

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185176	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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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

A standard recertification survey was initiated on 06/04/13 and concluded on 06/06/13 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code survey was initiated and concluded on 06/05/13 with deficiencies cited at the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY
SS=D

F 241

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

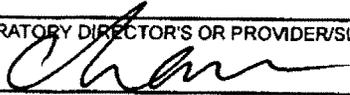
1. Tag F241: Dignity:

Residents identified in survey have window curtains, privacy curtains and room door closed during ADL care and treatments to ensure their personal privacy. To ensure residents residing in the facility have a dignified existence and privacy protected staff will receive education regarding privacy with all care according to policy. The DCE will conduct education of current employees by July 18, 2013, new employees on orientation and staff will have quarterly education thereafter for one year. The facility will have annual education around dignity and as needed. The ADNS will conduct visual audits ensuring resident privacy three times a week for four weeks, then one time a week for four weeks, then quarterly. Findings from audits will be reported to the monthly QAPI meeting. Compliance date 7/19/13

7/19/13

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to provide care to residents in a manner to promote dignity for one (1) of nineteen (19) sampled residents and one unsampled resident. Residents #3 and Unsampled Resident A. The facility staff failed to ensure the outside window curtains were closed during wound care for Resident #3. The staff left the hallway door open during medication administration via G-tube and the door was left open exposing Unsampled Resident A to the hallway when the nurse left the room.

The findings include:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X8) DATE 7/26/13
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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F 241 Continued From page 1

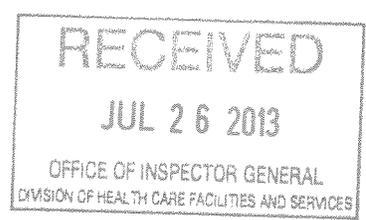
F 241

Review of the facility's Resident Rights Under Federal Law provided by the facility revealed the facility shall protect and promote the rights of each resident. Each resident has the right of a dignified existence and the resident has the right to personal privacy.

1. Observation during wound care for Resident #3, on 06/05/13 at 10:43 AM, revealed Licensed Practical Nurse (LPN) #3 entered the room of Resident #3 and proceeded with wound care. The window curtains remained open.

Review of the clinical record for Resident #3 revealed the facility admitted the resident on 01/27/13 with diagnoses of Acute Kidney Failure, Dementia, Depressive Disorders, Essential Hypertension, Severe Osteoarthritis and Bilateral Heel Wounds. The facility completed the Initial Minimum Data Set (MDS) on 02/01/13. The facility assessed the cognition status of the resident with the Brief Interview of Mental Status (BIMS) tool. The facility scored Resident #3 as a three (3) (0-7 severe impairment) of fifteen (15).

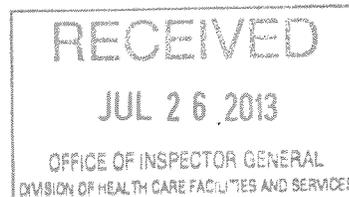
Observation of medication administration via G-Tube for Unsampled Resident A, on 06/06/13 at 2:20 PM, revealed the privacy curtain remained open to the doorway. The door remained open to the corridor during verification of G-Tube placement. The LPN exposed the abdomen listening for proper G-tube placement. Upon completion of the medication administration, LPN #3 acknowledged to the resident his/her bedsheets was wet. LPN #3 folded the sheet back in a manner that exposed the resident's abdomen. LPN #3 exited the room, left the door open and



