

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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185326</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/20/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CLINTON-HICKMAN COUNTY NURSING FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>366 S. WASHINGTON ST.</b> <b>CLINTON, KY 42031</b>
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{F 000}	INITIAL COMMENTS  Based upon implementation of the acceptable PoC, the facility was deemed to be in compliance, 08/28/13 as alleged.	{F 000}		
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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  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. OFFICE OF INSPECTOR GENERAL CLINTON, KY 42031		
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F 000	INITIAL COMMENTS  A recertification survey was conducted on 07/31/13 through 08/02/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity at a "D".	F 000	This plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy/procedure review it was determined the facility failed to ensure the appropriate treatment and services were provided for one (1) resident (#8), in the selected sample of twelve (12) residents, related to improper placement of an indwelling urinary catheter drainage bag. Resident #8 was observed sitting in a beauty shop chair with the indwelling urinary catheter drainage bag attached to the chair arm, above the level of the resident's bladder.  Findings include:	F 315	The Plan of Correction is submitted solely because it is required by the provision of federal and state law.  This plan of correction serves as Clinton-Hickman County ICF credible allegation of compliance.  <u>F315:</u>  The facility must ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  1. What corrective action(s) will be accomplished for those residents patients found to have been affected by the deficient practice;  Corrective action was taken immediately for resident #8 by lowering drainage bag below bladder.		

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

*Koe BL*

TITLE

Administrator

(X5) DATE

9/20/2013

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 60 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 315	<p>Continued From page 1</p> <p>Review of an undated policy titled, Catheter Care, Urinary, revealed when a resident is ambulatory the bag must always be lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.</p> <p>A record review revealed Resident #8 was admitted to the facility on 2/13/13 with diagnoses to include Alzheimer's, Legal Blindness and Urinary Retention. Review of the quarterly Minimum Data Set (MDS) assessment revealed the facility assessed Resident #8 as having cognitive impairment and required extensive assistance with all activities of daily living.</p> <p>An observation, on 08/01/13 at 10:30 AM, revealed Resident #8 was in the beauty shop sitting in the shop chair. The resident's urinary catheter drainage bag was attached to the arm rest of the chair and was well above the level of the resident's bladder.</p> <p>An interview with Registered Nurse (RN) #4, on 08/01/13 at 10:30 AM, revealed the urinary catheter drainage bag should never be above the level of a resident's bladder.</p> <p>An interview with the Activity Director, on 08/01/13 at 2:00 PM, revealed she usually assisted Resident #8 to the beauty shop once a week. She had attached the urinary catheter drainage bag to the arm rest of the chair as she has done in the past. The Activity Director did not know the drainage bag was to be below the level of the resident's bladder but did know it was not to touch the floor. She did not recall any training provided by the facility related to urinary catheters with drainage bags.</p>	F 315	<p>2. How you will identify other residents patients having the potential to be affected by the same deficient practice;</p> <p><i>Any resident with a catheter has the potential to be affected. On 8/01/13 the DON performed an audit on all other residents with a catheter and no resident was found to be affected.</i></p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p><i>To ensure the deficient practice does not reoccur, a window was installed in the beauty shop for walk by monitoring.</i></p> <p><i>The DON in-serviced nursing staff, activity staff and beauty shop staff on proper placement of an indwelling f/c drainage bag. (8/22/13)</i></p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained;</p> <p><i>The DON/designee will do monthly audits for three months and then quarterly for one year to assure proper placement of drainage bag with a report to QA quarterly.</i></p> <p><i>QA committee will monitor facility performance to make sure corrections are achieved and permanent.</i></p>	F 315 8/27/13	

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F 315	Continued From page 2	F 315		
F 329 SS=D	<p>483.25(i) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p>	F 329	<p><u>F 329:</u></p> <p>The facility must ensure that a drug dose reduction recommendation is addressed with clinical rationale.</p> <p>1. What corrective action(s) will be accomplished for those residents patients found to have been affected by the deficient practice;</p> <p><i>Corrective action for resident #2 achieved with dose reduction of Ambien 8/15/13.</i></p>	

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F 329	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy/procedure review it was determined the facility failed to ensure a hypnotic dose reduction recommendation was addressed with clinical rationale for one (1) resident (#2), in the selected sample of twelve (12) residents. Recommendations from the monthly pharmacy review revealed the pharmacist made recommendations for a dose reduction; however, the physician failed to document in the clinical record the rationale for why the dose reduction would be contraindicated.</p> <p>Findings include:</p> <p>A review of facility policy titled, "Unnecessary Drugs", last revised 06/14/11, revealed the Pharmacist reviews medication regimen monthly to ensure proper dosage and interactions, and a trial lowering or discontinuing of medication is performed at a minimum of every 6 months by working with the resident, family and MD.</p> <p>A review of "AGS Beers Criteria for Potentially Inappropriate Medication Use in older Adults" revealed Non benzodiazepine hypnotics, Zolpidem (Ambien), recommends to avoid chronic use greater than 90 days.</p> <p>A record review revealed Resident #2 was admitted to the facility on 05/17/10 with diagnoses to include Dementia with behavioral disturbances, Congestive Heart Failure and Myocardial</p>	F 329	<p>2. How you will identify other residents patients having the potential to be affected by the same deficient practice;</p> <p><i>Any resident receiving sedatives had the potential to be affected. On 8/15/13 a chart audited was conducted by two LPNs on all residents to identify that the drug dose reduction recommendation were addressed with clinical rationale. No resident was found to be affected.</i></p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p><i>Pharmacy recommendations will be followed up on by DON or designee with action by PCP as indicated within 7 business days of receiving recommendations. On 8/22/13 the DON Inserviced the nursing staff on proper procedure for drug reduction.</i></p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained;</p> <p><i>The QA note form has been updated to include med monitoring. The DON or designee will complete a monthly recommendation audit for three months and then quarterly for one year with reports to the QA committee quarterly. QA will monitor facility performance to make sure corrections are achieved and permanent.</i></p>	F 329: 8/28/13	

