

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

PRINTED: 04/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185269	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/07/2014
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS Based on implementation of the acceptable POC, the facility was deemed to be in compliance, 05/07/14 as alleged.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064
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F 371	Continued From page 1 revealed staff should wash their hands before and after handling food. Interview with the Administrator, on 03/28/14 at 12:00 PM, revealed he expected staff to follow the policy. Observation of the tray line, on 03/26/14 at 11:30 AM, revealed the cook served one (1) tray from the tray line, wearing gloves used from completing food temperatures. She obtained two (2) meat patties from an aluminum foil packet, holding the meat with her soiled gloved hands. She left the tray line to get two hamburger buns. With the same gloved hands, she put the meat inside the buns and placed them on a plate. She returned to the tray line without removing the gloves or washing her hands. Interview with the Dietary Manager, on 03/27/14 at 9:02 AM, revealed she expected staff to don new gloves before handling food. She revealed staff should remove their gloves and wash their hands prior to returning to the tray line.	F 371	demonstrating proper sanitation techniques for handling food on the food serving line. 2. The Dietary Manager observed all Dietary staff who work on the food serving line on 4/9/14, 4/10/14 and 4/11/14 demonstrating proper sanitation techniques for handling food and no further issues were identified. 3. The Dietary Manager will re-train all Dietary staff on proper sanitation techniques for handling food on the serving line. No Dietary staff will work after 4/24/14 without this training. 4. The Dietary Manager will observe proper handling techniques for handling food on the food serving line three (3) times per week for four (4) weeks, then weekly for two (2) months. The findings of the observations will be reported to the Quality Assurance Committee for three (3) months. Any issues related to the observations will be presented to the Quality Assurance Committee for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and the Medical Director.	
F 441 SSPE	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 to help prevent the development and transmission of disease and infection. (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	F 441	5. Completion Date: 5/7/14. F441 1. C.N.A. #1 and 2 were observed by the Unit Manager on 4/1/14	5/7/14

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F 441	<p>Continued From page 2</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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</p> <p>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, review of facility policy and review of the Center for Disease Control Guidelines for Isolation Precautions, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for two (2) of fourteen (14) sampled residents (Resident #1 and Resident #6) and one (1) unsampled resident (Resident C). Staff failed to don gloves before entering into a room of residents on isolation and failed to wash their</p>	F 441	<p>demonstrating proper infection control techniques with residents with contact precautions including hand washing and donning/un-donning of gloves when serving food trays. The Unit Manager is no longer employed by the facility.</p> <p>2. The Director of Nursing and/or Unit Managers observed all C.N.A's and LPN's who work with residents with contact precautions on 4/16/14 and 4/17/14 and no further issues related to infection control were noted.</p> <p>3. The Director of Nursing and/or Unit Managers will re-train all staff on proper infection control techniques with residents with contact precautions. No staff will work after 4/24/14 without this training.</p> <p>4. The Director of Nursing and/or Unit Managers will observe proper infection control techniques for residents with contact precautions three (3) times per week for four (4) weeks, then weekly for two (2) months. The findings of the observations will be reported to the Quality Assurance Committee for three (3) months. Any issues related to the observations will be reported to the Quality Assurance Committee for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and the Medical Director.</p> <p>5. Completion Date: 5/7/14.</p>	

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F 441	<p>Continued From page 3 hands prior to exiting the room.</p> <p>The findings include:</p> <p>Review of the facility's "Pathway to Infection Precautions, Contact Precautions" Policy, dated 3/2010, revealed staff should wash hands and wear gloves when caring for ALL residents with infections requiring contact isolation.</p> <p>Review of the facility's "Methicillin-resistant Staphylococcus Aureus (MRSA) policy, dated 6/2011, and the "Extended Spectrum Beta Lactamase (ESBL)" policy, dated 6/2011, revealed contact precautions should include wearing of gloves when entering the room and the changing of gloves after contact with infective material.</p> <p>Review of the Center for Disease Control Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings published 2007 page 84, section V.B.3.a of Contact Precautions revealed to wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient. Don gloves upon entry into the room or cubicle and handwashing should be performed immediately upon removing gloves and before leaving the room or cubicle.</p> <p>1. Record review revealed the facility admitted Resident #6 on 06/28/09 with diagnoses which included Hypertension, Depression, Alzheimer's, Sepsis, Prostatitis, Psychosis, Anxiety and ESLB of the Urine.</p> <p>Review of the Physician's orders, dated 03/18/14, revealed the resident was started on Penicillin VK</p>	F 441		