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F 241	<p>Continued From page 2</p> <p>stopped at the medication cart and continued with documentation.</p> <p>2. Review of the clinical record for Unsampled Resident A revealed the facility admitted the resident on 05/04/12. His/Her diagnoses included Anemia, Diabetes Mellitus, Cardiovascular Accident, Dementia, Schizophrenia and Chronic Obstructive Pulmonary Disease (COPD). The facility completed the Quarterly MDS on 06/01/13. The facility assessed the cognition status of the resident with the Brief Interview of Mental Status (BIMS) tool. The facility scored Unsampled Resident A as a twelve (12) (8-12 moderately impairment) of fifteen (15).</p> <p>Interview and observation with LPN #3 in the hallway near the entrance of Unsampled Resident A's room, on 06/06/13 at 2:45 PM, revealed the resident's exposed abdomen could be seen from the hallway. Unsampled Resident A motioned for LPN #3 to come back into his/her room and pointed at his/her sheet. LPN #3 stated, the resident should have had the door closed during the G-tube placement checks and with medication administration. She further stated she could see the resident's abdomen from the hallway and should not have been exposed or seen from the hallway as this compromised the resident's dignity.</p> <p>Interview with the Unit Manager #1, on 06/06/13 at 2:45 PM, revealed the curtains on the windows should be closed and doors should be shut during procedures, such as wound care and with G-tube verification with a medication pass. She stated the resident's dignity was not protected when a</p>	F 241		



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F 241 Continued From page 3
window was left open or an abdomen was left exposed to the corridor.

Interview with the Director of Nurses, on 06/06/13 at 3:15 PM, revealed the resident's dignity should be protected by the use of closed curtains during wound care and medication pass. She reported the door should be closed when ever the G-tube placement was verified. She reported the resident's dignity would have been protected by closed curtains and doors.

F 241

F 431 483.60(b), (d), (e) DRUG RECORDS, SS=E LABEL/STORE DRUGS & BIOLOGICALS

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.

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.

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.

The facility must provide separately locked, permanently affixed compartments for storage of

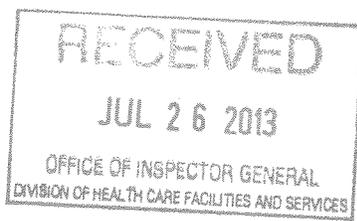
F 431

2. Tag F431: expired lab supplies and IV solution.

Specific residents were not cited in connection with survey.

Upon survey findings on 6/6/13, facility medication rooms, medication carts and crash cart were audited for any further expired biologicals with none found. The Unit Managers will audit medication rooms and crash cart on a weekly basis for one month, bi-weekly for one month, then monthly for one year. Medication room audits will continue on a monthly basis there after. These audits will include lab supplies, all biologicals and IV solutions. Compliance audits will be conducted monthly for six months by the ADNS. Findings from these audits will be reported to the QAPI meeting monthly for six months Initial audits to be completed by the Unit on Managers by July 3, 2013. **Compliance date will be July 19/13**

7/19/13



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F 431 Continued From page 4
controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to 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.

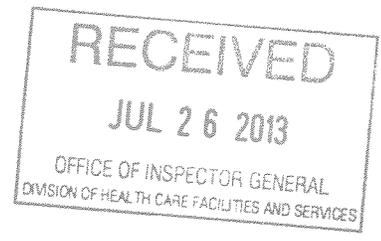
F 431

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and facility policy review, it was determined the facility failed to remove expired biologicals from two (2) of two (2) medication rooms. The facility failed to remove expired laboratory specimen collection containers, expired Central Line dressing change kit, Lift Loc Safety Infusion with a Hueber needle attached, IV catheter and Normal Saline from the crash cart stored in the Main Medication Room. The Annex Medication Room contained blue top blood collection Vacutainers and stool specimen collection containers that had expired.

The findings include:

Review of the facility's policy regarding Medication Storage, dated 12/2008, revealed medications and biologicals were to be stored properly, following the manufacturer's recommendations or those of the supplier to maintain their integrity and to support safe administration.

