

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



PRINTED: 07/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185363	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/26/2014
NAME OF PROVIDER OR SUPPLIER  GLASGOW STATE NURSING FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE  207 STATE AVENUE GLASGOW, KY 42141		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification Survey was conducted 06/24/14 through 06/26/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of an "E".	F 000	Address what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.  No residents were affected by the deficient practice.	7/20/14
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview, and facility policy review, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen, revealed undated food items stored in the refrigerator and freezer; the range hood vents were noted to have a coating of dust and debris and a sanitizer bucket had no evidence of measurable sanitizer in the bucket.  Review of the facility's Census and Condition, dated 06/24/14, revealed there were seventy-five (75) residents in the facility and ten (10) of those residents were tube feeders and did not eat food from the kitchen area.	F 371	Address how the facility will identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken.  All residents, staff, and visitors have the potential to be affected.  On June 25, 2014 all food items stored in the dietary department refrigerator and freezer without dates were discarded by the dietary manager.  On June 25, 2014, immediately following the observation of no sanitizer noted on the chemical test strip, the water in the bucket was changed and tested for appropriate concentration of sanitizing agent by a dietary employee. A service manager from a commercial supplier of cleaning and sanitation products inspected both dietary sanitizing dispensing units on July 3, 2014 and July 17, 2014.  On June 26, 2014 range hood filters were removed and cleaned by the dietary manager. On July 17, 2014 a representative from a hood and duct cleaning company inspected the grease exhaust system. On July 20, 2014 the same hood and duct cleaning company conducted the monthly cleaning.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Amel Benichou* TITLE: *Facility Director* (X6) DATE: *7/22/14*

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

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F 371	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the facility's, "Frozen Storage Policy", dated 08/15/13, revealed all frozen food would be properly wrapped, dated and labeled.</p> <p>1. Observation of the freezer and refrigerators on 06/25/14 at 8:45 AM, revealed the following items undated: one (1) quart of "Specialty Salad", four (4) pints of chicken base, one (1) pint of beef base, fifteen (15) popsicles, four (4) ice cream "Drumsticks", one (1) bag of French fries, five (5) coconut pies, two (2) boxes of sugar cookie dough; and one (1) apple pie.</p> <p>Interview with the Dietary Manager on 06/25/14 at 9:00 AM revealed the facility went by the food vendor's date on the box of food or the stamped "use by" date to tell the expiration dates of food items. However, some of the food items had been taken out of the boxes and some had no "use by" dates marked on the product. The Dietary Manager stated "they should have been marked."</p> <p>Interview with the Dietician on 06/26/14 at 9:45 AM, revealed the pies were good for four-hundred and twenty-five (425) days when kept in the freezer. However, there was no box or markings to indicate what date the products had been placed in the refrigerator and freezer.</p>	F 371	<p>Address what measures will be put into place, or what systemic changes the facility will make to ensure that the deficient practice does not recur.</p> <p>Dietary policy A.4.2 Dry Storage was revised on 7/11/14 to reflect that all food would be labeled with delivery date. Dietary Policy A.4.3 Refrigerated Storage was revised on 7/11/14 to add the definitions of use by date, expiration date, sell by date and best by date.</p> <p>The dietary manager/food service coordinator / cook will utilize a new form Dating of Food, Dry Storage and Refrigeration and Freezer Storage daily for two weeks (start date 07/12/14) , then three times per week for two weeks, then weekly thereafter to ensure dating of all items.</p> <p>Dietary Policy A.6.8 Pots and Pans was revised on 7/11/14 to reflect that the sanitizer in the pot/pan sink will be recorded each time the water is changed and that the test strip needs to read 200-400 ppm. The Three Compartment Sink Log was revised for testing of the sanitizer four times a day with concentration levels of 200-400 ppm. A new Dietary Policy A.6.29 Sanitizing Work Surfaces was initiated on 7/11/14 to properly clean and sanitize work surfaces. A Monitor for Sanitizing Bottles was implemented 7/11/14. Sanitizing solution will be checked every four hours for two weeks beginning 7/11/14, then twice a day thereafter.</p> <p>Monthly cleanings will be managed by a contracted full-service mechanical maintenance company by the 20<sup>th</sup> of each month pursuant to Section 1.032 Exhaust Hoods. The dietary manager/ food service coordinator /cook will utilize the Monthly Range Hood Vent Cleaning form to document cleaning by vendor.</p> <p>All dietary staff was in-serviced on the above policies on 7/11/14 by the dietary manager. Any staff on leave will be in-serviced before receiving assignment of duties.</p>	

