	SEE Attachments	6/23/12
	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to store and serve food under sanitary conditions, as evidenced by temperatures in dry storage not being regulated or monitored, and hot food items not measured for temperature, and other hot food items leaving the kitchen at less than 140 degrees Fahrenheit.			
	The findings include:			
	Review of the facility's policy revealed no stipulation for monitoring dry storage temperatures.			
	Observation of the dry storage area, on 06/19/12 at 10:15 AM, revealed no thermometer in place to monitor the temperature in the area. Further			

RECEIVED
JUL 12 2012
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ken Gilage
TITLE: Administrator
(X6) DATE: 7/12/2012

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 371	Continued From page 1 observation revealed no evidence of central heating or air in the storage room, and no evidence the temperature could be controlled. An interview with the Dietary Manager, on 06/19/12 at 10:30 AM, revealed she was unaware the temperature in dry storage area needed to be monitored. Further interview revealed recognition that high temperatures could lead some food items in dry storage to spoil. Observation during meal service, on 06/19/12 at 6:40 PM, revealed Dietary #1 measured the temperature of pureed squash on the steam table at 132 degrees Fahrenheit. The pureed squash was not reheated or re-temped. At 6:16 PM, Dietary #1 was observed preparing trays to go out to the floor, four (4) of which included pureed squash. Further observation of the meal service on 06/19/12 revealed additional squash was added to the steam table, which was not temped prior to adding to trays to go out to the floor. An interview with Dietary #1 on 06/19/12 at 6:40 PM revealed hot food items should leave the kitchen between 150 and 170 degrees Fahrenheit, and that hot food items that were below this were to be reheated. When asked about the pureed squash, she revealed she didn't have time to warm it up prior to service. When asked about the squash that was added to the steam table, Dietary #1 revealed she should have taken the temperature, but failed to do so as she needed it right away. An interview with the Dietary Manager, on 06/19/12 at 6:35 PM, revealed all hot food items were to leave the temperature at 140 degrees	F 371	SEE Attachments	6/23/12

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F 371	Continued From page 2 Fahrenheit or above, and when hot food items were added or replaced on the steam table, said items were to be measured to ensure they were at 140 degrees Fahrenheit or above. The Dietary Manager went on to reveal all dietary staff had been trained on this, and attributed the error to nervousness on the part of Dietary #1.	F 371	SEE Attachments	4/23/12

F 371 483.35(I) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY SS=E

The facility must – (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions

- No specific resident was cited in this deficient practice.
- All residents have the potential of being affected by the deficient practice. This was determined via review of citation and that all residents receive their meals via the dietary department.
- An accurate, calibrated thermometer was placed in the dry goods storage room, to provide food that is stored, prepared, distributed, and served in a safe manner. Dry storage temperature should be between 50º - 70º. All dietary staff was reeducated on the proper practice of checking and recording freezer, refrigerator and dry good room temperatures. A Room air conditioning unit has been placed in dry good storage room.
- The food storage policy and the food temperature policy has been reviewed and revised. To ensure that food is cooked and held at temperatures to ensure food safety and palatability, temperatures will continue to be taken at the beginning, midway and near the end of tray line. Temperatures will be taken before food is placed on the steam table and must be 160º or above. Food under 140º will be reheated. Staff has been reeducated in the proper practice and importance of taking temperatures.
- Morning and Evening Cooks will check and record temperature twice daily for 3 months and then once a day. Quality assurance monitoring will be conducted by the Registered Dietician and the Dietary Manager. The Dietary Manager will monitor the dry good storage temperatures (at least once weekly) for one month (30 days). After the first month, the Dietary Manager will monitor dry good storage temperatures once biweekly for one month (30 days), then monthly times three months (90 days). The Registered Dietician and/or Dietary Manager will monitor food temperatures at least three times a week for one month (30 days). After one month, the Dietary Manager will monitor temperatures at least once a

week for one month (30 days), then biweekly times six months (180 days). The Dietary Manager will extend quality assurance checks based on concerns noted. The Registered Dietician will continue to observe and monitor for proper temperature compliance. The Dietician alerts the Dietary Manager, Administrator, and DON, when she finds concerns that need to be addressed. Teaching moments will be given and explained by the Dietary Manager as she observes any dietary staff not utilizing proper temperature procedures.

- **Compliance with F371 was completed on June 23, 2012**.