Observation of the Main Medication Room, on 06/06/13 at 8:00 AM, revealed the Crash Cart and laboratory supplies were stored in the



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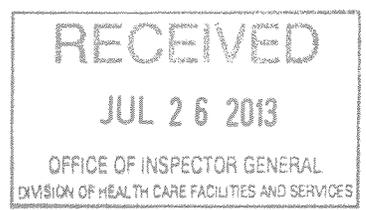
F 431 Continued From page 5
 medication room. The Crash Cart contained one (1) 100 ml Normal Saline, expired 12/2012, one (1) 24 gauge Intravenous (IV) catheter, expired 12/2012, a Lift Loc Safety Infusion (with a Huber needle), expired 03/2012 and a Central Line Dressing change kit, expired date 04/2011. There were fourteen (14) purple top Vacutainer, Expiration date of 02/2013, two (2) purple top Vacutainer, expiration date 06/2012, 26 (twenty-six) blue top containers, one (1) yellow top Vacutainer, expiration date 11/2012, six (6) Protocol C&S Medium, expired 10/2012, one (1) Protocol C&S Medium expired 09/2011, one (1) Stool Spec Collection expired 07/2012 and three (3) Stool Specimen collection kits expired 04/2013.

Observation of the Annex Medication Room, on 06/06/13 at 9:00 AM, revealed four (4) expired Blue Top Vacutainer's, dated 05/2013, four (4) stool specimen culture container with expiration date of 05/2013 and four (4) Stool culture kits with an expiration date 10/2012.

Interview with Unit Manager #1, on 06/06/13 at 8:40 AM, revealed the dates were checked in the supply room daily. She stated the night shift nurse checks the crash cart nightly. She was not aware the expiration dates were not checked and she stated they should have been checked.

Interview with the Director of Nurses, on 06/06/13 at 8:50 AM, revealed the Unit Manager checked the records to verify the crash cart was checked. She reported the nurses signed off on a form to confirm the crash cart was checked nightly. She stated the medication rooms were checked for

F 431



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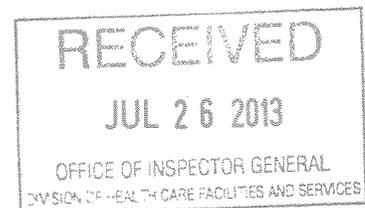
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F 441	<p>Continued From page 7</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to utilize sanitary technique during wound care for one (1) of nineteen (19) sampled residents and one (1) unsampled resident. Resident #3. Licensed Practical Nurse (LPN) #3 failed to practice proper hand hygiene between glove changes, contaminated a clean dressing field during a dressing change and returned contaminated dressing supplies to the treatment cart.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Hand Hygiene and Proper Handwashing Techniques, undated, revealed an additional form titled Clean Dressing Change Audit, undated, that instructed the staff to wash their hands after removal of gloves. No policy was provided regarding contamination of a clean dressing field and returning contaminated supplies to a treatment cart.</p> <p>Observation of wound care provided to Resident #3, on 06/05/13 at 10:43 AM, revealed Licensed Practical Nurse (LPN) #3 did not complete hand hygiene five (5) times out</p>	F 441		

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 441	<p>Continued From page 8</p> <p>of nine (9) glove changes during wound care. LPN #3 applied a clean barrier on the over the bed table and placed packaged wound care supplies on the barrier and on the bare table surface. She opened a two (2) pack of Q-tips, applied Normal Saline and cleaned the left heel wound. She placed the used Q-tips on the barrier with the clean supplies. Once the bilateral wound care to the heels was completed, the nurse gathered the excess supplies of one (1) Aquacel dressing, two (2) 2 X 2 gauze packs and one (1) roll of tape and returned them to the treatment cart. Those supplies had been placed on the uncovered table surface. Each item was returned to universal drawer in the treatment cart.</p> <p>Review of the clinical record for Resident #3 revealed the facility admitted the resident on 01/27/13 with diagnoses of Acute Kidney Failure, Essential Hypertension, Severe Osteoarthritis and Bilateral Heel Wounds. The facility completed the Initial MDS on 02/01/13. The facility assessed the cognition status of the resident with the Brief Interview of Mental Status (BIMS) tool. The facility scored Resident #3 as a three (3) (0-7 severe impairment) of fifteen (15).</p> <p>Interview with Unit Manager #1, on 06/06/13 at 3:15 PM, revealed the staff should only take into a resident's room the supplies needed for a dressing change. She stated some over zealous staff may have taken too many supplies into the resident's room. The Unit Manager stated she had encouraged staff to take in only the supplies they need to do wound care and they should not be returning contaminated supplies to the treatment cart. She reported they needed to keep the treatment carts clean and to prevent</p>	F 441		



