

APR 26 2013
 OFFICE OF INSPECTOR GENERAL
 DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 04/15/2013
 FORM APPROVED
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/11/2013
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NAME OF PROVIDER OR SUPPLIER KENSINGTON CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE: 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 431 SS=D	<p>A standard health survey was conducted 04/09/13 through 04/11/13 and Life Safety Code survey was conducted on 04/10/13. Deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to</p>	F 431	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Kensington Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F 431 The 7 blue vacutainers that expired on 10/20/12 and the 8 anaerobic vials that expired on 3/30/13, were immediately disposed of per policy on 4/10/13 by the licensed nurse.</p> <p>The Director of Nursing Services audited medications and lab supplies in the center on 4/11/13 to determine there were no expired biologicals available for resident use. No additional expired biologicals were noted to be available for resident use.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *4/26/13*

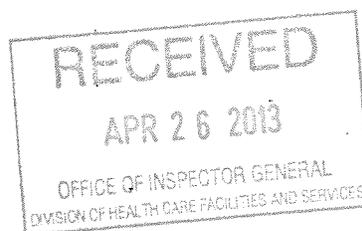
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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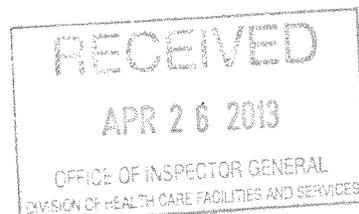
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F.431	<p>Continued From page 1</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to dispose of expired biologicals that were observed to be ready for use. Seven (7) blue Vacutainers and eight (8) anaerobic vials were expired in one (1) of two (2) medication rooms.</p> <p>The findings include:</p> <p>Review of the facility's Pharmacy Services and Procedures Manual, effective 12/01/07, revealed the facility should ensure that drugs and biologicals that have an expired date on the label, be stored separate from other medications, until destroyed or returned to the supplier.</p> <p>Observation of the medication room on the Rehab Unit, on 04/10/13 at 9:20 AM, revealed seven (7) blue Vacutainers expired on 10/2012 and eight (8) anaerobic vials expired on 03/30/13 and were readily available for staff use.</p> <p>Interview with the Licensed Practical Nurse (LPN) #1, on 04/10/13 at 11:50 AM, revealed the night shift staff normally checked the medication room for expired medications and biologicals. LPN #1 stated nurses do obtain blood draws at times and when doing a blood draw the nurse was to always check for the expiration date on the vial. LPN #1</p>	F 431	<p>F 431-continued</p> <p>Re-education will be provided to the licensed nursing staff by the Director of Nursing Services and/or Assistant Director of Nursing Services on the storage of biologicals, including medication and lab supplies as of 4/25/2013.</p> <p>The Director of Nursing Services and/or Assistant Director of Nursing Services will review medication rooms, medication and treatment carts monthly to validate there are no expired biologicals available for resident use. The results of these reviews will be discussed by the Performance Improvement Committee for further review and recommendations.</p> <p>Date of compliance 4/26/2013</p> <p>Kensington Center Performance Improvement Committee Members: Administrator, DNS, ADNS, CCM, DMA, Activity Director, Maintenance Supervisor, Medical Records, Social Service Director, Dietary Manager and Medical Director.</p>



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F 431	<p>Continued From page 2</p> <p>stated if you send out an expired vial to the laboratory, you may not receive accurate results.</p> <p>Interview with LPN #2, on 04/11/13 at 2:33 PM, revealed typically the laboratory staff removed the expired vials on Tuesday and Thursdays. LPN #2 stated on occasion she has had to draw a lab. LPN #2 stated she had noticed the dates on the vials and she monitored the date when drawing a lab on a resident. LPN #2 stated a false reading could occur if a lab was drawn in an expired vial.</p> <p>Interview with the Director of Nursing (DON), on 04/11/13 at 2:38 PM, revealed the night shift nurses normally removed the expired medications and biologicals. The DON stated she had a night supervisor who ensured the nurses were doing their nightly duties. The DON stated the wrong results could occur if an expired Vacutainer was sent to the laboratory. The DON stated she has had no concerns with having to re-obtain labs for residents and she was ultimately responsible to ensure all expired medications and biologicals were removed from the medication rooms.</p>	F-431		



