

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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/14/2013
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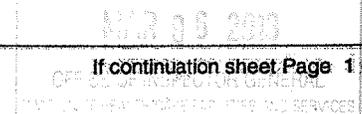
NAME OF PROVIDER OR SUPPLIER FLAGET MEMORIAL HOSPITAL NF	STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A recertification survey was initiated on 02/12/13 and concluded on 02/14/13 with a Life Safety Code survey conducted on 02/14/13 with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sue Downs</i>	TITLE: <i>President</i> <i>Nursing Home Adm.</i>	(X6) DATE 3/6/2013
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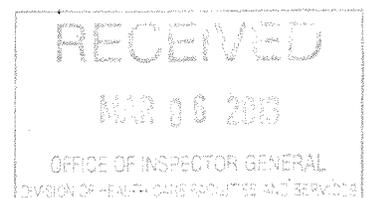
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 156	<p>Continued From page 1</p> <p>inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the</p>	F 156	<p>F156 The Director of Skilled Nursing unit has developed a policy regarding the posting and providing of information on how to apply for Medicare and Medicaid Services on 3/5/2013 to be effective on 3/12/2013.</p> <p>F156 The Director of Skilled Nursing Unit has posted a display sign in the Skilled Nursing Unit that gives residents information on how to apply for Medicare and Medicaid on 3/5/2013.</p>	<p>March 12, 2013</p> <p>March 5, 2013</p>



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F 156	<p>Continued From page 2 facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to prominently display written information on how to apply for Medicare and Medicaid.</p> <p>The findings include:</p>	F 156		



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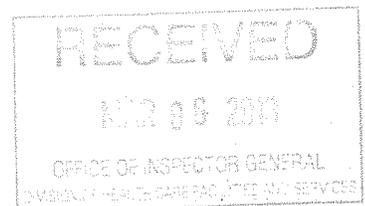
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F 156	<p>Continued From page 3</p> <p>The facility did not provide a policy regarding the posting of how to apply for Medicare and Medicaid services.</p> <p>Observation of the Unit during Environmental Tour, on 02/13/13 at 12:06 PM, revealed there was no posting of how to apply for Medicare and Medicaid services.</p> <p>Interview with the Director of Nursing (DON), on 9:10 AM, revealed she was not aware there needed to be a posting in the facility on how to apply for Medicare and Medicaid. She had been in the facility for seven years and was not aware there needed to be a posting.</p> <p>Interview with the Clinical Operations Officer, on 02/14/13 at 3:00 PM, revealed she was not aware there needed to be a posting of how to apply for Medicare and Medicaid.</p>	F 156	<p>F156</p> <p>The Nursing Administrator for the Skilled Nursing Unit will verify and monitor the completion of the action plans through quarterly performance improvement meetings and monthly reviews with the Director of Skilled Nursing.</p>	March 30, 2013
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to provide ongoing inservice training on Abuse, for three (3) of eight (8) sampled</p>	F 226		

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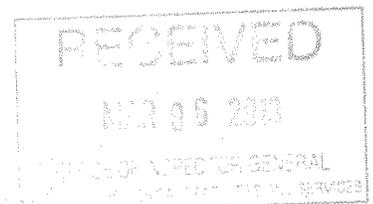
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F 226	<p>Continued From page 4</p> <p>employee records reviewed. In addition, the facility failed to complete a nurse aide abuse registry check for six (6) of eight (8) employee records reviewed.</p> <p>The findings include:</p> <p>Review of the Abuse Policy regarding Abuse, Neglect and Exploitation of Patients for Administrative and Skilled Nursing, dated 05/10/07, revealed IX. Prevention (B). Training 1. General orientation includes a segment to educate new employees of the abuse policy. 2. Ongoing inservice through learning modules include: a) what constitutes abuse, neglect, and exploitation; b) methods to report allegations of abuse without fear of reprisal, and; c) How to recognize signs of burnout, frustration and stress that may lead to abuse.</p> <p>In addition, review of the Abuse Policy, dated 05/10/07 revealed IX Prevention (A). Screening of new employees criminal background checks are conducted through the Kentucky State Police. The policy did not include Nurse Aide Registry Checks in the Abuse Policy.</p> <p>Review of the employee records, on 02/14/13 at 1:30 PM, revealed three of eight files reviewed did not contain evidence of ongoing abuse training. All three employees worked in housekeeping on the skilled unit, and had resident contact daily. Abuse interviews with housekeeping during the survey revealed they had not received abuse training since initial hire, however they received a different type of yearly training from the clinical staff, or non-clinical orientation.</p>	F 226	<p>F226</p> <p>The Director of Skilled Nursing Unit provided a class for Abuse Inservice Training for all the housekeepers on 2/20/2013. Education Department will provide Abuse Inservice Training by Clinical Learn Module to every new employee starting with hospital orientation on 3/5/2013. The Director of Skilled Nursing provided the Director of Physical Therapy a written Abuse Inservice Training to present to all therapy employees. Training initiated on 2/20/2013 to be completed on 3/20/2013. The Director of Physical Therapy will provide Abuse Inservice Training for every new employee starting 3/20/2013.</p> <p>F226</p> <p>Learn Modules training for clinical personnel will be conducted annually on Abuse Inservice Training beginning 3/8/2013 to be completed on March 30, 2013. To repeat competencies on Clinical Abuse Training for every employee on an annual basis. The non-clinical abuse training will not be used any longer as of 3/5/2013.</p>	<p>March 5, 2013</p> <p>March 20, 2013</p> <p>March 30, 2013</p>