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F 441	<p>Continued From page 4 (antibiotic) 500 milligrams (mg) BID x ten (10) days for ESLB of the urine.</p> <p>Observation, on 03/26/27 at 11:50 AM during meal pass, revealed there was a "See Nurse Before Entering" sign posted at the door of Resident #6 and an isolation cart was stationed outside the door to alert staff and visitors of precautions; however, Certified Nurse Aide (CNA) #2 entered Resident #6's isolation room with the meal tray and without donning gloves. CNA #2 proceeded to set up the meal tray on the over the bed table, then exited the room and continued to pass meal trays without washing her hands.</p> <p>Further observation, on 03/27/14 at 11:33 AM, revealed the Unit Manager entered Resident #6's room without gloves to deliver the meal tray.</p> <p>2. Record review revealed the facility readmitted Resident C 01/23/14 with diagnoses which included Anorexia, Depression, Paraplegia, Weakness, Osteomyelitis, MRSA, Infection resistant to drugs, Pressure Ulcer of the Buttock and Neurogenic Bladder.</p> <p>Observation of a meal pass on hallway 400 and 500, on 03/26/14 at 11:39 AM, revealed there was a "See Nurse Before Entering" sign posted at the door of Resident C's room and an isolation cart was stationed outside the door to alert staff and visitors of precautions; however, further observation revealed CNA # 2 entered Resident C's isolation room without donning gloves, placed the meal tray on the over the bed table and adjusted it to the resident's comfort. CNA #2 then exited the room with Resident C's personal cup without washing her hands and handed the cup to another staff. CNA #2 continued to pass trays to</p>	F 441			

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F 441	<p>Continued From page 5</p> <p>other residents on the hall without washing hands.</p> <p>Observation during a meal pass, on 03/27/14 at 11:31 AM, revealed CNA #1 entered Resident C's isolation room without donning gloves, prepared the tray on the over the bed table, then exited the room without washing her hands and continued to pass trays to other residents on the hall.</p> <p>3. Record review revealed the facility readmitted Resident #1 on 03/12/14 with diagnoses which included Septic Shock, Pneumonia and Incontinence of urine and feces.</p> <p>Review of a physician's order, dated 03/26/14, revealed an order for Tetracycline (antibiotic) 500 mg three times a day (TID) for seven (7) days for ESBL of the urine.</p> <p>Observation of a meal service, on 03/27/14 at 11:23 AM, revealed there was a "See Nurse Before Entering" sign posted at the door of Resident C's room and an isolation cart was stationed outside the door to alert staff and visitors of precautions; however, CNA #1 entered the resident's room without donning gloves to deliver the resident's meal tray. CNA #1 then left the residents room without washing hands and went to another hall and obtained ketchup packages out of a container on top of the meal cart. The CNA returned to Resident #1's room and entered without donning gloves. The CNA then opened the ketchup packages of the resident and completed the meal set up. The CNA then washed her hands prior to leaving the room.</p> <p>Interview with CNA #1, on 03/28/14 at 8:58 AM,</p>	F 441			