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F 329	<p>Continued From page 4</p> <p>Infarction.</p> <p>A review of Resident #2's quarterly Minimum Data Set, (MDS) assessment, dated 05/27/13, revealed the facility assessed Resident #2 to have severe cognitive impairment, was non ambulatory, and required extensive assist from staff for all activities of daily living.</p> <p>A review of Resident #2's physician order, dated 10/17/12, revealed the resident should receive Ambien 10 milligrams (mg.) at bedtime (HS).</p> <p>A review of Resident #2's Pharmacy reviews, dated 7/11/12 and 01/29/13 revealed Ambien 10 mg. at HS was due for an attempted dose reduction with a response from the physician to not reduce the medication at this time,; however there was no documentation to clarify the rationale for and benefits of continuing the medication without an attempted gradual dose reduction.</p> <p>Observations of Resident #2 on 07/31/13 at 1:30 PM and 08/01/13 at 9:22 AM, revealed the resident was in bed with eyes closed and did not respond when spoken to. Interview at the time with Licensed Practical Nurse (LPN) #1 revealed resident #2 sleeps a lot. An observation of Resident #2's skin assessment, on 08/01/13 at 10:45 AM, conducted by LPN #1 and LPN #2 revealed the resident was not easily aroused and did not verbally respond during the assessment despite repositioning and wound care. At 12:30 PM, the patient was observed at the Nurses Station sitting in a wheelchair with eyes closed. The resident was transferred to the bed by staff and was not observed to participate in the transfer process. At 1:15 PM, the resident was</p>	F 329			

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F 329	Continued From page 5 observed to have eyes closed.  Interview with the Pharmacist, on 8/02/13 at 1:40 PM, revealed Ambien has a short half life and works well, and wears off quickly. He stated that research indicates the elderly especially women are showing a higher blood concentration the next day than what was previously thought, and in his opinion they could be obtunded the next day, the medication is intended for short term use. The Pharmacist stated he had written the recommendation for dose reduction as 5 mg because he felt that dosage would probably work. He stated patients become tolerant and if we can taper the dosage or get them off the drug altogether and use only occasionally, the medication works better. Additionally, the Pharmacist stated that the medication is on the Beer's list as not appropriate for the elderly.	F 329			
F 441 SS=0	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 (3) Maintains a record of incidents and corrective actions related to infections.	F 441	<b>F 441:</b>  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.  1. What corrective action(s) will be accomplished for those residents patients found to have been affected by the deficient practice;  <i>No residents were found to have been affected by the deficient practice.</i>		

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F 441	<p>Continued From page 6</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy/procedure review it was determined the facility failed to maintain an infection control program to help prevent the development and transmission of disease and infection. Observation of a medication pass revealed staff did not wash and sanitize her hands between residents when administering medications to multiple residents. Additionally, observation of a skin assessment and dressing change revealed the nurse failed to wash her hands between glove changes.</p> <p>Findings include: Review of the undated facility policy titled,</p>	F 441	<p>2. How you will identify other residents patients having the potential to be affected by the same deficient practice;</p> <p><i>All residents receiving medications and dressing changes has the potential to be affected. On 08/05/13 the DON reviewed all residents with known infections for patterns and trends related to hand washing and through the infection control report no resident was found to be affected.</i></p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p><i>RN #4 was educated on proper hand washing technique while passing medications. LPN #1 was educated on the need to wash hands when changing gloves. Completed 8/02/13</i></p> <p><i>On August 22, 2013 The nursing staff were reeducated on proper hand washing procedures by the DON.</i></p>		

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F 441	<p>Continued From page 7</p> <p>Handwashing Policy (Medication Administration), revealed the facility should provide a safe, sanitary environment and prevent the development and transmission of disease and infection for the residents and staff" by administering medication to the first resident, if hands are not visibly soiled, may use hand sanitizer between second and third residents, wash hands prior to administering medication to fourth resident".</p> <p>1. On 08/01/13 starting at 10:30 AM an observation of a medication pass revealed Registered Nurse (RN) #4 to administer medication to Resident #8 and then to reposition the resident's urinary catheter drainage bag. RN #4 then administered medication to Resident #13, at 10:50 AM. RN #4 then administered medications to Resident #14, without washing or sanitizing her hands. RN #4 failed to wash and/or sanitize her hands between the residents.</p> <p>An interview with RN #4, on 08/01/13 at 11:05 AM revealed she normally sanitizes her hand between residents but had failed to wash or sanitize her hands between residents this time and should have.</p> <p>An interview with the Director of Nursing (DON), on 08/01/13 at 3:05 PM, revealed she expected nurses and medication technicians to ensure proper hand sanitation between residents. The DON said staff must sanitize their hands with the approved sanitizer between every resident and wash their hands every third resident.</p> <p>2. Review of the undated facility policy titled, Dressing Change Policy, included: Wash hands</p>	F 441	<p>4. How the facility plans to monitor its performance to ensure that solutions are sustained;</p> <p><i>The DON or designee will monitor 1- Medication pass and 2- dressing changes monthly for three months and then quarterly for one year with reports to the QA quarterly. QA will monitor facility performance to make sure corrections are achieved and permanent.</i></p>	F 441: 8/27/13	