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F 226	<p>Continued From page 5</p> <p>Interview with Housekeeper #1, on 02/14/13 at 9:10 AM, revealed she was not aware of the different types of abuse. When the Housekeeper was asked to give an intervention on how to handle a combative resident, Housekeeper #1 stated she would hold their hands down to get the resident to calm down. The housekeeper stated she was not sure when the last time she had training on abuse.</p> <p>Interview with the Housekeeping Director, on 02/14/13 at 2:45 PM, revealed she monitored the housekeeping staff and made sure the housekeeping staff finished their modules on the computer. The Housekeeping Director stated she was aware the abuse module was to be completed yearly. The Housekeeping Director stated the module was very vague and did not teach on the seven components of abuse including when and who to report to.</p> <p>Review of the non-clinical orientation information, on 01/24/13, revealed no evidence of the seven components of abuse offered to the housekeeping employees, and interviews revealed they did not have knowledge of the different types of abuse, or reporting requirements.</p> <p>Interview with the Director of Nursing, on 02/14/13 at 12:00 Noon, revealed the nurse aide abuse training was completed on line and was done yearly. The DON stated all staff should be doing yearly abuse training, and Human Resources was responsible for monitoring these nurse aide checks. The DON also stated the Education Department (Staff Development</p>	F 226	<p>F226</p> <p>Nurse Aide Abuse Registry Check will be conducted on every employee who may work in Skilled Nursing Unit by Human Resource Department by 3/20/2013. Every new employee will have Nurse Aide Abuse Registry Checks on entering the facility by Human Resources during hiring process.</p> <p>F226</p> <p>Abuse Policy updated to include Nurse Aide Registry Checks on all employees of Skilled Nursing Unit to included housekeeping personnel as of 3/8/2013.</p>	<p>March 20, 2013</p> <p>March 8, 2013</p>



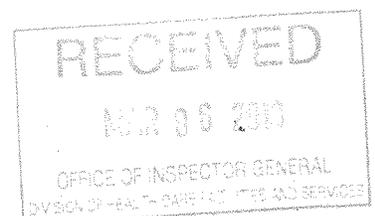
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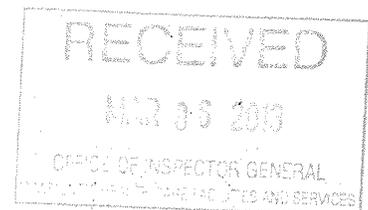
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F 226	<p>Continued From page 6</p> <p>Coordinator) was responsible for monitoring that this was done as well as any education with the contract therapy companies.</p> <p>Interview with the Human Resources Personnel, on 02/14/13 at 2:05 PM, revealed abuse registry checks had not been completed for housekeeping, nor was she aware they needed to be completed on or before hire. The HR personnel revealed she knew non-clinical training was required, but had not looked at the contents closely to see if the abuse information was given on hire.</p> <p>Further interview with the Human Resources Personnel, on 02/14/13 at 2:39 PM, revealed she had taken the non-clinical test and felt like it was a very vague test. The HR Personnel did not think to report that the test was not inclusive of all seven abuse components.</p> <p>Interview with the Staff Development Coordinator (SDC), on 02/14/13 at 2:10 PM, revealed clinical and non clinical staff were given modules to be completed yearly over the clinical and non-clinical areas, however, she did not realize the non clinical modules did not contain abuse training, and had not reviewed to see what the contents contained. The SDC stated she just monitored to see if they were completing the training. The SDC revealed the non-clinical training did not contain the required seven (7) components of abuse.</p> <p>Interview with the Clinical Operations Officer (COO), on 02/14/13 at 2:00 PM, revealed no one had reported that the non-clinical training was vague or did not contain the abuse training. The</p>	F 226	<p>F226</p> <p>The Nursing Administrator for the Skilled Nursing Unit will verify and monitor the completion of the action plans through quarterly performance improvement meetings and monthly reviews with the Director of Skilled Nursing.</p>	3/30/2013