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F 441	<p>Continued From page 6</p> <p>revealed the facility's policy was for staff to wear gloves when entering a room and to wash hands prior to exiting the room of a resident who was on isolation precautions. CNA #1 stated "I messed up, I shouldn't have opened the ketchup with my teeth, I should have worn gloves and should have washed hands when I left the room to get the ketchup from the cart".</p> <p>Interview with CNA #2, on 03/28/14 at 10:30 AM, revealed staff should use hand sanitizer between delivering each resident's meal tray and wash their hands after every third resident. CNA #2 revealed if a resident was in isolation, gloves should be donned before entering the room, the tray prepared, then th gloves should be removed and hands washed before leaving the room. CNA #2 stated she did not sanitize or wash hands between delivering each resident's tray and did not don gloves upon entering a resident's isolation room during the meal pass on 03/26/14. The CNA stated she should have been alerted by the sign on the door and the isolation cart outside the door.</p> <p>Interview, on 03/26/14 at 3:15 PM with Licensed Practical Nurse (LPN) #1, revealed Resident C was in contact isolation for MRSA of the wound on his/her buttocks. The LPN stated the staff should have worn Personal Protective Equipment (PPE) to include gown, gloves and mask during personal care such as wound care, urinary catheter care or direct contact. LPN #1 revealed if staff entered the room to serve water or deliver a meal tray, the staff should don gloves. LPN #1 revealed Resident #6 was in contact isolation for ESBL of the Urine and Resident #6 was continent of urine. The LPN stated the staff was expected to wear PPE during any direct care of the resident</p>	F 441			

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F 441	<p>Continued From page 7</p> <p>and gloves should be used if entering the room to deliver food trays to prevent the spread of infection.</p> <p>Interview with the Unit Manager, on 03/27/14 at 11:44 AM, revealed staff were expected to use PPE when entering a resident's isolation room. She stated if the resident was on contact isolation, staff should wear a full gown and gloves, and if on respiratory isolation, a mask should be used, in addition to other PPE. The Unit Manager revealed any surface area in a resident's room on isolation precautions was potentially contaminated. She stated she expected staff at a minimum to don gloves when serving a tray to a resident in contact isolation. She revealed when the staff does not perform handwashing and use gloves, it causes a strong potential for cross-contamination to other residents.</p> <p>Interview with the Director of Nursing (DON) and Administrator, on 03/28/14 at 11:36 AM, revealed they expected staff to use hand sanitizer between every resident while passing food trays and should wash hands after every third resident tray pass. If the staff touches something such as anything on the floor, the staff should stop and wash their hands then. They revealed if a resident was in isolation, the staff should have worn gloves into the room while passing the meal tray, set up the tray for the resident, then removed the gloves and washed their hands before exiting the room. They stated the staff not washing their hands created a risk for the spread of infection. The DON revealed the current residents on isolation had ESBL and MRSA and if the surface was infected with either of these, the person touching the surface had the potential to</p>	F 441			