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NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 2000, Original building; 2010, Physical Therapy and Rehabilitation addition. SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III unprotected. SMOKE COMPARTMENTS: Six (6) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic, dry sprinkler system. GENERATOR: Type II, 55KW generator, fuel source is natural gas. A standard Life Safety Code survey was conducted on 04/10/13. Kensington Manor Care and Rehab was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for eighty two (82) beds with a census of seventy three (73) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

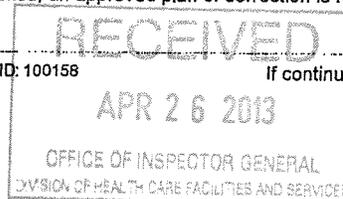
TITLE

(X6) DATE

[Signature]

Administrator 4/26/13

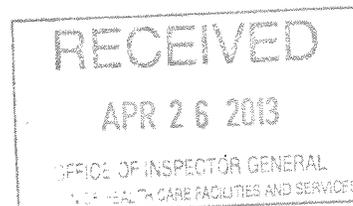
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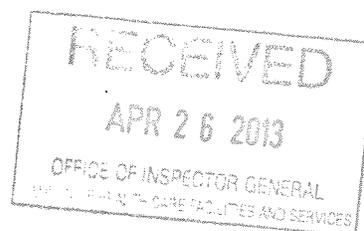
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K 000 K 025 SS=E	<p>Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)</p> <p>Deficiencies were cited with the highest deficiency identified at an "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers 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 eighty two (82) beds with a census of seventy three (73) on the day of the survey. The penetrations of pipes and wires through the smoke barriers were not sealed with material rated or equal to the wall.</p> <p>The findings include:</p>	K 000 K 025	<p>K 025 The (3) pipe sleeves 3 inches in diameter, located above room 302 were sealed with appropriate rated material on 4/25/13 by the Maintenance Supervisor. The small sprinkler pipe, located above room 102 was sealed with appropriate rated material on 4/25/13 by the Maintenance Supervisor.</p> <p>A review was conducted to determine that no other openings in the smoke wall barriers existed on 4/11/13 by Maintenance Supervisor. There were no additional penetrations to the smoke barrier identified.</p> <p>Re-education was provided to the Maintenance Supervisor on 4/19/13 by the Administrator regarding maintaining smoke barrier walls in accordance with NFPA standards.</p> <p>The Maintenance Supervisor will audit smoke barrier walls monthly times two, then every six months to validate that smoke barrier walls have no penetrations and are sealed with fire material as needed. The results of this audit will be discussed by the Performance Improvement Committee monthly for further review and recommendations.</p> <p>Compliance Date: 4/26/2013</p>



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K 025	<p>Continued From page 2</p> <p>Observations, on 04/10/13 between 9:15 AM and 2:30 PM, with the Maintenance Director revealed the smoke barriers, extending above the ceiling had penetrations of pipes and wires. The penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. The locations of the penetrations were as follows:</p> <ol style="list-style-type: none"> 1) Three (3) pipe sleeves, three (3) inches in diameter were not sealed inside the sleeves, located above room 302. 2) A small sprinkler pipe was penetrating the smoke barrier, leaving an unsealed penetration around the pipe located above room 102. <p>Interview, on 04/10/13 between 9:15 AM and 2:30 PM, with the Maintenance Director revealed he was not aware of the penetrations in the smoke barriers.</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> <ol style="list-style-type: none"> (a) The space between the penetrating item and the smoke barrier shall <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be 	K 025	



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K 025 Continued From page 3
solidly set in the smoke barrier, and the space between the item and the sleeve shall
1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or
2. Be protected by an approved device designed for the specific purpose.
(c) Where designs take transmission of vibration into consideration, any vibration isolation shall
1. Be made on either side of the smoke barrier, or
2. Be made by an approved device designed for the specific purpose.