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F 441	Continued From page 8 and don gloves prior to removal of current dressing, Dispose of dressing appropriately, Remove gloves and wash hands, Don clean gloves and perform dressing change as ordered.  An observation on 08/01/13 at 10:45 AM revealed Licensed Practical Nurse (LPN) #1 providing wound care and a dressing change to Resident #2. LPN #2 failed to wash her hands between glove changes during the wound care and dressing change as per the facility policy.  An interview on 08/01/13 at 2:10 PM with the Director of Nursing revealed the facility policy was for hands to be washed between glove changes. The DON expected hand hygiene to be performed between each glove change.	F 441			
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility	F 514	<u>F 514:</u>  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  1. What corrective action(s) will be accomplished for those residents/patients found to have been affected by the deficient practice?  <i>Medical records for resident #5 were updated on 8/01/13 by DON to ensure consistent and accurate information.</i>		

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F 514	<p>Continued From page 9</p> <p>policy review, it was determined the facility failed to ensure the medical record was accurately maintained for one (1) resident (#5), in the selected sample of twelve (12) residents. The facility failed to accurately and consistently document the residents Code Status in the medical record.</p> <p>Findings include:</p> <p>A record review revealed Resident #5 was readmitted to the facility on 4/30/13 with diagnoses to include Osteoporosis, Peripheral Vascular Disease, Depressive Disorder, Chronic Airway Obstruction, and Morbid Obesity.</p> <p>A review of Resident #5's admission orders, dated July 2013, April 2013, May 2013, and June 2013; the July 2013 Medication Administration Record (MAR), Treatment record and the Respiratory record and the April and May 2013 Nursing Assistant Care Plans, revealed the resident had a "Do Not Resuscitate (DNR)" status. A review of the Comprehensive Care Plan revealed there was no entry for the resident's code status. A review of the Nursing Assistant Care Plans, dated June 2013 and July 2013, revealed the resident was a "full code" status.</p> <p>Further review of the physician orders, revealed on 04/30/13, a notation was made that the family had revoked Resident #5's DNR status.</p> <p>An interview with Certified Nurse Aide (CNA) #1, on 08/01/13 at 3:10 PM, revealed after viewing Resident #5's August CNA Care Plan, the resident was listed as a full code. The CNA reports the information is found in the CNA Book that is kept at the nurses station.</p>	F 514	<p>2. How you will identify other residents patients having the potential to be affected by the same deficient practice;</p> <p><i>All resident in the facility had potential to be affected. On 8/01/13 the DON and medical records personnel conducted a chart audit on all residents to ensure the code status information was consistent and accurate. No resident were found to be affected.</i></p> <p>3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;</p> <p><i>On 8/22/13 the nursing staff were re-educated by DON on proper procedures and documentation related to residents code status.</i></p> <p>4. How the facility plans to monitor its performance to ensure that solutions are sustained;</p> <p><i>10% of all residents charts will be audited monthly for three months and then quarterly for one year by the DON or designee to ensure that information related to residents code status is accurate and consistent, with reports to the QA committee quarterly. QA will monitor facility performance to make sure corrections are achieved and permanent.</i></p>	F 514: 8/27/13	

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:  185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/02/2013
NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031		
(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 514	Continued From page 10  An interview with Licensed Practical Nurse (LPN) #1, on 08/01/13 at 3:25 PM, revealed after looking at Resident #5's record the resident was listed as a full code. LPN #1 also reviewed the MAR for Resident #1 and it indicated the resident was a DNR. It was determined that there was inconsistency within the chart and the LPN stated she would talk with the Director of Nursing (DON).  An interview with the DON, on 08/01/13 at 3:30 PM, revealed after reviewing Resident #5's chart, it was determined Resident #5 was listed as a full code on the physician order written on 4/30/13 at 12:30 PM. The DON was made aware of the inconsistency within the chart.	F 514			

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NAME OF PROVIDER OR SUPPLIER  <b>CLINTON-HICKMAN COUNTY NURSING FACILITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>366 S. WASHINGTON ST. CLINTON, KY 42031</b>		
(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 000}	INITIAL COMMENTS  Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/07/2013 as alleged.	{K 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  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031		
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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: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type II (222).</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with 62 smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/01/13. Clinton-Hickman Nursing Facility was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for forty six (46) beds with a census of forty five (45) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>This plan of correction does not constitute admission or agreement by the provider of the truth or the facts alleged or conclusions set forth in the Statement of Deficiencies.</p> <p>The Plan of Correction is submitted solely because it is required by the provision of federal and state law.</p> <p>This plan of correction serves as Clinton-Hickman County ICF credible allegation of compliance.</p> <p><b>K025:</b> NFPA 101 Life Safety Code Standard</p> <p>No residents were found to have been affected by the deficient practice:</p> <p>For residents having the potential to be affected by same deficient practice:</p> <p>All residents in the (3) of the (6) smoke compartment areas have the potential to be affected.</p>		

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

*Rob Bob*

TITLE

Administrator

(X6) DATE

9/13/2013

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  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 386 S. WASHINGTON ST. CLINTON, KY 42031	
(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 000	Continued From page 1	K 000		
K 025 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for forty six (26) beds with a census of forty five (45) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 08/01/13 between 9:00 AM and 9:39 AM, with the Maintenance Director revealed the smoke barriers extending above the ceiling to be penetrated by pipes and wires. The smoke barrier located above room # 223 had unsealed</p>	K 025	<p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>The unsealed open penetration in the smoke barrier wall located above room #223 has been sealed with (3M Fire Barrier Sealant CP 25WB+) a fire and smoke stopping sealant. This was completed on August 5, 2013</i></p> <p><i>The unrated expandable foam located in the smoke barrier wall above room #211 has removed and the open penetration has been sealed with (3M Fire Barrier Sealant CP 25WB+) a fire and smoke stopping sealant. This was completed on August 5, 2013</i></p> <p><i>The smoke barrier that shares a common wall with the west stairwell will be extended to fully continue to the roof.</i></p> <p><i>The wall is scheduled to be completed on September 6, 2013</i></p>	