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K 000 K 018 SS=E	<p>Continued From page 1 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>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors of resident rooms were in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect five (5) of eight (8) smoke</p>	K 000 K 018	<p>K018</p> <ol style="list-style-type: none"> The Maintenance Director has adjusted the privacy curtains in rooms 314, 308, 311, 509, 511, 414, 407, 404 and 402 so that it does not 	5/7/14
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K 018	<p>Continued From page 2</p> <p>compartments, twenty-six (26) residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and at the time of the survey, the census was seventy-four (74).</p> <p>The findings include:</p> <p>Observation, on 03/26/14 at 1:45 PM with the Maintenance Supervisor, revealed the corridor door to resident room #314 was blocked from closing by the privacy curtain in the room.</p> <p>Interview, on 03/26/14 at 1:46 PM with the Maintenance Supervisor, revealed he was unaware the privacy curtain was affecting the door from closing.</p> <p>Observation, on 03/26/14 at 1:47 PM with the Maintenance Supervisor, revealed the corridor door to the resident room #308 was blocked from closing by the privacy curtain in the room.</p> <p>Interview, on 03/26/14 at 1:48 PM with the Maintenance Supervisor, revealed he was unaware the privacy curtain was affecting the door from closing.</p> <p>Observation, on 03/26/14 at 1:50 PM with the Maintenance Supervisor, revealed the corridor door to resident room #311 was blocked from closing by the privacy curtain in the room.</p> <p>Interview, on 03/26/14 at 1:51 PM with the Maintenance Supervisor, revealed he was unaware the privacy curtain was affecting the door from closing.</p> <p>Observation, on 03/26/14 at 2:30 PM with the Maintenance Supervisor, revealed the corridor</p>	K 018	<p>affect the door from closing on 4/24/14. The Maintenance Director has removed the shoe in 511 from propping the door open on 3/28/14. The Maintenance Director has removed the trash cans that were preventing the door from closing in rooms 606, 618 and 517 on 3/28/14. The Maintenance Director has removed the heart decoration from 609 that was preventing the door from closing on 3/28/14.</p> <ol style="list-style-type: none"> The Maintenance Director inspected all resident room doors on 4/3/14 to identify doors that were impeded from closing. Doors that had impediments were identified on 4/3/14 and repaired on 4/24/14. The Administrator in-serviced the Maintenance Director on 4/2/14 on the requirement that doors not be impeded from properly closing. The Maintenance Director will inspect resident room doors for proper closing without impediments three (3) days per week for four (4) weeks; then, one (1) day per week for two (2) months. The Maintenance Director's inspections will be reviewed by the Quality Assurance Committee on a monthly basis for three (3) months. Any issues related to the inspections will be reviewed by the Quality Assurance Committee for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 189269	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2014	
NAME OF PROVIDER OR SUPPLIER CRITTENDEN COUNTY HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 201 WATSON STREET MARION, KY 42064		
(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 018	<p>Continued From page 3</p> <p>door to resident room #509 was blocked from closing by the privacy curtain in the room.</p> <p>Interview, on 03/26/14 at 2:31 PM with the Maintenance Supervisor, revealed he was unaware the privacy curtain was affecting the door from closing.</p> <p>Observation, on 03/26/14 at 2:35 PM with the Maintenance Supervisor, revealed the corridor door to resident room #511 was blocked from closing by the privacy curtain in the room and a shoe was propping the door.</p> <p>Interview, on 03/26/14 at 2:36 PM with the Maintenance Supervisor, revealed he was unaware the curtain was blocking the door and was unsure why the shoe was wedged under the door.</p> <p>Observation, on 03/26/14 at 2:45 PM with the Maintenance Supervisor, revealed the corridor door to resident room #414 was blocked from closing by the privacy curtain in the room.</p> <p>Interview, on 03/26/14 at 2:46 PM with the Maintenance Supervisor, revealed he was unaware the privacy curtain was affecting the door from closing.</p> <p>Observation, on 03/26/14 at 2:50 PM with the Maintenance Supervisor, revealed the corridor door to resident room #407 was blocked from closing by the privacy curtain in the room.</p> <p>Interview, on 03/26/14 at 2:51 PM with the Maintenance Supervisor, revealed he was unaware the privacy curtain was affecting the door from closing.</p>	K 018	<p>Unit Manager, Social Services Director, Dietary Manager and the Medical Director.</p> <p>5. Date of Completion: 5/7/14.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 018	Continued From page 4 Observation, on 03/26/14 at 2:55 PM with the Maintenance Supervisor, revealed the corridor door to resident room # 04 was blocked from closing by the privacy curtain in the room. Interview, on 03/26/14 at 2:56 PM with the Maintenance Supervisor, revealed he was unaware the privacy curtain was affecting the door from closing. Observation, on 03/26/14 at 3:02 PM with the Maintenance Supervisor, revealed the corridor door to resident room #402 was blocked from closing by the privacy curtain in the room. Interview, on 03/26/14 at 3:03 PM with the Maintenance Supervisor, revealed he was unaware the privacy curtain was affecting the door from closing. Observation, on 03/26/14 at 3:10 PM with the Maintenance Supervisor, revealed the corridor door to resident room #606 was blocked from closing by a trash can placed in front of the door. Interview, on 03/26/14 at 3:11 PM with the Maintenance Supervisor, revealed he was unaware the trash can was being placed in front of the resident door to keep it open. Observation, on 03/26/14 at 3:17 PM with the Maintenance Supervisor, revealed the corridor door to resident room #618 was blocked from closing by a trash can placed in front of the door. Interview, on 03/26/14 at 3:18 PM with the Maintenance Supervisor, revealed he was unaware the trash can was being placed in front	K 018		