K 029 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for eighty two (82) beds with a census of seventy two (72) on the

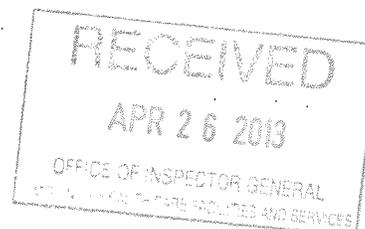
K 025

K 029

K 029
A self closing device was installed on the door to the storage room/office across from the conference room on 4/25/13 by the Maintenance Supervisor. The storage cabinets in the MDS Office and Social Services Office have been removed as of 4/22/13 by the Maintenance Director. The seven boxes of files were removed from the Business Office on 4/22/13 by the Business Office Manager. The Business Office Manager was re-educated on 4/18/13 by the Administrator to properly store file boxes in an area with a rated door and self closing device.

Center rounds were conducted on 4/18/13 by the Administrator to determine that no other areas in the center containing hazardous amounts of combustible materials were improperly secured. There were no additional areas identified.

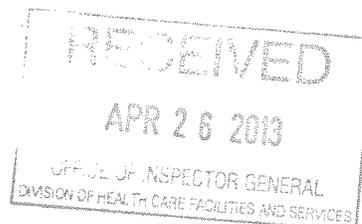
Re-education was provided to the Maintenance supervisor on 4/19/13 by the Administrator on the requirements of Protection of Hazards in accordance with NFPA standards.



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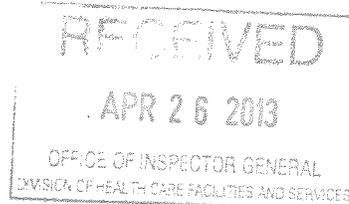
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K 029	<p>Continued From page 4</p> <p>day of the survey. The facility failed to provide self-closing devices for rated doors protecting hazardous areas:</p> <p>The findings include:</p> <p>Observation, on 04/10/13 between 9:15 AM and 2:30 PM, with the Maintenance Director revealed rooms required being self-closing or containing a hazardous amount of combustibles did not have self-closing devices to keep the doors closed. The rooms identified as hazardous requiring a rated door with a self-closing device were located in the following areas:</p> <ol style="list-style-type: none"> 1) A Storage Room/Office located across from the Conference Room had twenty one (21) boxes of combustible paper files and the door did not have a self-closing device installed on the door. 2) The MDS Office had a storage cabinet for paper to be shredded with no self-closer on the door. 3) The Business Office had seven (7) boxes of combustible paper files with no self-closer on the door. 4) The Social Services Office had a storage cabinet for paper to be shredded with no self-closer on the door. <p>Interview, on 04/10/13 between 9:15 AM and 2:30 PM, with the Maintenance Director revealed he was not aware the doors to these rooms did not meet the requirements for protection from hazards.</p> <p>8.4.1.3</p>	K 029	<p>K 029 continued:</p> <p>The Maintenance Supervisor will complete center rounds monthly to validate that self closing devices and rated doors are in place to protect hazardous areas. These rounds will be discussed by the Performance Improvement Committee monthly for further review and recommendations.</p> <p>Compliance Date:</p>	4/26/13



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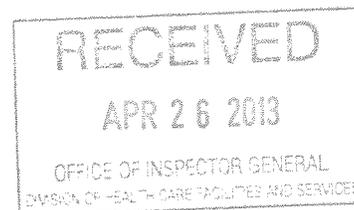
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K 029	<p>Continued From page 5.</p> <p>Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ol style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than 	K 029	