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 368 S. WASHINGTON ST. CLINTON, KY 42031		
(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 025	<p>Continued From page 2</p> <p>penetrations. The smoke barrier located above room # 211 was sealed with unrated expandable foam. The smoke barrier that shared a common wall with the West Stairwell did not continue to the roof above and would not resist the passage of smoke.</p> <p>Interview, on 08/01/13 between 9:00 AM and 9:39 AM, with the Maintenance Director revealed he was not aware of the penetrations, use of expandable foam, or that the stairwell wall did not extend to the roof above.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>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:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> <li>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or</li> <li>2. Be protected by an approved device designed for the specific purpose.</li> </ol> <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> <li>1. Be made on either side of the smoke barrier, or</li> <li>2. Be made by an approved device designed for</li> </ol>	K 025	<p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p>Maintenance dept In-servicing was conducted by the Administrator on "Smoke Barrier Penetration" including proper repair techniques, to walls, door gaps and follow-up after outside vendors have completed their service/repair work in the building. This was completed on August 6, 2013</p> <p>Smoke barrier walls have been inspected for any openings or improper sealed penetrations. This was completed on August 12, 2013</p> <p>QA tool will be used for notification of service technicians doing work in the building so maintenance can monitor service work to smoke barrier walls to ensure ongoing compliance and that corrections are permanent.</p>	K025: 9/07/13	

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 364 S. WASHINGTON ST. CLINTON, KY 42031		
(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 025  K 027 SS=E	Continued From page 3 the specific purpose.  NFFPA 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  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 deficiency had the potential to affect three (3) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for forty six (46) beds with a census of forty five (45) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would resist the passage of smoke.  The findings include:  Observation, on 08/01/13 at 9:14 AM, with the Maintenance Director revealed the cross corridor door in the two hour fire wall located in the Breezeway did not seal leaving a gap larger than 1/8th of an inch and would not resist the passage	K 025  K 027	<b>K 027:</b> <b>NFFPA 101 Life Safety Code Standard</b>  <i>No residents were found to have been affected by the deficient practice.</i>  <b>For residents having the potential to be affected by same deficient practice:</b>  <i>All residents in that smoke compartment areas have the potential to be affected.</i>  <b>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</b>  <i>A door has been installed at the Nurses report room and the corridor door located in the two hour fire wall in the breezeway has been replaced with a new metal door.</i>  <i>The installations were completed on August 20, 2013</i>  <b>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</b>  <i>Maintenance dept in-servicing was conducted by the Administrator on "Smoke Barrier Penetration" including proper repair techniques, to walls, door gaps and follow-up after outside vendors have completed their service/repair work in the building. This was completed on August 6, 2013</i>		

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031	
(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 027	Continued From page 4 of smoke. Further observation revealed a door to the Nurses' report room had been removed. The Nurses' Report Room is part of the smoke barrier.  Interview, on 08/01/13 at 9:39 AM, with the Maintenance Director revealed he was not aware the door did not seal properly. Further interview revealed he was not aware the door to the Nurses' Report Room was part of the smoke barrier.  Reference: NFPA 101 (2000 edition)  19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.  Reference: 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. Reference: 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.	K 027	All smoke corridor doors have been inspected to make sure they are properly sealing.  This was completed on August 22, 2013  The fire drill QA evaluation form has been updated adding monitoring of smoke barrier doors for gaps. These doors will be checked during fire drills and included in the monthly fire drill report. This report will be discussed by the Maintenance Director at the facility's quarterly QA meetings to ensure ongoing compliance and that corrections are permanent.	K 027: 8/23/13
K 034 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4	K 034	<u>K 034:</u> NFPA 101 Life Safety Code Standard  No residents were found to have been affected by the deficient practice.	

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K 034	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that a stairwell was maintained according to NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, visitors, and staff. The facility has forty six (46) certified beds with a census of forty five (45) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/01/13 at 9:35 AM, with the Maintenance Director revealed the West Stairwell walls did not extend to the roof above leaving the stairwell open to the attic above the drop ceiling.</p> <p>Interview, on 08/31/13 at 9:35 AM, with the Maintenance Director revealed he was not aware of the requirement.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.2.2.3 Stairs. Stairs complying with 7.2.2 shall be permitted.</p> <p>19.2.2.4 Smokeproof Enclosures. Smokeproof enclosures complying with 7.2.3 shall be permitted.</p> <p>7.2.2.5 Enclosure and Protection of Stairs. 7.2.2.5.1 Enclosures. All inside stairs serving as an exit or exit component shall be enclosed in accordance with 7.1.3.2. All other inside stairs shall be protected in accordance with 8.2.5. Exception: In existing buildings, where a two-story exit enclosure connects the story of exit</p>	K 034	<p>For residents having the potential to be affected by same deficient practice:</p> <p><i>All residents in the (2) of the (6) smoke compartment areas have the potential to be affected.</i></p> <p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>Maintenance dept in-servicing was conducted by the Administrator on "Smoke Barrier Penetration" including proper repair techniques, to walls, door gaps and follow-up after outside vendors have completed their service/repair work in the building to verify that there are no open penetrations. This was completed on August 6, 2013</i></p> <p><i>All smoke barrier walls have been inspected for any openings or improper sealed penetrations.</i></p> <p><i>The west stairwell walls that did not continue to the roof above will be laid with mortar and bricked so the wall fully runs from the floor to the roof.</i></p> <p><i>The installation of the brick and mortar is scheduled to be completed on September 6, 2013</i></p>	