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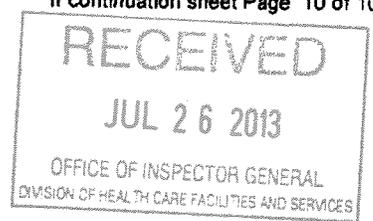
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F 441	Continued From page 9 possible cross contamination.	F 441		
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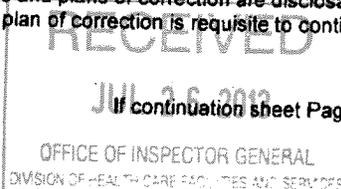
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) floor and a partial basement, Type V Protected Construction</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments on the Ground Floor.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II 18.5 KW generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 06/05/13. Golden Living Center-Mt Holly was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7/26/13
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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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K 000 Continued From page 1
Deficiencies were cited with the highest deficiency identified at "F" level.

K 000

K 027 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1 1/4-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7

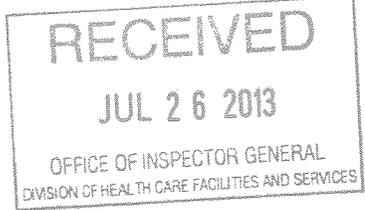
K 027

K027:
The cross-corridor doors located in the West Hall have been adjusted so they close completely. The magnetic hold open devices have been fixed. Work was completed by the maintenance director on June 11th 2013. Maintenance Director will test self-closing doors monthly for proper closure and report results in the Safety Committee monthly. it will be also incorporated to our monthly preventive maintenance schedule
Compliance date on 6/12/13

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors, located in a smoke barrier, would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately twenty-five residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-five (95) on the day of the survey.

The findings include:

Observation, on 06/05/13 at 1:20 PM, with the Director of Maintenance revealed the cross-corridor doors located in the West Hall



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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MT HOLLY	STREET ADDRESS, CITY, STATE, ZIP CODE 446 MT. HOLLY AVE LOUISVILLE, KY 40206
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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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K 027 Continued From page 2
would not completely close when tested, leaving a gap of approximately four (4) inches between the pair of doors in the closed position. The pair of doors could not close completely and resist the passage of smoke in the event of an emergency.

K 027

Interview, on 06/05/13 at 1:20 PM, with the Director of Maintenance revealed he was not aware of the pair of doors not completely closing and not being capable of resisting the passage of smoke in the event of an emergency. Further interview with the Director of Maintenance revealed the magnetic hold open devices had malfunctioned when tested and are in need of repair or replacement.

Reference: NFPA 101 (2000 edition)

8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.

Reference: NFPA 80 (1999 Edition)

Standard for Fire Doors 2-3.1.7
The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.

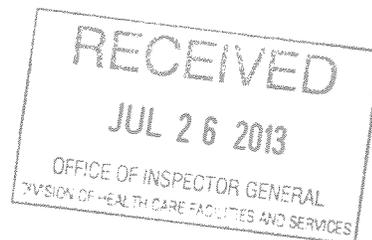
K 045 NFPA 101 LIFE SAFETY CODE STANDARD

K 045

SS=F

Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in

Please next page



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K 045 Continued From page 3
darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, residents, staff and visitors. The facility has one- hundred and ten (110) certified beds and the census was ninety-five (95) on the day of the survey. The facility failed to provide the required illumination outside an exit for discharge.