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K 018	<p>Continued From page 5 of the resident door to keep it open.</p> <p>Observation, on 03/26/14 at 3:23 PM with the Maintenance Supervisor, revealed the corridor door to resident room #517 was blocked from closing by a trash can placed in front of the door.</p> <p>Interview, on 03/26/14 at 3:24 PM with the Maintenance Supervisor, revealed he was unaware the trash can was being placed in front of the resident door to keep it open.</p> <p>Observation, on 03/26/14 at 3:30 PM with the Maintenance Supervisor, revealed the corridor door to resident room #609 was blocked from closing by a heart decoration placed on the resident door handle.</p> <p>Interview, on 03/26/14 at 3:31 PM with the Maintenance Supervisor, revealed he was unaware the decoration was placed on the door handle preventing the door from closing properly.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/26/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/26/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the</p>	K 018			

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K 018	Continued From page 6 passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that	K 018		

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K 018	Continued From page 7 release when the door is pushed or pulled are friction catches or magnetic catches.	K 018		
K 025 SS=E	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 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 deficient practice has the potential to affect four (4) of eight (8) smoke compartments, thirty-six (36) residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and at the time of the survey, the census was seventy-four (74). The findings include: Observation, on 03/26/14 at 11:12 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at room #202 did not extend to the roof decking of the facility.	K 025	K025 1. The Maintenance Director repaired the smoke partition located at room 202 on 4/22/14 and the smoke partition now extends to the roof decking of the facility. The Maintenance Director repaired the door above room 408 on 4/22/14 and it now is closed. 2. The Maintenance Director surveyed the attic for other areas that would allow the passage of smoke on 4/22/14. None were observed. 3. The Administrator in-serviced the Maintenance Director on 4/2/14 on smoke barriers not allowing the passage of smoke. 4. The Maintenance Director will survey the attic for smoke barriers penetrations weekly for one (1) month and monthly for two (2) months thereafter. The results of the observations will be reviewed by the Quality Assurance Committee on a monthly basis for three (3) months. Any issues related to the inspections will be reviewed by the Quality Assurance Committee for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and the	5/7/14

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K 025	Continued From page 8 Interview, on 03/26/14 at 11:13 AM with the Maintenance Supervisor, revealed he was unaware the wall was not properly constructed to resist the passage of smoke. Observation, on 03/26/14 at 11:30 AM with the Maintenance Supervisor, revealed the smoke partition, extending above the ceiling located at room #408 was penetrated by a door that was left open and the self-closing spring was removed from the door. Interview, on 03/26/14 at 11:31 AM with the Maintenance Supervisor, revealed he was unaware the door was left open. The census of seventy-four (74) was verified by the Administrator on 03/26/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/26/14. Actual NFPA Standard: 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	K 025	Medical Director. 5. Completion Date: 5/7/14.	

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K 025	Continued From page 9 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. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027		

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K 027	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficient practice has the potential to affect seven (7) of eight (8) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and at the time of the survey, the census was seventy-four (74). The findings include: Observation, on 03/26/14 at 1:40 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at 500 W would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Interview, on 03/26/14 at 1:41 PM with the Maintenance Supervisor, revealed he was under the impression that the allowable gap on the cross-corridor doors was a quarter of an inch. Observation, on 03/26/14 at 1:55 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at 500 E would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke. Interview, on 03/26/14 at 1:56 PM with the Maintenance Supervisor, revealed he was under	K 027	K027 1. The Maintenance Director has eliminated the gap(s) on cross-corridor doors located on 500W, 500E, 300E, 300W, 400S and 400N on 4/14/14. 2. The Maintenance Director inspected all cross-corridor doors on 4/14/14 and observed no additional issues related to gaps between cross-corridor doors. 3. The Administrator in-serviced the Maintenance Director on 4/2/14 on the requirement that gaps between cross-corridor doors not allow the passage of smoke. 4. The Maintenance Director will inspect the gaps between cross-corridor doors weekly for one (1) month and monthly for two (2) months thereafter. The results of the observations will be reviewed by the Quality Assurance Committee on a monthly basis for three (3) months. Any issues related to the inspections will be reviewed by the Quality Assurance Committee for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and the Medical Director. 5. Completion Date: 5/7/14.	5/7/14	