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 368 S. WASHINGTON ST. CLINTON, KY 42031		
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K 034	Continued From page 6 discharge with an adjacent story, the exit shall be permitted to be enclosed only on the story of exit discharge, provided that not less than 50 percent of the number and capacity of exits on the story of exit discharge are independent of such enclosures. 7.1.3.2 Exits. 7.1.3.2.1 Where this Code requires an exit to be separated from other parts of the building, the separating construction shall meet the requirements of Section 8.2 and the following. (a) * The separation shall have not less than a 1-hour fire resistance rating where the exit connects three stories or less. (b) * The separation shall have not less than a 2-hour fire resistance rating where the exit connects four or more stories. The separation shall be constructed of an assembly of noncombustible or limited-combustible materials and shall be supported by construction having not less than a 2-hour fire resistance rating. Exception No. 1: In existing non-high-rise buildings, existing exit stair enclosures shall have not less than a 1-hour fire resistance rating. Exception No. 2: In existing buildings protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, existing exit stair enclosures shall have not less than a 1-hour fire resistance rating. Exception No. 3: One-hour enclosures in accordance with 28.2.2.1.2, 29.2.2.1.2, 30.2.2.1.2, and 31.2.2.1.2 shall be permitted as an alternative. (c) Openings in the separation shall be protected by fire door assemblies equipped with door closers complying with 7.2.1.8. (d) Openings in exit enclosures shall be limited to those necessary for access to the enclosure	K 034	Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:  <i>Smoke barrier walls will be audited quarterly. Any area that did not pass inspection will be properly sealed immediately. This quarterly report will be discussed by the Maintenance Director at the facility's quarterly QA meetings to ensure ongoing compliance.</i>  <i>QA tool will be used for notification of service technicians doing work in the building so maintenance can monitor service work to smoke barrier walls to ensure ongoing compliance and that corrections are permanent.</i>	K 034: 9/7/13	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185326	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2013
NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 365 S. WASHINGTON ST. CLINTON, KY 42031	
(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 034	Continued From page 7 from normally occupied spaces and corridors and for egress from the enclosure. Exception No. 1: Openings in exit passageways in covered mall buildings as provided in Chapters 36 and 37 shall be permitted. Exception No. 2: In buildings of Type I or Type II construction, existing fire-protection rated doors shall be permitted to interstitial spaces provided that such space meets the following criteria: (a) The space is used solely for distribution of pipes, ducts, and conduits. (b) The space contains no storage. (c) The space is separated from the exit enclosure in accordance with 8.2.3. (e) Penetrations into and openings through an exit enclosure assembly shall be prohibited except for the following: (1) Electrical conduit serving the stairway (2) Required exit doors (3) Ductwork and equipment necessary for independent stair pressurization (4) Water or steam piping necessary for the heating or cooling of the exit enclosure (5) Sprinkler piping (6) Standpipes Exception No. 1: Existing penetrations protected in accordance with 8.2.3.2.4 shall be permitted. Exception No. 2: Penetrations for fire alarm circuits shall be permitted within enclosures where fire alarm circuits are installed in metal conduit and penetrations are protected in accordance with 8.2.3.2.4. (f) Penetrations or communicating openings shall be prohibited between adjacent exit enclosures.  8.2.3 Fire Barriers. 8.2.3.1 Fire Resistance-Rated Assemblies. 8.2.3.1.1	K 034		

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 368 S. WASHINGTON ST. CLINTON, KY 42031	
(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 034	Continued From page 8 Floor-ceiling assemblies and walls used as fire barriers, including supporting construction, shall be of a design that has been tested to meet the conditions of acceptance of NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials. Fire barriers shall be continuous in accordance with 8.2.2.2. Exception No. 1: Structural elements shall be required to have only the fire resistance rating required for the construction classification of the building where such elements support nonbearing wall or partition assemblies having a required fire resistance rating of 1 hour or less and where such elements do not serve as exit enclosures or protection for vertical openings. Exception No. 2*: This requirement shall not apply to assemblies calculated to have equivalent fire resistance, provided that the calculations are based on the conditions of acceptance and the fire exposure specified in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials. Exception No. 3: This requirement shall not apply to structural elements supporting floor assemblies in accordance with the exception to 18.1.6.2. 8.2.3.1.2 Fire barriers used to provide enclosure, subdivision, or protection under this Code shall be classified in accordance with one of the following fire resistance ratings: (1) 2-hour fire resistance rating (2) 1-hour fire resistance rating (3) * 1/2-hour fire resistance rating	K 034		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	<b>K 038:</b> NFPA 101 Life Safety Code Standard  <i>No residents were found to have been affected by the deficient practice.</i>	

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 368 S. WASHINGTON ST. CLINTON, KY 42031	
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K 038	Continued From page 9  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure delayed egress doors and exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for forty six (46) beds with a census of forty five (45) on the day of the survey. The facility failed to maintain signage for doors equipped with delayed egress locks.  The findings include:  Observation, on 08/01/13 at 11:33 AM, with the Maintenance Director revealed the South Porch exit was equipped with delayed egress locks, and did not have proper signage indicating the doors would open in fifteen (15) seconds.  Interview, on 08/01/13 at 11:33 AM, with the Maintenance Director revealed he was not aware the delayed egress signage had been overlooked.  Reference:  NFPA 101 (2000 edition)  7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress	K 038	For residents having the potential to be affected by same deficient practice:  All residents who need to exit that door in case of an emergency have the potential to be affected.  Measures taken by the facility to ensure that the problem will be corrected and will not recur:  The missing signage located at the south porch has been reposted indicating that the door can be opened in fifteen (15) seconds. This was completed on August 5, 2013  A backup supply of additional signs have been purchase. This was completed on August 22, 2013  Staff have been in-service on the importance's / reason for the signs and not to allow anyone to remove or damage them. This was completed on August 22, 2013	