The findings include:

Observations, on 06/05/13 between 9:30 AM and 1:25 PM, with the Director of Maintenance revealed the exits located at the South Wing, the Annex Wing, the West Wing, the North Wing, the East Wing and the Main Entrance did not have exterior egress lighting to provide the required illumination for exit discharge. The exits were equipped with a light fixture with only one bulb installed and were not backed up with emergency power from the generator.

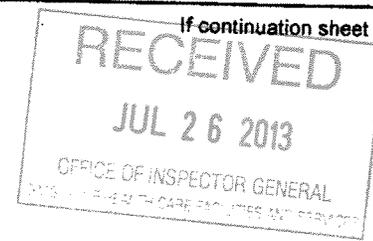
Interview, on 06/05/13 between 9:30 AM and 1:25 PM, with the Director of Maintenance revealed he was not aware of the requirement for exterior light fixtures for egress to have two (2) bulbs. He could not confirm if the light fixtures were backed up by

K 045:

K045:

Advanced Mechanical will be installing split head lighting to be wired in series with the emergency panel. Work to be completed by July 6, 2013. Maintenance Director was educated on the NFPA requirement. Monthly check has been added to the preventive maintenance rounds and safety committee meetings monthly maintenance rounds. Maintenance Director will monitor the lighting system during Monthly generator test a to ensure proper functioning and compliance will also report to QAPI monthly meetings. **Compliance date 07/7/13**

7/7/13



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K 045	<p>Continued From page 4 emergency power provided by the generator.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>19.2.8 Illumination of Means of Egress.</p> <p>Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS</p> <p>7.8.1 General.</p> <p>7.8.1.1*</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2</p> <p>Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified.</p> <p>Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum</p>	K 045		

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K 045 Continued From page 5
15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.
7.8.1.3*
The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor.
Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light.
Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels.
7.8.1.4*
Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.

K 045

K 069 SS=D
NFPA 101 LIFE SAFETY CODE STANDARD
Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure proper signage was displayed for the proper use of fire extinguishers in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, all residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-five (95) on the day of the

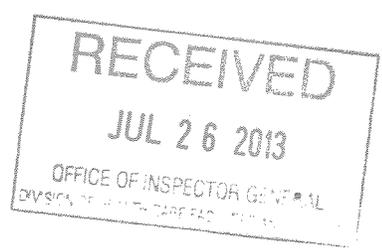
K 069

K069:

The proper signage for use of the K-Type fire extinguisher located in the kitchen has been installed. Work was completed on June 13th 2013. education on the use of proper signage was given to the Dietary staff and the Maintenance Director on requirement on proper signage. Maintenance Director will monitor monthly for 6 months during maintenance rounds and report all issues to QAPI monthly. In the event of remodeling in the future appropriate signage will be audited to ensure posting.

6/14/13

6/14/13



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K 069 Continued From page 6 survey.

K 069

The findings include:

Observation, on 06/05/13 at 9:50 AM, with the Director of Maintenance and the Kitchen Supervisor revealed the K-Type fire extinguisher, located within the Kitchen area, did not have the required signage posted for proper usage of the fire extinguisher. The K-Type extinguisher is a secondary backup means to the automatic fire suppression system.

Interview, on 06/05/13 at 9:50 AM, with the Director of Maintenance and the Kitchen Supervisor revealed they were not aware of the requirement for signage to be posted for proper usage of the K-Type fire extinguisher.

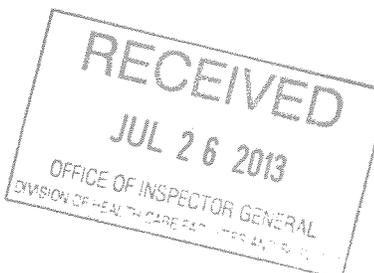
Reference: NFPA 96 (1998 edition)
7-2.1.1 A placard identifying the use of the extinguisher as a secondary backup means to the automatic fire suppression system shall be conspicuously placed near each portable fire extinguisher in the cooking area.