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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 03/15/72 SURVEY UNDER: NFPA 101 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story Type III (200) SMOKE COMPARTMENTS: Three (3) smoke compartments FIRE ALARM: Complete fire alarm system SPRINKLER SYSTEM: Complete (wet) sprinkler system GENERATOR: One (1) Type II Diesel generator. A standard Life Safety Code survey was conducted on 06/20/12. River Valley Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty (60) beds with a census of one fifty-eight (58) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest	K 000	SEE Attachments RECEIVED JUL 12 2012 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ken Neff
TITLE: Administrator
(X6) DATE: 7/12/2012

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/12/2012

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K 000	Continued From page 1 deficiency identified at "F" level.	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all residents, staff and visitors. The facility is licensed for sixty (60) beds and the census was fifty-eight (58) the day of the survey. The findings include: Observation, on 06/20/12 between 9:00 AM and 1:00 PM, revealed the smoke barriers for the A Wing and B Wing had penetrations where the steel trusses and the corrugated steel meet was not sealed with a material that is equal or greater than existing material or fire rated. Penetrations in smoke barriers must be sealed to prevent the	K 025	SEE Attachments	7/10/12

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K 025	Continued From page 2 spread of smoke during a fire. The observations were confirmed with the Maintenance Director. Interview, on 06/20/12 between 9:00 AM and 1:00 PM with the Maintenance Director, revealed he was not aware of what he could use to seal the penetrations. Reference: NFPA 101 (2000 edition) 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: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is	K 025	SEE Attachments	7/10/12

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K 025	Continued From page 3 designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 025	SEE Attachments	7/10/12
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are 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 Fire Drill record review and interview, 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 all three (3)smoke compartments, residents, staff, and visitors. The facility is licensed for sixty (60) beds and the census was fifty-eight (58) on the day of the survey. The findings include:	K 050	SEE Attachments	7/1/12

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K 050	Continued From page 4 Fire Drill record review, on 06/20/12 at 12:45 PM, with the Maintenance Director revealed the fire drills were not conducted and documented for the third quarter for all three shifts. Fire drills must be conducted at least quarterly on each shift. Interview, on 06/20/12 at 12:45 PM, with the Maintenance Director revealed he was unaware the 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	SEE Attachments	7/1/12
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 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the	K 056	SEE Attachment	8/3/12

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K 056	Continued From page 5 building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, thirty (30) 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 06/20/12 between 9:00 AM and 1:00 PM, with the Maintenance Director revealed one (1) overhang that extended out four (4) foot or greater, made of combustible materials, and were not sprinkler protected. The overhang was located outside the exit at the end of the A wing Hall. Interview, on 06/20/12 between 9:00 AM and 1:00 PM, with the Maintenance Director revealed they were not aware the overhang needed to be sprinkler protected. 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	SEE Attachments	8/3/12
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062	SEE Attachments	7/4/12

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K 062	Continued From page 6 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to maintain the fire sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, all 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: Record review, on 06/20/12 at 12:30 PM, with the Maintenance Director revealed the facility was due for Internal Pipe Inspection and that two (2) gauges needed to be replaced. No record of Internal Pipe Inspection being performed or Gauges replaced. All Fire Sprinkler Inspection records reviewed during the survey indicated that the Internal Pipe Inspection was required and gauges needed replaced in the remarks section. Interview, on 06/20/12 at 12:30 PM, with the Maintenance Director revealed he was unaware the sprinkler system requirements. Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of	K 062	SEE Attachments	7/6/12

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K 062	Continued From page 7 sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9. Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years	K 062	SEE Attachment	7/6/12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 8 thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction Investigation Maintenance 5 years or as needed Chapter 10	K 062	SEE Attachments	7/6/12
K 147 SS=D	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 the facility had an adequate number of electrical receptacles to meet the needs of residents without the use of extension cords or multiple outlet adapters according to National Fire Protection Association (NFPA). The deficiency had the potential to affect one (1) smoke compartment, thirty (30) residents, staff and visitors. The findings include: Observation, on 06/20/12 between 9:00 AM and 1:00 PM, with the Maintenance Director revealed multi outlet strip being used as permanent wiring. Oxygen concentrator, bed, comp mist machine was observed plugged into power strip in room #1A. Facilities must provide an adequate number of electrical receptacles to meet the needs of	K 147	SEE Attachments	6/22/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	186355		06/20/2012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 9 residents. Also extension cords and multi outlet strip cannot be used as a substitute for permanent wiring. Interview, on 06/20/12, between 9:00 AM and 1:00 PM, with the Maintenance Director revealed he thought the power strips could be used. This was also confirmed with the Administrator upon exit conference. Reference: NFPA 99 (1999 Edition). 3-3.2.1.2 D 2. 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). 400-8. Uses Not Permitted Unless specifically permitted in Section 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 Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped	K 147	SEE Attachments	4/22/12

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185355	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/20/2012

NAME OF PROVIDER OR SUPPLIER
RIVER VALLEY NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
306 TAYLOR STREET #402
BUTLER, KY 41006

(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)	(X6) COMPLETION DATE
K 147	Continued From page 10 ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code.	K 147	SEE Attachments	6/22/12

Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the federal and state law.