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K 038	Continued From page 10 locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.  (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.  (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.  (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once	K 038	Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:  <i>The door alarm QA form has been updated adding monitoring of signage. Indicating that the door sign "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" is secured in proper location. Any missing or damaged signs needing replacement will be immediately replaced.</i>  <i>This report will be discussed at the facility's quarterly QA meetings to ensure ongoing compliance with fire and safety and that corrections are permanent.</i>	K 038: 8/23/13

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 388 S. WASHINGTON ST. CLINTON, KY 42031	
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K 038	<p>Continued From page 11</p> <p>the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO.</p> <p>7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors.</p>	K 038		

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 365 S. WASHINGTON ST, CLINTON, KY 42031	
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K 038	<p>Continued From page 12</p> <p>Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met:</p> <p>(a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress.</p> <p>(b) They are installed across an opening that is at least 6 ft (1.8 m) in width.</p> <p>(c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.</p> <p>7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>Exception No. 1: This requirement shall not apply</p>	K 038		

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K 038	Continued From page 13 to interior exit discharge as otherwise provided in 7.7.2. Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6. Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.	K 038		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, and staff. The facility is certified for forty six (46) beds with a census of forty five (45) on the day of the survey.  The findings include:  Observation, on 08/01/13 at 9:58 AM, with the Maintenance Director revealed the Kitchen did not have proper exit signage to make the path of egress clearly recognizable.  Interview, on 08/01/13 at 9:58 AM, with the	K 047	<b>K 047:</b> <b>NFPA 101 Life Safety Code Standard</b>  <i>No residents were found to have been affected by the deficient practice.</i>  <b>For residents having the potential to be affected by same deficient practice:</b>  <i>(The location of K047 was in the kitchen)</i> <i>No residents are allowed in the kitchen area so therefore no residents have potential to be affected.</i>  <b>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</b>  <i>To make the path of egress clearly recognizable three (3) exit signs have been installed in the kitchen area.</i>  <i>This was completed on August 13, 2013</i>	

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 386 S. WASHINGTON ST. CLINTON, KY 42031	
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K 047	Continued From page 14 Maintenance Director revealed he was not aware the Kitchen did not have proper exit signage.  Reference: NFPA 101 (2000 edition)  18.2 MEANS OF EGRESS REQUIREMENTS 18.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 18.2.2 through 18.2.11.  18.2.10 Marking of Means of Egress. 18.2.10.1 Means of egress shall have signs in accordance with Section 7.10.  7.10 MARKING OF MEANS OF EGRESS 7.10.1 General. 7.10.1.1 Where Required. Means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 42. 7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access. 7.10.1.3 Exit Stair Door Tactile Signage. Tactile signage shall be located at each door into an exit stair enclosure, and such signage shall read as follows: EXIT Signage shall comply with CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, and shall be	K 047	Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:  <i>The new exit signs have been added to the QA - Emergency lighting &amp; Exit Sign Test Sheets for testing and monitoring to ensure ongoing compliance and that corrections are permanent.</i>	K 047: 8/14/13

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031	
(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 047	Continued From page 15 installed adjacent to the latch side of the door 60 in. (152 cm) above the finished floor to the centerline of the sign. Exception: This requirement shall not apply to existing buildings, provided that the occupancy classification does not change. 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked railing for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. 7.10.1.5* Floor Proximity Exit Signs. Where floor proximity exit signs are required in Chapters 11 through 42, signs shall be placed near the floor level in addition to those signs required for doors or corridors. These signs shall be illuminated in accordance with 7.10.5. Externally illuminated signs shall be sized in accordance with 7.10.6.1. The bottom of the sign shall be not less than 6 in. (15.2 cm) but not more than 8 in. (20.3 cm) above the floor. For exit doors, the sign shall be mounted on the door or adjacent to the door with the nearest edge of the sign within 4 in. (10.2 cm) of the door frame. 7.10.1.6* Floor Proximity Egress Path Marking. Where floor proximity egress path marking is required in Chapters 11 through 42, a listed and approved floor proximity egress path marking system that is internally illuminated shall be installed within 8 in. (20.3 cm) of the floor. The system shall provide a visible delineation of the path of travel along the designated exit access	K 047		

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 368 S. WASHINGTON ST. CLINTON, KY 42031		
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K 047	Continued From page 16 and shall be essentially continuous, except as interrupted by doorways, hallways, corridors, or other such architectural features. The system shall operate continuously or at any time the building fire alarm system is activated. The activation, duration, and continuity of operation of the system shall be in accordance with 7.9.2. 7.10.1.7* Visibility. Every sign required in Section 7.10 shall be located and of such size, distinctive color, and design that it is readily visible and shall provide contrast with decorations, interior finish, or other signs. No decorations, furnishings, or equipment that impairs visibility of a sign shall be permitted. No brightly illuminated sign (for other than exit purposes), display, or object in or near the line of vision of the required exit sign that could detract attention from the exit sign shall be permitted. 7.10.2* Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the direction of travel shall be placed in every location where the direction of travel to reach the nearest exit is not apparent. 7.10.3* Sign Legend. Signs required by 7.10.1 and 7.10.2 shall have the word EXIT or other appropriate wording in plainly legible letters. 7.10.4* Power Source. Where emergency lighting facilities are required by the applicable provisions of Chapters 11 through 42 for individual occupancies, the signs, other than approved self-luminous signs, shall be illuminated by the emergency lighting facilities. The level of illumination of the signs shall be in accordance with 7.10.6.3 or 7.10.7 for the required emergency lighting duration as specified in 7.9.2.1. However, the level of illumination shall be permitted to decline to 60 percent at the end of the emergency lighting duration.	K 047			

