

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

PRINTED: 07/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185201	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2014
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NAME OF PROVIDER OR SUPPLIER TANBARK HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1121 TANBARK ROAD LEXINGTON, KY 40515
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A Standard Recertification Survey was initiated on 06/24/14 and concluded on 06/26/14. Deficiencies were cited with the highest scope and severity of an "F".	F 000		
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility's policy, it was determined the facility failed to ensure hair restraints were worn in the kitchen while food was prepared in the food preparation area. Additionally, it was determined the facility failed to ensure beverages and food were stored in a manner to conserve nutritive value and flavor. Observation, on 06/24/14 revealed milk was stored for use in the facility's refrigerator with a "Best By" date of 06/21/14 which was three (3) days before the date of surveyor observation. The findings include: 1. Review of the facility's policy titled "Environmental Sanitation/Infection Control" Policy 9.1 dated 2006, revealed a hair net or head	F 371	No residents were said to be affected by the deficient practice. All residents have the potential to be affected by the deficient practice therefore a review of the 24 hour report sheet was done for the dates of June 27, 2014 through July 3, 2014 to insure that no residents contacted food borne illness. None were identified. The area where hair nets are being stored has been changed to an area that is outside of the food prep/preparing area. All dietary staff were in-serviced by the Administrator on the need to wear hairnets if in the food prep/ preparing area. They were also in-serviced on the insuring food is not outdated when delivered to the kitchen, being prepared or served. The milk identified was thrown away on 6/24/14 On this date all other foods storage areas were assessed by Administrator to insure there were no outdated food items. None were found. The employee identified as not having a hairnet on placed one on when	8/8/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Conyuma Collier TITLE: Administration (X6) DATE: 7/28/14

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

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F 371	<p>Continued From page 1 covering that effectively restrains head and facial hair should be worn in food preparation areas. Hair was to be arranged to prevent contamination of food, equipment and utensils.</p> <p>Observation of facility staff in the kitchen food preparation area while on tour of the facility, on 06/24/14 at 2:51 PM, revealed the Assistant Dietary Director in the food preparation area without a hair restraint in place.</p> <p>Interview with Assistant Dietary Director, on 06/25/14 at 10:28 AM, revealed that her expectations were for staff to wear hair restraints while in food preparation areas. She stated that she should have worn a hair net when observed in a food preparation area. She stated this was an infection control issue.</p> <p>Interview with the Administrator, on 06/25/14 at 10:54 AM, revealed her expectations were for staff to wear a hair net when in the kitchen in food preparation areas due to infection control reasons.</p> <p>2. Review of facility's policy "Food and Non-Food Storage" Policy Sections 7.6 and 7.8 revealed for both perishable and non-perishable items, the use-by and expiration dates are checked. Foods marked within three (3) days of these dates are not accepted from the supplier. Additionally the policy stated, upon receiving food and non-food items, products are inspected for quality.</p> <p>Observation of the facility's kitchen refrigerator while on tour with the facility Assistant Dietary Director, on 06/24/14 at 2:51 PM, revealed Deans 2% Milk with a "Best By" date of 06/21/14 was stored in the refrigerator for resident use. The</p>	F 371	<p>Through observation daily monitoring of wearing of haimets will occur by the Dietary Manager/ designee. Weekly rounds by the Administrator will be completed to insure compliance. Monitoring of foods to insure nothing is expired will be done daily through rounds from the Dietary Manger/ designee and weekly from the Administrator. Any out dated foods found will be removed from stock and reported to the vendor. The dietary staff will review dates of food prior to serving or preparing to insure they are not outdated.</p>	
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F 371	<p>Continued From page 2</p> <p>observation date was three (3) days from the date indicated on the milk jug. The Assistant Dietary Director stated the milk should not have been in the refrigerator and removed it for disposal.</p> <p>Interview with the Personal Care Director, on 06/24/14 at 3:03 PM, revealed her expectations with regard to expired items were that staff remove and dispose of them from the refrigerator daily.</p> <p>Interview with the facility's Administrator, on 06/24/14 at 3:16 PM, revealed "Best By" dated items were to be removed from the refrigerator on the third day after the date. She further stated that it was her expectation that these items be removed promptly. She stated that if she were to notice expired items in the refrigerator, she would dispose of the items so that they would not be served to the residents. Additionally, on 06/25/14 at 10:54 AM, the Administrator stated that the milk was delivered on 06/24/14 with the expired date. She stated the milk should not have been accepted and/or stored in the facility refrigerator.</p>	F 371		
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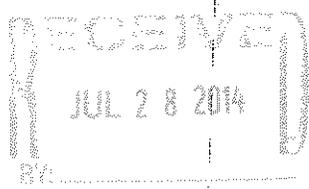
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70 (a) Building: 01 Plan Approval: 05/11/88 Survey: 2000 Existing Facility Type: Skilled Nursing Facility (SNF) Type of Structure: One (1) story with full basement Type V (111) Smoke Compartments: 2 Fire Alarm: Complete fire alarm. Sprinkler System: Complete (wet) sprinkler system A Life Safety Code Survey was initiated on 06/24/14 and concluded on 06/25/14. The Survey began using the 2786S, short form. Concerns were identified effecting complete sprinkler coverage and the survey was then changed to the 2786R standard form. The facility was found not in compliance with the requirements for participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire) Deficiencies were cited with the highest scope and severity of an "F" level.	K 000	No residents were said to affected by the deficient practice. All residents have the potential to have been affected by the deficient practice as the doors / frame / smoke barriers have the potential to fail to prevent fire/smoke from escaping into the resident areas. The doors/ frames are scheduled to be installed by August 29, 2014. All other doors were assessed on 6/26/14 to insure compliance. The smoke barriers identified had approved #3m Fire Barrier Caulk placed in openings on 6/27/14. An assessment of all smoke barriers was completed on 6/27/14 with any issues being corrected. The Maintenance staff were in-serviced on the need to insure that all smoke barriers provide at least a 1 hour fire rating. They were also educated on the need for fire doors be in compliance with the state and federal regulations on fire ratings. Until doors/frame is installed staff were educated to not evacuate into the deficient compartment. They were to use smoke compartment 301-311 south hallway as indicated the evacuation plan. The Maintenance Director/ designee will insure smoke barriers provide at least a 1 hour rating through observation in rounds completed monthly. The Administrator will monitor compliance through review of documentation of rounds monthly. The Regional Maintenance Director will assess doors every 6 months to insure they meet state and federal requirements on fire ratings.	8/29/14
K 011	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Coryna Collier* TITLE *Administration* (X6) DATE *7/28/14*