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F 371	<p>Continued From page 2</p> <p>2. Review of the "Employee Sanitary Practices" policy dated 08/25/10 revealed cloths used for wiping food spills on food contact surfaces would be stored in a sanitizing solution between uses during the day.</p> <p>Observation of the chemical test strip measure of sanitizer in the sanitizer bucket, on 06/25/14 at 11:50 AM, revealed the sanitizer bucket had no evidence of sanitizer noted on the chemical test strip.</p> <p>Interview with Dietary Aide #1, on 06/25/14 at 11:50 AM, revealed she had filled the bucket with the sanitizing agent, and mixed it with water, at approximately 6:30 AM. She further stated she had wiped the counters with the solution "10 minutes ago".</p> <p>Interview with the Dietary Manager, on 06/25/14 at 11:53 AM, revealed the sanitizer buckets were to be changed at 6:00 AM, after each use or when the staff noticed the water was dirty.</p> <p>Interview with the Dietician, on 06/24/14 at 9:50 AM, revealed she had interviewed the staff and found the sanitizer bucket had been changed at 8:30 AM that morning. She further stated the buckets should be changed "about every two hours". In addition, she stated "every food particle decreases the sanitizer agent". Further interview revealed the sanitizer agent should have measured 200 parts per million (PPM).</p>	F 371	<p>Address how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance will be put into place.</p> <p>The dietitian will complete a monthly Foodborne Illness Risk Factors/Sanitation Audit, which will be given to the Superintendent Associate/Director by the 30<sup>th</sup> of each month. This audit will be reviewed at the quarterly CQI meeting.</p>		

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F 371	<p>Continued From page 3</p> <p>3. Observation of the kitchen equipment, on 06/25/14 at 9:10 AM; and, on 06/26/14 at 9:00 AM, revealed a build up of dust and debris on the vents of the range hood, over the stove.</p> <p>Interview with the Dietary Manager, on 06/25/14 at 9:15 AM; and, on 06/26/14 at 9:05 AM, revealed the hood was last cleaned on 04/26/14 when the hood was inspected by an outside contractor. Further interview revealed the Dietary Manager had been hesitant to clean the hood due to a gas pipeline and separation wall that ran behind the stove.</p> <p>Interview with the Dietician, on 06/25/14 at 9:20 Am, revealed the range hood was scheduled to have been cleaned every two (2) weeks.</p> <p>Interview with the Administrator, on 06/25/14 at 2:55 PM, revealed she was not aware of any problems with undated food items, the sanitizer bucket or the range hood until "today" and stated this would be remedied.</p>	F 371			

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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: 2012.</p> <p>SURVEY UNDER: 2000 New.</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story. Type II (222).</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 2013 with 77 smoke detectors and 2 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 2013.</p> <p>GENERATOR: Type II generator installed in 2013. Fuel source is Diesel.</p> <p>A Standard Life Safety Code Survey was conducted on 06/25/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred (100) beds with a census of seventy-four (74) 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</p>	K 000	<p><i>To Kurtis 7/28/14</i></p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;"> <p>POC ACCEPTED</p> <p>JUL 28 2014</p> <p><i>Kurtis</i></p> </div>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Anna C. Buckwalter* TITLE *Facility Director* (X6) DATE *7/18/14*