RECEIVED JUL 12 2012

K025 NFPA LIFE SAFETY CODE STANDARDS SS=F

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, venting, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.4

- No resident was affected in this deficient practice. Since this was found in all three sections of the building this can affect all individuals who are in the facility, not just the residents. The Measures put in place to ensure that this will not recur are, 1.The proper type material designed to limit the smoke penetration has been purchased. 2. The improper material has been removed and the proper material applied as required.
- All residents, family, staff and visitors have the potential to be affected by this practice since it is a Life Safety Code issue that involves potentially the entire facility.
- The maintenance Director has removed the inappropriate material from the facility.
- All work done in the facility will be monitored by the Maintenance Director to insure any and all penetrations thru these Barriers will be filled with the proper material.
- **K025 NFPA 101 Life Safety Code Standard** **Completed July 10, 2012.**

K050 NFPA 101 Life Safety Code Standard SS=F

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 9pm and 6am a coded announcement may be used instead of audible alarms. 19.7.1.2

- No specific resident was affected, but all residents have the potential to be affected. Fire drills were held and will be conducted on all shifts as required and will be documented.
- All residents, families, visitors and staff would be affected by this deficient practice if a fire were to occur and the staff not be properly trained.
- In this case, the drills were held but not on a rotating quarterly shift. For the dills that were held during that quarter the paper work was not found or available on the date of survey. The Maintenance Director will conduct shift fire drills at unexpected times (under varying conditions) on each shift at least quarterly. The fire drills will be documented and copies will be placed in the Maintenance Department and the Business Office, to insure copies are available when requested.
- This will be monitored by the Administrator monthly to insure continued compliance.
- **K 050 NFPA 101 Life Safety code Standard Completed on July 1, 2012**

K056 NFPA LIFE SAFETY CODE STANDARD SS=D

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 fire alarm system. 19.3.5.

- No resident was affected by this deficient practice. This deficiency has the potential to directly affect one (1) of three (3) smoke compartments with thirty (30) residents, staff and visitors. The "A" wing has thirty (30) resident beds licensed and certified. The additional sprinkler will be installed.
- Should the facility ever have the unfortunate circumstance of a fire the "A" wing exit might be the only exit available, this would then have the potential to affect all residents, staff and visitors.
- The sprinkle company has been notified and requested to provide a bid for the work to be completed. Once the bid has been received and a price accepted the work will be completed in a timely manner in accordance with all applicable Standards.

- Not only will the facility be monitoring the work on the sprinkler system according to the sprinkler installer the plans would need to be submitted to the State of Kentucky Department of Housing for approval. Pending approval by State Agencies, if required, the installation will be completed as quickly as possible.
- **K 056 NFPA Life Safety code Standard Completion Date 8/3/2012**

K 062 NFPA LIFE SAFETY CODE STANDARD SS=F

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.

19.7.6, 4.6.12, NFPA 25, 9.7.5

- No residents were affected by this deficient practice. However, when needed the sprinkler system is necessary for the safety of all residents, staff and visitors. Therefore, all residents have the potential to be affected. Inspection has been completed to insure no residents will be affected. New gauges were ordered and installed.
- All residents have the potential of being affected by this deficient practice.
- The sprinkler company was contacted the day of survey. The sprinkler company completed the work the following week to insure the internal pipes were inspected and the gauges replaced.
- The sprinkler company is to provide written proof of inspection and replacement of the gauges which will be kept on file in the facility to show compliance (when requested).
- **K 062 NFPA Life Safety Code Standard completed 7/6/2012**

K 147 NFPA LIFE SAFETY CODE STANDARD SS=D

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

- Resident in Room #1A was affected by this deficient practice. The power strip was removed immediately and the equipment plugged in to proper receptacle. A room audit was conducted to verify no other resident had medical equipment improperly connected. Based on a review of patient records there are thirteen (13) residents (at present) with medical equipment in their rooms, that requires electrical receptacles.
- Any resident could have the potential to be affected by this deficient if the need for electrical medical equipment arises in the future.
- To insure no reoccurrence the maintenance director and Administrator will do "Teaching Moments" with all staff to make them aware of the issue and what corrective action is required.
- The Maintenance director and Administrator will do weekly rounds to insure power strips are not being used on medical equipment. In addition all staff have been instructed to report the use of power strips on any equipment, so it can be determined if it must be plugged into a wall receptacle.
- **K 147 NFPA Life Safety Code Standard completed 7/12/2012**