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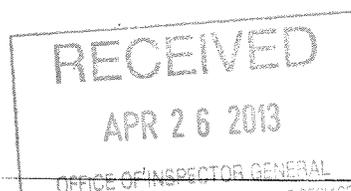
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 029 K 038 SS=E	<p>Continued From page 6</p> <p>those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>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 three (3) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for eighty two (82) beds with a census of seventy three (73) on the day of the survey. The facility failed to ensure doors equipped with delayed egress had proper signage.</p> <p>The findings include:</p> <p>Observation, on 04/10/13 between 9:10 AM and 2:30 PM, with the Maintenance Director revealed the delayed egress signage located at the exits in the Lobby, 200 Hall, and 300 Hall did not have</p>	K 029 K 038	<p>K 038</p> <p>Egress signage located at the exits in the lobby, 200 hall and 300 hall have been replaced with letters that are one inch high with contrasting background as of 4/23/13 by the Maintenance Supervisor.</p> <p>Center rounds were conducted on 4/18/13 by the Maintenance Supervisor, no other exits were identified as not having proper egress signage.</p> <p>The Maintenance Supervisor was re-educated on 4/19/13 by the Administrator on maintaining exits and egress doors in accordance with NFPA standards.</p> <p>The Maintenance Supervisor will review exit and egress doors to determine exit signage is maintained as appropriate during monthly center rounds. These rounds will be discussed by the Performance Improvement Committee monthly for further review and recommendations.</p> <p>Compliance Date: 4/26/13</p>



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K 038	<p>Continued From page 7</p> <p>letters 1" high with a contrasting background.</p> <p>Interview, on 04/10/13 between 9:15 AM and 2:30 PM, with the Maintenance Director revealed he was unaware the facility failed to meet the signage requirements for delayed egress signage.</p> <p>Reference:</p> <p>NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress 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.</p> <p>(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</p>	K 038	



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K 038 Continued From page 8
accordance with Section 9.6.

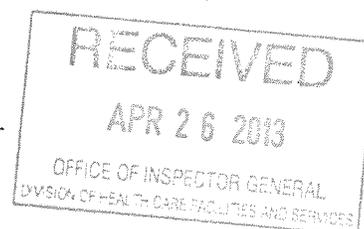
(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.

(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 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.

(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

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

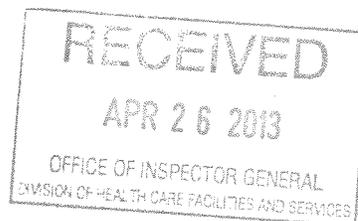
K 038



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K 038	Continued From page 9 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. 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. 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: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (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.	K 038			



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K 038 Continued From page 10
Reference: NFPA 101 (2000 edition)

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.

7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.

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.

Exception No. 1: This requirement shall not apply 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.

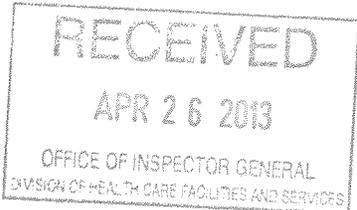
K 046 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F
Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.

This STANDARD is not met as evidenced by:
Based on observation, and interview it was determined the facility failed to test emergency

K 038

K 046

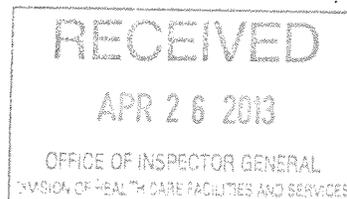
K 046
An emergency electrical light with battery back up was installed in the transfer switch room which will provide emergency lighting of at least one and one half hour duration on 4/25/13 by the Maintenance Supervisor.