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K 000	Continued From page 1  Fire).  Deficiencies were cited with the highest deficiency identified at Scope and Severity of "D" Level.	K 000			
K 056 SS = D	NFPA 101 LIFE SAFETY CODE STANDARD  There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has the capacity for one-hundred (100) beds. At the time of the survey, the census was seventy-four (74). According to CMS' Survey and Certification	K 056	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.  No residents were affected by the deficient practice.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  All residents, staff, and visitors have the potential to be affected.  All sprinklers in the facility were inspected on 07-16-2014 by Michael McFarland of Fire Team Cont. The sprinkler in the men's bathroom in the basement was relocated to cover the shower area. Room 318 sprinkler head was adjusted to extend downward. All other sprinklers were found to be installed properly in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.  Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.  Maintenance personnel will complete a Sprinkler preventative maintenance audit by the 30 <sup>th</sup> of the month and give to the Superintendent Associate.  Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.  The sprinkler report will be reviewed at the monthly Fire and Safety meeting.	7-16-14	

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K 056	<p>Continued From page 2</p> <p>13-55-LSC (Life Safety Code) the enforcement implication would be a fully sprinklered facility with minor problems.</p> <p>The findings include:</p> <p>Observation, on 06/25/14 at 11:50 AM with the Maintenance Personnel, revealed the men's bathroom in the basement did not have sprinkler protection at the area by the shower.</p> <p>Interview, on 06/25/14 at 11:51 AM with the Maintenance Personnel, revealed he was unaware the shower area was not properly sprinkler protected.</p> <p>The census of seventy-four (74) was verified by the Administrator on 06/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Personnel at the exit interview on 06/25/2014.</p> <p>Actual NFPA Standard:</p> <p>NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1 Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p>	K 056			

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K 056	Continued From page 3  Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.  NFPA 13 (1999 Edition) 7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied:  (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft. (6.1-m) maximum ceiling height  The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response	K 056			

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K 056	Continued From page 4  sprinklers shall be permitted to be used.	K 056			
K 066 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 18.7.4</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on observation, interview and smoking policy review, it was determined the facility failed to ensure the use of approved smoking areas, in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice has the potential to affect one (1) of five (5) smoke compartments, residents, staff and</p>	K 066	<p>Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>No residents were affected by the deficient practice.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents, staff, and visitors have the potential to be affected.</p> <p>A metal smoke bucket with self-closing cover was purchased from Fastenal and placed in the employee smoking area for proper disposal of cigarette butts.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>Maintenance staff will utilize QA Tool ES-3 Life Safety monthly. Section #4 states maintenance will check for metal containers with self-closing cover devices for disposal of smoking ashes in resident and employee smoking areas. This report will be reviewed by the Superintendent Associate monthly.</p> <p>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</p> <p>QA Tool ES-3 Life Safety will be reviewed at the quarterly CQI meeting.</p>	07-18-2014	

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K 066	<p>Continued From page 5</p> <p>visitors. The facility has the capacity for one-hundred (100) beds. At the time of the survey, the census was seventy-four (74).</p> <p>The findings include:</p> <p>Observation, on 06/25/14 at 11:43 AM with the Maintenance Personnel, revealed the employee smoking area located at the back of the facility did not have a metal bucket with a self-closing lid to dump the ashtrays into.</p> <p>Interview, on 06/25/14 at 11:44 AM with the Maintenance Personnel, revealed he was unaware the smokers' pole could not be used in place of the self-closing metal bucket.</p> <p>The census of seventy-four (74) was verified by the Administrator on 06/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 06/25/2014.</p> <p>Actual NFPA Standard:</p> <p>NFPA 101 (2000 Edition) 19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In health care occupancies where</p>	K 066			

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K 066	Continued From page 6  smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception. The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066			
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3 18.3.2.6, NFPA 96  This STANDARD is not met as evidenced by:  Based on observation and interview, it was determined the facility failed to maintain the cooking appliances in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one-hundred (100) beds with a census of seventy-four (74) on the day of the survey. The facility failed to ensure the grease	K 069	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.  No residents were affected by the deficient practice.  Address how the facility will identify other residents having the potential to be affected by the same deficient practice.  All residents and staff have the potential to be affected by the deficient practice.  A steel baffle/splash guard was purchased from Service Solutions and installed on 7-16-14 to allow 10 inches in height between the fryer and stove. All dietary staff was in-serviced on the placement of the steel baffle by 7-19-14. Any staff on leave will be in-serviced before receiving assignment of duties.  Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.  The dietary manager will monitor the placement of the steel baffle monthly per preventative maintenance report. The report is given to the Superintendent Associate by the 30 <sup>th</sup> of each month.	07-19-2014	