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F 226	Continued From page 7 Clinical Operations Officer stated all of the clinical staff received training on abuse; however, the non-clinical staff had not. The COO stated that housekeeping was not paid by the skilled side, and was not aware they had to be trained.	F 226		



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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/NF</p> <p>TYPE OF STRUCTURE: Three (3) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system.</p> <p>GENERATOR: Two (2) Type I generators. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 02/14/13. Flaget Memorial Hospital Nursing Facility was found 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 twelve (12) beds with a census of eight (8) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X* Lee Downs, NHA President TITLE President + (X6) DATE 3/11/2013
X Nursing Home Admin *X*

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MAR 11 2013
OFFICE OF INSPECTOR GENERAL
CENTERS FOR MEDICARE & MEDICAID SERVICES

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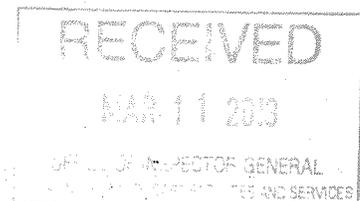
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "F" level.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twelve (12) beds with a census of eight (8) on the day of the survey. The facility failed to ensure bathroom doors would not obstruct the corridor door from closing. The findings include: Observations, on 02/14/13 at 10:24 AM, with the Facility Manager revealed the corridor doors to the resident rooms numbered 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, and 312 were	K 018	K018 The bathroom doors in rooms 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, and 312 had self-closing devices reinstalled on 2/28/2013 by Flaget Memorial Hospital Maintenance Department. The self-closing devices were installed immediately to resident rooms then vacant rooms. The self-closing device allows the bathroom door to close automatically which allows the corridor door to close without obstruction. Self-closing device operation for the bathroom doors education per NFPA 101 Life Safety Code Standard K018 was educated to the Director of Facilities Management and Director of Skilled Nursing Unit by the Nursing Administrator on 2/18/2013. The Director of Facilities Management educated the maintenance staff on the reasons to keep the self-closing devices in place on 2/18/2013. Maintenance to the doors closing mechanism will not be allowed until verified and approved by the Director of Skilled Nursing and Nursing Home Administrator.	Feb. 28, 2013 Feb. 18, 2013 Feb. 18, 2013



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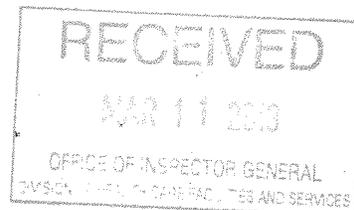
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NAME OF PROVIDER OR SUPPLIER FLAGET MEMORIAL HOSPITAL NF	STREET ADDRESS, CITY, STATE, ZIP CODE 4305 NEW SHEPHERDSVILLE ROAD BARDSTOWN, KY 40004
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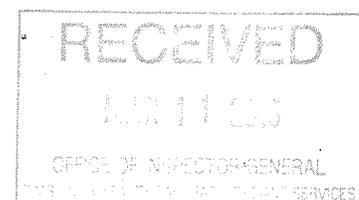
K 018	<p>Continued From page 2</p> <p>blocked from closing if the bathroom door was left fully opened. The bathroom doors had originally been installed with a self-closing device but the self-closers were removed a few years ago because residents were having trouble opening the doors.</p> <p>Interviews, on 02/14/13 at 10:24 AM, with the Facility Manager revealed the self-closers had been removed to make it easier for residents to open the bathroom doors and was not aware the bathroom doors would become an impediment to the closing of the corridor door if the bathroom door was left fully opened.</p> <p>Interviews, on 02/14/13 at 10:46 AM, with the OB/SNU Director revealed she was not aware the bathroom doors would be an impediment to the closing of the corridor doors.</p> <p>18.3.6.3.1* Doors protecting corridor openings shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>18.3.6.3.2 Doors shall be provided with positive latching hardware. Roller latches shall be prohibited. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary</p>	K 018	<p>K018 All other doors were checked in the Skilled Nursing Unit Department for obstruction to closure on 2/28/2013. No obstruction while closing the door was found with any other doors.</p> <p>K018 The Nursing Administrator for the Skilled Nursing Unit will verify and monitor the self-closing device is intact on each of the corridor doors in the skilled nursing unit quarterly. Report results in quarterly performance improvement meeting.</p>	<p>2/28/2013</p> <p>3/30/2013</p>
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K 062	<p>Continued From page 4</p> <p>Interview, on 02/14/13 at 11:20 AM, with the Facility Director revealed he was not aware of the requirement.</p> <p>Interview, on 02/14/13 at 1:20 PM, with the OB/SNU Director revealed she was not aware of the requirement.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.</p> <p>hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:</p> <p>(1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height</p> <p>The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers</p>	K.062	<p>K062</p> <p>The Nursing Administrator for the Skilled Nursing Unit will verify and monitor the completion of the action plans through quarterly performance improvement meetings and monthly reviews with the Director of Skilled Nursing.</p>	3/30/2013