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K 046	<p>Continued From page 11</p> <p>lighting in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for eighty two (82) beds with a census of seventy three (73) on the day of the survey. The facility failed to test emergency battery lighting for 30 seconds monthly and 90 minutes annually.</p> <p>The findings include:</p> <p>Observation, on 04/10/13 at 10:00 AM, with the Maintenance Director revealed the facility did not have evidence of monthly testing, or the annual testing of emergency battery lighting located in the transfer switch room.</p> <p>Interview, on 04/10/13 at 10:45 AM, with the Maintenance Director revealed he was not aware documentation was to be kept on emergency battery light testing.</p> <p>Reference: NFPA 101 (2000 edition) 7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p>	K 046	<p>K 046 continued:</p> <p>The Maintenance Supervisor tested center emergency lighting, no battery failure was identified.</p> <p>The Maintenance Supervisor was re-educated by the Administrator on testing emergency lighting in accordance with NFPA standards on 4/19/13.</p> <p>Maintenance Supervisor will test emergency battery lighting for 30 seconds monthly and 90 minutes annually. The emergency battery lighting test results will be discussed by the Performance Improvement Committee monthly for further review and recommendation.</p> <p>Compliance Date: 4/26/13</p>



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K 046 Continued From page 12.

7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction.

Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.

K 047 NFFA 101 LIFE SAFETY CODE STANDARD
SS=D

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

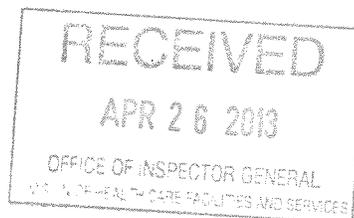
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure exit signs were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified

K 046

K 047

K 047
Exit sign was placed in the kitchen making a path of egress clearly recognizable as of 4/25/13 by the Maintenance Supervisor.

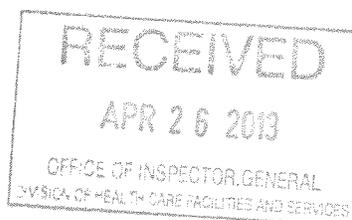
Maintenance Supervisor completed center rounds on 4/19/13 to determine no other doors needed an exit sign to show path of egress; none were identified.



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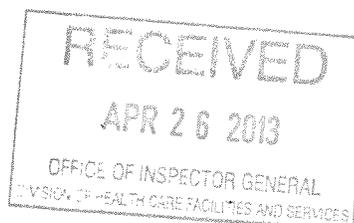
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K 047	<p>Continued From page 13</p> <p>for eighty two (82) beds with a census of seventy three (73) on the day of the survey. The facility failed to ensure exits were clearly recognizable with proper exit signage.</p> <p>The findings include:</p> <p>Observation, on 04/03/13 at 2:00 PM, with the Maintenance Director revealed the fire suppression pull for the Kitchen Hood was located next to the exit door in the Kitchen. The door did not have an exit sign making the path of egress clearly recognizable.</p> <p>Interview, on 04/10/13 at 2:00 PM, with the Maintenance Director revealed he was not aware the egress path through the Kitchen did not have proper signage.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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.</p> <p>Reference: NFPA 96 (1998 edition)</p> <p>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</p>	K 047	<p>K 047 continued:</p> <p>Re-education was provided to the Maintenance Supervisor by the Administrator on 4/19/13 on maintaining exit signs in accordance with NFPA standards.</p> <p>The Maintenance Supervisor will complete center rounds monthly to validate exits are clearly recognizable with proper exit signage. These rounds will be discussed by the Performance Improvement monthly for further review and recommendations.</p> <p>Compliance Date: 4/26/13</p>



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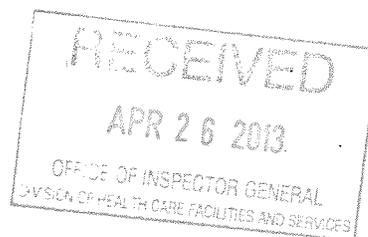
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K 047	Continued From page 14 manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The 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 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for eighty two (82) beds with a census of seventy three (73) on the day of the survey. The facility failed to ensure the fire drills were conducted at	K 050	K 050 The Maintenance Supervisor conducted a fire drill on 4/22/13 at 11:12am. The Maintenance Supervisor and Administrator revised the fire drill schedule for the remainder of the calendar year on 4/18/13, to ensure drills are conducted on each shift and under varied conditions and unexpected times at least quarterly. Maintenance Supervisor was re-educated by Administrator on 4/19/13 regarding fire drills at least quarterly on each shift and unexpected times, in accordance with NFPA standards.	