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NAME OF PROVIDER OR SUPPLIER  GLASGOW STATE NURSING FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 207 STATE AVENUE GLASGOW, KY 42141		
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K 069	Continued From page 7  fryer was properly separated from the stove top.  The findings include:  Observation, on 06/25/14 at 12:20 PM with the Maintenance Personnel, revealed the grease fryer was located twelve (12) inches from the cooking surface. Per the NFPA, the grease fryer must be at least sixteen (16) inches from the cooking surface.  Interview, on 06/25/14 at 10:33 AM with the Maintenance Personnel, revealed he was unaware the grease fryer did not have proper separation from the cook top.  The census of seventy-four (74) was verified by the Administrator on 06/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Personnel at the exit interview on 06/25/14.  Actual NFPA Standard:  Reference: NFPA 96 (1998 Edition) 9-1.2.3 All deep fat fryers shall be installed with at least 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed at a minimum 8 in. (203 mm) in height between the fryer and surface flames of the adjacent appliance.	K 069	Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.  The dietary manager will present the report for review at the monthly Fire & Safety meeting.		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are	K 076	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice.  No residents were affected by the deficient practice.	7/14/14	

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K 076	<p>Continued From page 8</p> <p>protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu. ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu. ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is certified for one-hundred (100) beds with a census of seventy-four (74) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/25/14 at 2:45 PM with the Maintenance Personnel, revealed ten (10) oxygen tanks stored in the oxygen room in room #203. The oxygen tanks were being stored within five (5) feet of a cart containing cardboard boxes.</p> <p>Interview, on 06/25/14 at 2:45 PM with the Maintenance Personnel, revealed he was unaware oxygen tanks could not be stored within five (5) feet of combustible materials if the oxygen storage was under twelve (12) tanks.</p>	K 076	<p><b>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</b></p> <p>All residents, visitors and staff have the potential to be affected.</p> <p>The oxygen supply cart and supplies were removed on 6-25-14.</p> <p><b>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</b></p> <p>The Oxygen Storage Room record was revised on 6-27-14 to include "No items are to be stored in the oxygen room other than cylinders and holders (i.e., no cannulas, tubing, etc., or anything combustible)." All nursing and maintenance staff have been in-serviced on oxygen storage, no items are to be stored in oxygen room other than cylinders and holder. Staff on leave will be in-serviced before assignment of duties.</p> <p>Contract vendor, Pennyrile Home Medical Supply, is responsible for oxygen supplies. Pennyrile staff was in-serviced on proper storage of oxygen supplies on 7-1-14.</p> <p><b>Indicate how the facility plans to monitor its performance to ensure the solutions are sustained.</b></p> <p>Maintenance personnel will utilize QA Tool ES-3 Life Safety monthly, which will be given to the Superintendent Associate/designee by the 30<sup>th</sup> of each month. Paragraphs 10, 11 and 12 cover no combustibles and proper storage of cylinders and supplies.</p> <p>This report will be reviewed at the quarterly Continuous Quality Improvement meeting.</p>		

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K 076	<p>Continued From page 9</p> <p>The census of seventy-four (74) was verified by the Administrator on 06/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Personnel at the exit interview on 06/25/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.1.2</p> <p>Storage for nonflammable gases greater than 8.5 m<sup>3</sup> (300 ft<sup>3</sup>) but less than 85 m<sup>3</sup> (3000 ft<sup>3</sup>)</p> <p>(a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry.</p> <p>(b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor.</p> <p>(c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following:</p> <p>(1) A minimum distance of 6.1 m (20 ft)</p> <p>(2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>(3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage.</p> <p>(d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4.</p> <p>(e) Cylinder and storage container storage locations shall meet 4-3.1.1.2(a)1 e with respect to temperature limitations.</p>	K 076			

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K 076	Continued From page 10  (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b) 13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft. (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b) 14.	K 076			