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 368 S. WASHINGTON ST. CLINTON, KY 42031	
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K 047	Continued From page 17 7.10.5 Illumination of Signs. 7.10.5.1* General. Every sign required by 7.10.1.2 or 7.10.1.4, other than where operations or processes require low lighting levels, shall be suitably illuminated by a reliable light source. Externally and internally illuminated signs shall be legible in both the normal and emergency lighting mode. 7.10.5.2* Continuous Illumination. Every sign required to be illuminated by 7.10.6.3 and 7.10.7 shall be continuously illuminated as required under the provisions of Section 7.8. Exception*: Illumination for signs shall be permitted to flash on and off upon activation of the fire alarm system. 7.10.6 Externally Illuminated Signs. 7.10.6.1* Size of Signs. Externally illuminated signs required by 7.10.1 and 7.10.2, other than approved existing signs, shall have the word EXIT or other appropriate wording in plainly legible letters not less than 6 in. (15.2 cm) high with the principal strokes of letters not less than 3/4 in. (1.9 cm) wide. The word EXIT shall have letters of a width not less than 2 in. (5 cm), except the letter l, and the minimum spacing between letters shall be not less than 3/8 in. (1 cm). Signs larger than the minimum established in this paragraph shall have letter widths, strokes, and spacing in proportion to their height. Exception No. 1: This requirement shall not apply to existing signs having the required wording in plainly legible letters not less than 4 in. (10.2 cm) high. Exception No. 2: This requirement shall not apply to marking required by 7.10.1.3 and 7.10.1.5. 7.10.6.2* Size and Location of Directional Indicator. The directional indicator shall be located outside	K 047		

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K 047	Continued From page 18 of the EXIT legend, not less than 3/8 in. (1 cm) from any letter. The directional indicator shall be of a chevron type, as shown in Figure 7.10.6.2. The directional indicator shall be identifiable as a directional indicator at a distance of 40 ft (12.2 m). A directional indicator larger than the minimum established in this paragraph shall be proportionately increased in height, width and stroke. The directional indicator shall be located at the end of the sign for the direction indicated. Exception: This requirement shall not apply to approved existing signs. Figure 7.10.6.2 Chevron-type Indicator.  7.10.6.3* Level of Illumination. Externally illuminated signs shall be illuminated by not less than 5 ft-candles (54 lux) at the illuminated surface and shall have a contrast ratio of not less than 0.5. 7.10.7 Internally Illuminated Signs. 7.10.7.1 Listing. Internally illuminated signs, other than approved existing signs, or existing signs having the required wording in legible letters not less than 4 in. (10.2 cm) high, shall be listed in accordance with UL 924, Standard for Safety Emergency Lighting and Power Equipment. Exception: This requirement shall not apply to signs that are in accordance with 7.10.1.3 and 7.10.1.5. 7.10.7.2* Photoluminescent Signs. The face of a photoluminescent sign shall be continually illuminated while the building is occupied. The illumination levels on the face of the photoluminescent sign shall be in accordance with its listing. The charging illumination shall be a reliable light source as determined by the authority having jurisdiction. The charging light source shall be of a type specified in the product	K 047		

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NAME OF PROVIDER OR SUPPLIER  CLINTON-HICKMAN COUNTY NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 366 S. WASHINGTON ST. CLINTON, KY 42031	
(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 047	Continued From page 19 markings. 7.10.8 Special Signs. 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs. 7.10.8.2 Elevator Signs. Elevators that are a part of a means of egress (see 7.2.13.1) shall have the following signs, with minimum letter height of 5/8 in. (1.6 cm), in every elevator lobby: (1) * Signs that indicate that the elevator can be used for egress, including any restrictions on use (2) * Signs that indicate the operational status of elevators 7.10.9 Testing and Maintenance. 7.10.9.1 Inspection. Exit signs shall be visually inspected for operation of the illumination sources at intervals not to exceed 30 days. 7.10.9.2 Testing. Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.	K 047		

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K 047	Continued From page 20  7.10.1.2* Exits. Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign readily visible from any direction of exit access.  Reference: NFPA 96 (1998 edition) 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 047		
K 068 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Smoking regulations are adopted and include no less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 068	<b>K 068:</b> NFPA 101 Life Safety Code Standard  <i>No residents were found to have been affected by the deficient practice.</i>  <b>For residents having the potential to be affected by same deficient practice:</b>  <i>We have one (1) resident that smokes, Therefore only one resident may have potential to be affected.</i>	

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K 066	<p>Continued From page 21</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect smokers, staff and visitors. The facility is certified for forty six (46) beds with a census of forty five (45) on the day of the survey. The facility failed to ensure the smoking areas had a metal container with a self-closing lid to dump ashtrays.</p> <p>The findings include:</p> <p>Observation, on 08/01/13 at 9:51 AM, with the Maintenance Director revealed the facility failed to provide a metal container with a self-closing lid to dump the ashtrays, located in the designated smoking area outside the Dining Room exit.</p> <p>Interview, on 08/01/13 at 9:51 AM, with the</p>	K 066	<p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>A new metal container with a self closing lid to dump the ashtrays, has been purchased and placed in the designated smoking area outside the dining room exit. This can has been labeled: " Empty Ash Trays Here" "No Trash".</i></p> <p><i>This was completed on August 13, 2013</i></p> <p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent!</p> <p><i>Staff have been in-service on the purpose and proper usage of this can to ensure ongoing compliance with fire and safety. This was completed on August 22, 2013</i></p> <p><i>The one (1) resident that smokes has also been in-service on the purpose and proper usage of this can to ensure ongoing compliance with fire and safety. This was completed on August 26, 2013</i></p> <p><i>The monitoring and emptying of this container has been added to the Housekeepers daily duties to ensure ongoing compliance and that corrections are permanent.</i></p>	K 066: 8/27/13