K 072 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

K 072

Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.
7.1.10

please see next page



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K 072 Continued From page 7

K 072

K072:

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately thirty (30) residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-five (95) on the day of the survey. The facility failed to ensure the means of egress was free of all obstructions or impediments.

The findings include:

Observation, on 06/05/13 at 10:30 AM, with the Director of Maintenance and Housekeeping Supervisor revealed a platform scale was permanently located within the egress path for exiting the facility in the Annex Hall.

Interview, on 06/05/13 at 10:30 AM, with the Director of Maintenance and Housekeeping Supervisor revealed they were unaware of the platform scale's location being within the required path of egress.

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

The platform scale has been folded up so that means of egress from the Annex Hall is free of obstructions.
Staff has been educated by the DCE on the appropriate method to store the platform scale in order to maintain egress path for exiting the Annex Hall. Education completed on June 13th 2013. Maintenance of clear path to exit facility in the Annex Hall will be added to non-clinical rounds sheet for weekly monitoring by the interdisciplinary team and reviewed by the ED weekly. follow up of this matter will be discuss on a monthly bases during QAPI meetings
Compliance date of 6/14/13



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K 072 Continued From page 8
impediments to full instant use in the case of fire or other emergency.

K 147 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

K 072

K 147

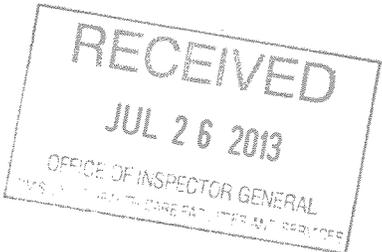
This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately forty (40) residents, staff, and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-five (95) on the day of the survey.

The findings include:

Observation, on 06/05/13 at 9:25 AM, with the Director of Maintenance revealed the hydrocollator (therapy equipment containing hot water) located within the Physical Therapy Gym, was not plugged into a ground fault circuit interrupter (GFCI) outlet as required in wet areas.

Interview, on 06/05/13 at 9:25 AM, with the Director of Maintenance revealed he was not aware of the hydrocollator being plugged into a standard electrical outlet and acknowledged the requirement of medical equipment containing water to be plugged in a GFCI outlet.

K147:
Maintenance Director installed a ground fault circuit interrupter GFI plug in therapy where the hydro collator is plugged in on 6/11/13 general audit on equipment that's required GFI to be completed by Maintenance Director by June **6/29/13** 19/2013 monthly follow up will be done on equipment that require GFI and reported to QAPI on a monthly basis for three months Compliance date of 6/29/13



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K 211	<p>Continued From page 10</p> <p>Based on observation and interview, it was determined the facility failed to ensure Alcohol Based Hand Rub (ABHR) dispensers were not installed over or adjacent to an electrical ignition source, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, approximately forty (40) residents, staff and visitors. The facility has one-hundred and ten (110) certified beds and the census was ninety-five (95) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/05/13 at 9:20 AM, with the Director of Maintenance revealed an Alcohol Based Hand Rub (ABHR) dispenser was located adjacent to a light switch in the Rehab Office. The wall and cover plate on the light switch had been stained with splash marked from the alcohol based sanitizer in the dispenser.</p> <p>Interview, on 06/05/13 at 9:20 AM, with the Director of Maintenance revealed he was unaware of the ABHR dispenser being installed adjacent to an electrical source (light switch) and the wall and cover plate being stained with splash marks from usage of the dispenser.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of 	K 211		

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K 211 Continued From page 11
rooms)
o The dispensers have a minimum spacing of 4 ft from each other
o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.
o Dispensers are not installed over or adjacent to an ignition source.
o If the floor is carpeted, the building is fully sprinkled. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623

K 211