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K 027	<p>Continued From page 11</p> <p>the impression that the allowable gap on the cross-corridor doors was a quarter of an inch.</p> <p>Observation, on 03/26/14 at 2:25 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at 300 E would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke.</p> <p>Interview, on 03/26/14 at 2:26 PM with the Maintenance Supervisor, revealed he was under the impression that the allowable gap on the cross-corridor doors was a quarter of an inch.</p> <p>Observation, on 03/26/14 at 3:02 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at 300 W would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke.</p> <p>Interview, on 03/26/14 at 3:03 PM with the Maintenance Supervisor, revealed he was under the impression that the allowable gap on the cross-corridor doors was a quarter of an inch.</p> <p>Observation, on 03/26/14 at 3:15 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at 400 S would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke.</p> <p>Interview, on 03/26/14 at 3:16 PM with the Maintenance Supervisor, revealed he was under</p>	K 027		

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K 027	<p>Continued From page 12</p> <p>the impression that the allowable gap on the cross-corridor doors was a quarter of an inch.</p> <p>Observation, on 03/26/14 at 3:32 PM with the Maintenance Supervisor, revealed the cross-corridor doors located at 400 N would not close completely when tested, leaving a gap of approximately one-quarter of an inch or greater between the pair of doors and would not resist the passage of smoke.</p> <p>Interview, on 03/26/14 at 3:33 PM with the Maintenance Supervisor, revealed he was under the impression that the allowable gap on the cross-corridor doors was a quarter of an inch.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/26/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/26/14.</p> <p>Actual NFPA Standard: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.</p>	K 027			
K 045 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Illumination of means of egress, including exit</p>	K 045			

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K 045	Continued From page 13 discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 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 deficient practice has the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and at the time of the survey, the census was seventy-four (74). The findings include: Observation, on 03/26/14 at 2:54 PM with the Maintenance Supervisor, revealed the exterior exit at the rear of the kitchen had a single light for illumination of the outside of the exit. Interview, on 03/26/14 at 2:55 PM with the Maintenance Supervisor, revealed he was unaware the exterior exit was only equipped with one light. Observation, on 03/26/14 at 3:10 PM with the Maintenance Supervisor, revealed the exterior exit for the basement had a single light for illumination of the outside of the exit. Interview, on 03/26/14 at 3:11 PM with the Maintenance Supervisor, revealed he was unaware the exterior exit was only equipped with	K 045	K045 1. The Maintenance Director has removed the "one bulb" fixtures and replaced them with "two bulb" fixtures on 4/2/14 at the following locations: Rear kitchen exit and the exterior basement exit. 2. The Maintenance Director inspected all exits for "two-bulb" light fixtures. For instances with "one bulb" fixtures, they were replaced with "two bulb" fixtures on 4/12/14. 3. The Administrator in-serviced the Maintenance Director on 4/2/14 on the requirement for using "two bulb" fixtures on all exits. 4. The Maintenance Director will inspect the facility exits for "two bulb" fixtures one (1) time per week for four (4) weeks and then monthly for two (2) months thereafter. The Maintenance Director's inspections will be reviewed by the Quality Assurance Committee on a monthly basis for three (3) months. Any issues related to the inspections will be reviewed by the Quality Assurance Committee will be reviewed for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and the Medical Director. 5. Completion Date: 5/7/14.	5/7/14

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

PRINTED: 04/11/2014
FORM APPROVED
OMB NO. 0938-0391

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K 045	Continued From page 14 one light. The census of seventy-four (74) was verified by the Administrator on 03/26/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/26/14. Actual NFPA Standard: NFPA 101 (2000 edition) 7.B.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.	K 045		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 052		