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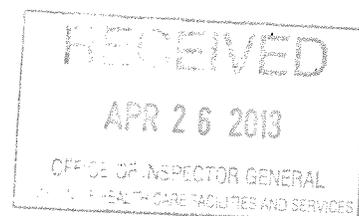
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K 050	<p>Continued From page 15 unexpected times on all shift.</p> <p>The findings include:</p> <p>Fire Drill review, on 04/10/13 at 10:45 AM, with the Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on all shifts. The facility conducted fire drills monthly on all shifts; however, the times were within the same hours on all shifts, and the fire drills were mostly conducted within a few days of each other at the end of the month.</p> <p>Interview, on 04/10/13 at 10:45 AM, with the Maintenance Director revealed he was not aware the fire drills were not being conducted as required. The Maintenance Director stated he thought since the facility was conducting more fire drills than required, they would be compliant.</p> <p>Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition). 19.7* OPERATING FEATURES 19.7.1 Evacuation and Relocation Plan and Fire Drills. 19.7.1.1 The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan</p>	K 050	<p>K 050 continued: The Maintenance Supervisor will record dates and times of fire drills conducted each month and bring to the Performance Improvement Committee meeting monthly for further review and recommendations.</p> <p>Compliance Date: 4/26/13</p>



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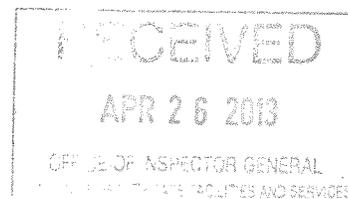
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K 050	Continued From page 16 for the protection of all persons in the event of fire, for their evacuation to areas of refuge, and for their evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. The provisions of 19.7.1.2 through 19.7.2.3 shall apply. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.	K 066	K 066 Metal containers with self closing cover devices into which ash trays can be emptied were placed in areas where smoking is permitted as of 4/25/13 by the Maintenance Supervisor.



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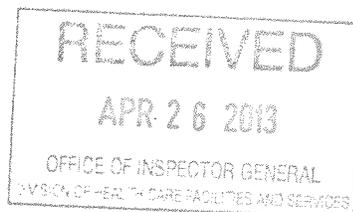
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185443	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/10/2013
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K 066	<p>Continued From page 17.</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 eighty two (82) beds with a census of seventy three (73) 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 04/10/13 between 9:15 AM and 2:30 PM, 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>	K 066	<p>K 066 continued:</p> <p>The Maintenance Supervisor observed other center smoking areas on 4/18/13 to determine metal containers with self closing devices were present. Center designated smoking areas had appropriate metal containers with self closing devices as of 4/25/13.</p> <p>Maintenance Supervisor was re-educated by the Administrator on 4/19/13 regarding the use of metal containers with self closing lid to empty ashtrays into located in center designated smoking areas per NFPA standards.</p> <p>Center smoking areas will be observed monthly to validate continued use of metal self-closing containers for the purpose of disposal of astray contents by the Maintenance Supervisor. These observations will be discussed by the Performance Improvement Committee monthly for further review and recommendations.</p> <p>Compliance Date: 4/26/13</p>



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K 072	<p>Continued From page 19</p> <p>The findings include:</p> <p>Observations, on 04/10/13 between 9:15 AM and 2:30 PM, with the Maintenance Director revealed linen carts and trash carts were being stored in the 200, and 300 Hall.</p> <p>Interview, on 04/10/13 between 9:15 AM and 2:30 PM, with the Maintenance Director revealed linen carts and trash carts were routinely stored in these areas.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 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>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are 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, 19.3.2.4</p>	K 072	<p>K 072 continued:</p> <p>Center hallways will be monitored on a daily basis (Mon-Fri) by the Maintenance Supervisor and/or Environmental Services Supervisor to validate means of egress is free from obstructions or impediments. The outcomes of this monitoring will be discussed by the Performance Improvement Committee monthly for further review and recommendations.</p> <p>Compliance Date: 4/26/13</p>
K 076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are 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, 19.3.2.4</p>	K 076	