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K 144	<p>Continued From page 23</p> <p>The findings include:</p> <p>Observation, on 08/01/13 at 10:09 AM, with the Maintenance Director revealed the facility did not have documentation for the transfer times, on the monthly generator testing. Further observation revealed the generators transfer switch did not transfer automatically. The staff would have to walk out of the building to the transfer switch located on a telephone pole in the middle of the grassy yard area and manually transfer power in the event of an emergency.</p> <p>Interview, on 08/01/13 at 10:09 AM, with the Maintenance Director revealed he was not aware the transfer times were to be documented. Further interview revealed he was not aware the transfer was to be automatic and within ten (10) seconds.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator</p>	K 144	<p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p>An automatic transfer switch and a new alarm annunciator panel was ordered through John Hicks Electric on 8/9/13 after the contractor came and obtained needed specifications. Because the items were unattainable locally we have been given an estimated part delivery of 3 or more weeks. The administrator has met with the contractor, John Hicks Electric and confirmed that once the parts have been received, the contractor will return and install the new equipment to the generator allowing automatic transfer within ten (10) seconds.</p> <p>Once the parts arrive a new annunciator panel will also be installed at the nurses desk to indicate alarm conditions of the emergency or auxiliary power source.</p> <p><u>On 8/23/2013 an agreement was signed with John Hicks Electric and a check for 20% down payment has been given to John Hicks Electric. Due to the unavailable parts needed the estimated installation date schedule for completion is around 9/20/13.</u></p>	

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K 144	<p>Continued From page 24</p> <p>alarm condition shall indicate the following:</p> <ol style="list-style-type: none"> <li>1. Low lubricating oil pressure</li> <li>2. Low water temperature (below those required in 3-4.1.1.8)</li> <li>3. Excessive water temperature</li> <li>4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply</li> <li>5. Overcrank (failed to start)</li> <li>6. Overspeed</li> </ol> <p>Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p> <p>Reference: NFPA 99 (1999 Edition)</p> <p>Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all</p>	K 144	<p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p><i>The maintenance QA generator log has been revised to include placement for documentation of transfer times on the log. This log will be used by the maintenance department to monitor that the transfers have been completed within ten (10) seconds to ensure ongoing compliance and that corrections are permanent.</i></p>	K 144; 8/24/13

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K 144	<p>Continued From page 25</p> <p>appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b). Actual Standard: NFPA 110, 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position. Actual Standard: NFPA 99, 3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>(b) Inspection and Testing. 1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6. 2. Test Conditions. The scheduled test under</p>	K 144			

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K 144	<p>Continued From page 26</p> <p>load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction</p> <p>6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established</p> <p>6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly.</p> <p>6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the</p>	K 144		

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K 144	<p>Continued From page 27</p> <p>transfer switch from the standard position to the alternate position and then a return to the standard position.</p> <p>Reference: NFPA 101 ( 2000 edition)</p> <p>7.9.1.2 Where maintenance of illumination depends on changing from one energy source to another, a delay of not more than 10 seconds shall be permitted. Reference: NFPA 110 (1999 ed.) 5-7 Heating, Cooling, and Ventilating. 5-7.1* Consideration shall be given to properly sizing the ventilation or air-conditioning systems to remove all the heat rejected to the EPS equipment room by the energy converter, uninsulated or insulated exhaust pipes, and other heat-producing equipment. 5-7.2 Adequate ventilation shall be provided to prevent temperatures or temperature rises in the EPS and related accessory equipment that exceed the recommendations of the manufacturer. 5-7.3 For the EPS equipment room, the ventilation or cooling equipment, or both, shall be sized so that the ambient temperature shall not exceed the EPS equipment manufacturer ' s criteria or allowable maximum temperatures.</p> <p>Reference: NFPA 110 (1999 Edition)</p>	K 144			

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K 147 SS=D	<p>5-2.1 The EPS shall be installed in a separate room for Level 1 installations. EPSS equipment shall be permitted to be installed in this room. The room shall have a minimum 2-hour fire rating or shall be located in an adequate enclosure located outside the building capable of resisting the entrance of snow or rain at a maximum wind velocity required by local building codes. No other equipment, including architectural appurtenances, except those that serve this space, shall be permitted in this room.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for forty six (46) beds with a census of forty five (45) on the day of the survey.</p>	K 147	<p><b>K 147:</b> NFPA 101 Life Safety Code Standard</p> <p><i>No residents were found to have been affected by the deficient practice.</i></p> <p><b>For residents having the potential to be affected by same deficient practice:</b></p> <p><i>All residents in that smoke compartment areas have the potential to be affected.</i></p>	

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K 147	<p>Continued From page 29</p> <p>The findings include:</p> <p>Observations, on 08/01/13 between 9:00 AM and 9:39 PM, with the Maintenance Director revealed an open electrical junction box located above the ceiling in the breezeway by the two (2) hour wall, and above the Nurses' Report Room.</p> <p>Interview, on 08/01/13 between 9:00 AM and 9:39 PM, with the Maintenance Director revealed he was not aware of the open electrical junction boxes.</p> <p>Reference: NFPA 70 (1999 edition) 370.28(c) Covers.</p> <p>All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.</p>	K 147	<p>Measures taken by the facility to ensure that the problem will be corrected and will not recur:</p> <p><i>The open electric junction box located above the ceiling in the breezeway and above the Nurses report room has been covered to ensure electrical wiring is maintained in accordance with NFPA standards.</i></p> <p><i>This was completed on August 2, 2013</i></p> <p>Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:</p> <p><i>QA tool will be used for notification of service technicians doing work in the building so maintenance can monitor service work to smoke barrier walls to ensure ongoing compliance and that corrections are permanent.</i></p>	K 147: 8/03/13	