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

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K 052	Continued From page 15 This STANDARD is not met as evidenced by: Based on fire alarm inspections and interview, it was determined the facility failed to ensure the fire alarm system was inspected and tested in accordance with NFPA Standards. The deficient practice has the potential to affect eight (8) of eight (8) smoke compartments, all residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and at the time of the survey, the census was seventy-four (74). The findings include: Fire alarm inspection review, on 03/26/14 at 10:30 AM with the Maintenance Supervisor, revealed the charger test was not documented on the fire alarm inspection paperwork. Interview, on 03/26/14 at 10:31 AM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a charger test on the fire alarm batteries on an annual basis. Fire alarm inspection review, on 03/26/14 at 10:32 AM with the Maintenance Supervisor, revealed the discharge test was not documented on the fire alarm inspection paperwork. Interview, on 03/26/14 at 10:33 AM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a discharge test on the fire alarm batteries on an annual basis. Fire alarm inspection review, on 03/26/14 at 10:34 AM with the Maintenance Supervisor, revealed the load voltage test was not documented on the fire alarm inspection	K 052	K052 1. The Maintenance Director had the "charger test" conducted on 3/31/14. The Maintenance had the "discharge test" conducted on 3/31/14. The Maintenance Director had the "load voltage test" conducted on 3/31/14. 2. Same as #1. 3. The Administrator in-serviced the Maintenance Director on the requirement to conduct a "charger test" and a "discharge test" on an annual basis, and a "load voltage test" on a semi-annual basis. 4. The Maintenance Director will audit his documentation of the "charger test," the "load voltage test" and the "discharge test" monthly for three (3) months. The results of the observations will be reviewed by the Quality Assurance Committee on a monthly basis for three (3) months. Any issues related to the audit will be reviewed by the Quality Assurance Committee for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and the Medical Director. 5. Completion Date: 5/7/14	5/7/14	

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

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K 052	Continued From page 16 paperwork. Interview, on 03/26/14 at 10:35 AM with the Maintenance Supervisor, revealed he was unaware the inspection company was to perform a load voltage test on the fire alarm batteries on a semi-annual basis. The census of seventy-four (74) was verified by the Administrator on 03/26/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/26/14. 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.	K 052		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	K056 1. The Maintenance Director will have a sprinkler head installed in the commode stall in the shower room on the 600 hall on 5/6/14. The Maintenance Director will have a sprinkler head installed on the un-	5/7/14

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

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K 056

Continued From page 17

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, in accordance with NFPA Standards. The deficient practice has the potential to affect two (2) of eight (8) smoke compartments, twenty-eight (28) residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and at the time of the survey, the census was seventy-four (74). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems.

The findings include:

Observation, on 03/26/14 at 1:55 PM with the Maintenance Supervisor, revealed the shower room on the 600 hall did not have sprinkler protection in the commode stall.

Interview, on 03/26/14 at 1:56 PM with the Maintenance Supervisor, revealed he was unaware the commode area in the shower room was not properly sprinkler protected.

Observation, on 03/26/14 at 2:18 PM with the Maintenance Supervisor, revealed the mechanical room on the 600 hall did not have sprinkler protection on the other side of the heating, ventilation, air conditioning duct in the room.

Interview, on 03/26/14 at 2:19 PM with the Maintenance Supervisor, revealed he was unaware the duct was blocking the sprinkler head from protecting the entire room.

K 056

protected side of the heating, ventilation, air conditioning duct in the mechanical room on the 600 hall on 5/6/14. The Maintenance Director will have a sprinkler head installed in the front part of the MDS office on 5/6/14. The Maintenance Director had the sprinkler heads in room 618 changed to all "quick response" heads on 5/6/14.

- The Maintenance Director will audit the facility to ensure that the facility has a complete, correctly installed sprinkler system on 5/6/14.
- The Administrator in-serviced the Maintenance Director on 4/2/14 regarding the requirements related to complete sprinkler heads.
- The Maintenance Director will audit the sprinkler system monthly for three (3) months to ensure that the facility is fully and correctly equipped with a sprinkler system. The results of the audits will be reviewed by the Quality Assurance Committee on a monthly basis for three (3) months. Any issues related to the audits will be reviewed by the Quality Assurance Committee will be reviewed for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and the Medical Director.
- Completion: 5/7/14.