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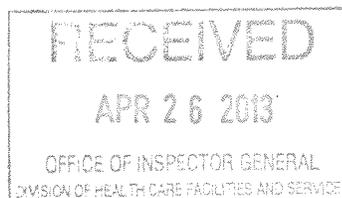
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<p>K 076 Continued From page 20</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of six (6) smoke compartments, residents, staff and visitors. The facility is certified for eighty two (82) beds with a census of seventy three (73) on the day of the survey. The facility failed to ensure oxygen storage over 300 cu ft. was stored in a room with an ignition source not located below five (5) feet from the floor.</p> <p>The findings include:</p> <p>Observation, on 04/10/13 at 2:29 PM, with the Maintenance Director revealed thirty eight (38) "E" oxygen tanks in the oxygen storage room. The oxygen storage room had a light switch installed under five (5) feet from the floor.</p> <p>Interview, on 04/10/13 at 2:29 PM with the Maintenance Director revealed he was unaware oxygen tanks could not be stored in a room with an ignition source below five (5) feet once the storage equaled over 300 cubic feet in a smoke compartment.</p> <p>Reference: NFPA 101 (2000 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (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</p>	<p>K 076</p> <p>K 076 The light switch located in the Oxygen Storage Room was moved as of 4/19/13 and is now greater than 5 feet from the floor, by the Maintenance Supervisor.</p> <p>The Maintenance Supervisor reviewed the second oxygen storage area in the center on 4/18/13 and determined that the light switch was greater than 5 feet from the floor.</p> <p>Maintenance Supervisor was re-educated by Administrator on 4/19/13 regarding NFPA standards on protection of oxygen areas.</p> <p>The Maintenance Supervisor will complete center rounds monthly to determine proper storage of oxygen in accordance with NFPA standards. These rounds will be discussed by the Performance Improvement Committee monthly for further review and recommendations.</p> <p>Compliance Date: 4/26/13</p>
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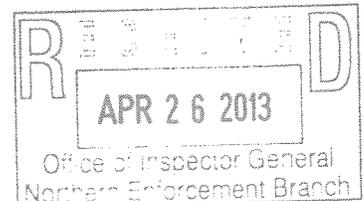


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K 144	<p>Continued From page 22</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for eighty two (82) beds with a census of seventy three (73) on the day of the survey. The facility failed to provide evidence of the generators monthly transfer times.</p> <p>The findings include:</p> <p>Observation, on 04/10/13 at 10:55 AM, with the Maintenance Director revealed the facility failed to provide documentation for the monthly transfer times of the generator. The facilities test records included the transfer time as an item to be documented; however the word "yes" was written on the line beside transfer time instead of a numeric figure to indicate the actual transfer time.</p> <p>Interview, on 04/10/13 at 10:55 AM, with the</p>	K 144	<p>K 144</p> <p>An emergency power generator test was completed on 4/22/13 by the Maintenance director. The start time of the test was 0830 and end time was 0930, the transfer time to emergency power was 10 seconds. The generator was determined to be functioning properly. The Maintenance Supervisor documented transfer time in a numeric figure.</p> <p>The emergency power generator will be documented in numeric figure as evidence of generators monthly transfer times.</p> <p>Re-education was provided to the 2013 Maintenance Supervisor on 4/19/13 by the Administrator regarding recording the transfer time in a numeric figures to ensure emergency generators are maintained in accordance with NFPA standards.</p> <p>The Maintenance supervisor will document generator transfer times in numeric form during each emergency power generator test and this documentation will be reviewed by the Performance Improvement Committee monthly for further recommendations:</p> <p>Compliance Date: 4/26/13</p>