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K 062	<p>Continued From page 5 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 25 (1998 Edition).</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p>	K 062		



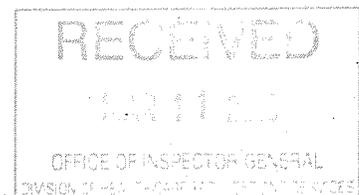
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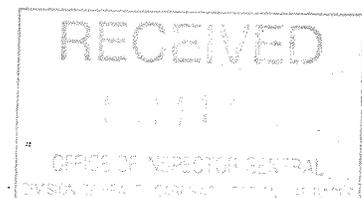
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K 062	<p>Continued From page 6 Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the 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.</p> <p>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</p>	K 062		



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K 062	Continued From page 7 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 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	K073 Decorations that were not flame retardant were removed from the Skilled Nursing Unit area on 2/15/2013. An inspection was conducted of each room to review for other non-flame retardant decorations that need to be removed or treated on 2/15/2013. The Director of Skilled Nursing Unit developed a policy that restricts decorations that are not flame retardant on 3/4/2013.	Feb. 15, 2013 Feb. 15, 2013
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 18.7.5.2, 18.7.5.3, 18.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that combustible decorations were used in accordance with NFPA standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, residents, staff and visitors. The facility is certified for twelve (12) beds with a census of eight (8) on the day of the survey. The findings include: Observation, on 02/14/13 at 10:32 AM, with the Facility Director revealed the facility did not have a flame retardant policy or documentation that newly introduced personal decorations for	K 073	Decorations that are not flame retardant must be treated with flame retardant agent with documentation on a log of decoration treated, person treating, date displayed, and date removed to be completed beginning 3/5/2013. The units Activity Director will document the decorations in the log. The Activity Director is in charge of decorating the unit and will review packages for flame retardant safety to determine the need for treatment. The log will be reviewed monthly and compared to the decorations by the Director of Skilled Nursing Unit.	March 4, 2013 March 5, 2013



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K 073	<p>Continued From page 8 patients or staff had been treated with a flame retardant material.</p> <p>Interview, on 02/14/13 at 10:32 AM, with the Facility Director revealed he was not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated.</p> <p>Interview, on 02/14/13 at 10:46 AM, with the OB/SNU Director revealed she was not aware decorations were required to be treated with a fire retardant and documentation was to be kept on the items that had been treated.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>18.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant. Exception: Combustible decorations, such as photographs and paintings, in such limited quantities that a hazard of fire development or spread is not present.</p>	K 073	<p>K073 Nursing Home Administrator provided education regarding the NFPA 101 Life Safety Code Standard K073 on 2/18/2013 to the Director of Facility Management, Director of Skilled Nursing Unit, and Activities Director.</p> <p>The Director of Skilled Nursing Unit educated all staff of new policy and flame retardant treatment log on 3/4/2013.</p> <p>K073 The Nursing Home Administrator for the Skilled Nursing Unit will verify and monitor the completion of the action plans through quarterly performance improvement meetings by reviewing the log for compliance of flame retardant treatment of the unit decorations.</p>	<p>Feb. 18, 2013</p> <p>March 4, 2013</p> <p>March 30, 2013</p>