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

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K 056	<p>Continued From page 18</p> <p>Observation, on 03/26/14 at 2:30 PM with the Maintenance Supervisor, revealed the front Minimum Data Set (MDS) office did not have sprinkler protection.</p> <p>Interview, on 03/26/14 at 2:31 PM with the Maintenance Supervisor, revealed he was unaware the room did not have sprinkler protection.</p> <p>Observation, on 03/26/14 at 3:10 PM with the Maintenance Supervisor, revealed room #618 had a quick response sprinkler head installed in the same compartment as a standard response head.</p> <p>Interview, on 03/26/14 at 3:11 PM with the Maintenance Supervisor, revealed he was unaware the room had mixed heads installed.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/26/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/26/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 13 (1999 Edition) 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</p>	K 056			

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

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K 056	<p>Continued From page 19</p> <p>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:</p> <p>(1) Sprinklers installed throughout the premises</p> <p>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</p> <p>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>NFPA 13 (1999 Edition) 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</p> <p>(2) Light hazard or ordinary hazard occupancy</p> <p>(3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a</p>	K 056		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 056	Continued From page 20 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.	K 056		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observation, smoking policy review, and interview, it was determined the facility failed	K 066		

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

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K 066	<p>Continued From page 21</p> <p>to ensure the use of approved smoking areas, in accordance with NFPA standards. The deficient practice has the potential to affect two (2) of eight (8) smoke compartments, twenty-eight (28) residents, staff and visitors. The facility has the capacity for one-hundred one (101) beds and at the time of the survey, the census was seventy-four (74).</p> <p>The findings include:</p> <p>Observation, on 03/26/14 at 2:30 PM with the Maintenance Supervisor, revealed the area at the courtyard exit was being used as a smoking area and a concrete flower pot was being used as an ashtray with trash placed inside with the cigarette butts. Further observation revealed the proper ashtray was taken apart and the liner was being used as an ashtray.</p> <p>Interview, on 03/26/14 at 2:31 PM with the Maintenance Supervisor, revealed he was unaware of the concrete flower pot was being used as an ashtray and he did not know the ashtray had been taken apart.</p> <p>Observation, on 03/26/14 at 3:10 PM with the Maintenance Supervisor, revealed the smoking shack area had the ashtrays taken apart and were being used on a table inside the smoke shack and on the picnic table.</p> <p>Interview, on 03/26/14 at 3:11 PM with the Maintenance Supervisor, revealed he was unaware the ashtrays at the smoke shack had been taken apart.</p> <p>The census of seventy-four (74) was verified by the Administrator on 03/26/14. The findings were</p>	K 066	<p>K066</p> <ol style="list-style-type: none"> 1. The Maintenance Director has put in place proper ashtray receptacles in place of the flower pot and dis-assembled ashtrays in the courtyard and the smoking shack on 4/22/14. 2. The Maintenance Director will inspect all other smoking areas for proper smoking receptacle on 4/22/14 and make corrections as needed. 3. The Administrator in-serviced the Maintenance Director on 4/2/14 on the requirement of using only approved cigarette receptacles on facility grounds. 4. The Maintenance Director will inspect all smoking areas for un-approved cigarette receptacles and remove them immediately five (5) times per week for four (4) weeks and then one (1) time per week for two (2) months. The Maintenance Director's inspections will be reviewed by the Quality Assurance Committee on a monthly basis for three (3) months. An issues related to the inspections will be reviewed by the Quality Assurance Committee for recommendations. The Quality Assurance Committee meets monthly and consists of the Administrator, Director of Nursing, Unit Manager, Social Services Director, Dietary Manager and the Medical Director. 5. Completion Date: 5/7/14. 	5/7/14

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K 066	<p>Continued From page 22</p> <p>acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 03/26/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions:</p> <p>(1) Smoking shall be 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 areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required.</p> <p>(2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available.</p>	K 066		

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

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K 066	Continued From page 23 to all areas where smoking is permitted.	K 066			