MST
4/26/13



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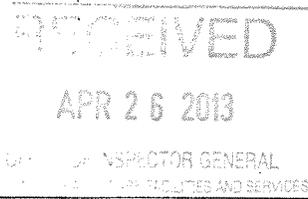
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<p>K 144</p> <p>Continued From page 22</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure emergency generators were maintained in accordance with NFPA standards. The deficiency had the potential to affect six (6) of six (6) smoke compartments, residents, staff, and visitors. The facility is certified for eighty two (82) beds with a census of seventy three (73) on the day of the survey. The facility failed to provide evidence of the generators monthly transfer times.</p> <p>The findings include:</p> <p>Observation, on 04/10/13 at 10:55 AM, with the Maintenance Director revealed the facility failed to provide documentation for the monthly transfer times of the generator. The facilities test records included the transfer time as an item to be documented; however the word "yes" was written on the line beside transfer time instead of a numeric figure to indicate the actual transfer time.</p> <p>Interview, on 04/10/13 at 10:55 AM, with the</p>	<p>K 144</p> <p>K 144</p> <p>An emergency power generator test was completed on 4/22/13 by the Maintenance director. The start time of the test was 0830 and end time was 0930, the transfer time to emergency power was 10 seconds. The generator was determined to be functioning properly. The Maintenance Supervisor documented transfer time in a numeric figure.</p> <p>The emergency power generator will be documented in numeric figure as evidence of generators monthly transfer times.</p> <p>Re-education was provided to the Maintenance Supervisor on 4/19/1113 by the Administrator regarding recording the transfer time in a numeric figures to ensure emergency generators are maintained in accordance with NFPA standards.</p> <p>The Maintenance supervisor will document generator transfer times in numeric form during each emergency power generator test and this documentation will be reviewed by the Performance Improvement Committee monthly for further recommendations.</p> <p>Compliance Date: 4/26/13</p>
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K. 144 Continued From page 23
Maintenance Director revealed he was not aware the monthly transfer time for the generator was to be documented. The Maintenance Director stated he thought he was to indicate only if the power was transferred.

Reference: NFPA 110 (1999 Edition).

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.

Reference: NFPA 99 (1999 Edition)

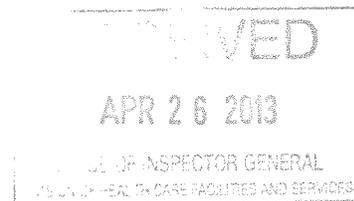
Actual NFPA Standard: NFPA 99, 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.

(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 3-5.3.1.

(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

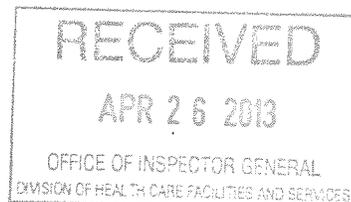
K 144 Kensington Center Performance Improvement Committee Members Administrator, DNS, ADNS, CCM, DMA, Activity Director, Maintenance Supervisor, Medical Records, Social Service Director, Dietary Manager and Medical Director.



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K 144	Continued From page 24. 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. (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. (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 load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. 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.	K 144	



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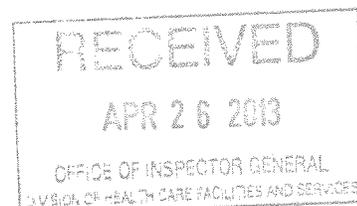
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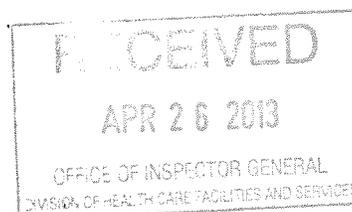
K 144	<p>Continued From page 25</p> <p>Actual Standard: NFPA 99, 3- 3-4.4.2. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction.</p> <p>6-1.1* The routine maintenance and operational 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 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</p>	K-144		
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K 144	<p>Continued From page 26</p> <p>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> <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</p>	K 144		



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NAME OF PROVIDER OR SUPPLIER KENSINGTON MANOR CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 225 SAINT JOHN ROAD ELIZABETHTOWN, KY 42701		
(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 144	Continued From page 27 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.	K 144		