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K 011 SS=F	Continued From page 1 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the fire wall was in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of two (2) smoke compartments, thirty four (34) residents, staff and visitors. The facility has the capacity for thirty four (34) beds and at the time of the survey, the census was thirty one (31). The findings include: Observation, on 06/24/14 at 1:44 PM with the Maintenance Director, revealed the two (2) hour wall separating the skilled nursing facility from the personal care home had doors installed in the corridor with a fire rating of thirty (30) minutes mounted in a frame with a fire rating of twenty (20) minutes. Interview, on 06/24/14 at 1:45 PM, with the Maintenance Director revealed he knew the fire doors in a fire wall were to be rated; however, he was not aware they did not have the proper rating	K 011			

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K 011	<p>Continued From page 2 to be installed in a two (2) hour fire wall.</p> <p>Observation, on 06/25/14 at 11:00 AM, with the Maintenance Director revealed the two (2) hour wall separating the skilled nursing facility from the personal care home had a three inch (3") by three inch (3") unsealed penetration by a wire. Further observation revealed a pipe was sealed to the concrete block wall with a material (drywall joint compound) that was not rated for use or equal to the wall.</p> <p>Interview, on 06/25/14 at 11:01 AM, with the Maintenance Director revealed he was not aware of the penetration or the use of an unrated material sealing around the pipe that was penetrating the wall.</p> <p>The census of thirty one (31) was verified by the Administrator on 06/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/25/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.1.1.4 Additions, Conversions, Modernization, Renovation, and Construction Operations. 19.1.1.4.1 Additions. Additions shall be separated from any existing structure not conforming to the provisions within Chapter 19 by a fire barrier having not less than a 2-hour fire resistance rating and constructed of materials as required for the addition. (See 4.6.11 and 4.6.6.) 19.1.1.4.2 Communicating openings in dividing fire barriers</p>	K 011		
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K 011	Continued From page 3 required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire doors. (See also Section 8.2.) 19.1.1.4.3 Doors in barriers required by 19.1.1.4.1 shall normally be kept closed. Exception: Doors shall be permitted to be held open if they meet the requirements of 19.2.2.2.6. 19.1.2.1* Sections of health care facilities shall be permitted to be classified as other occupancies, provided that they meet all of the following conditions: (1) They are not intended to serve health care occupants for purposes of housing, treatment, or customary access by patients incapable of self-preservation. (2) They are separated from areas of health care occupancies by construction having a fire resistance rating of not less than 2 hours. 8.2.3.2 Fire Protection-Rated Opening Protectives. 8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by	K 011			

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K 011	<p>Continued From page 4</p> <p>8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.</p> <p>8.2.3.2.3.1 Every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives shall be as follows: (1) 2-hour fire barrier - 1 1/2-hour fire protection rating (2) 1-hour fire barrier - 1-hour fire protection rating where used for vertical openings or exit enclosures, or 3/4-hour fire protection rating where used for other than vertical openings or exit enclosures, unless a lesser fire protection rating is specified by Chapter 7 or Chapters 11 through 42 Exception No. 1: Where the fire barrier specified in 8.2.3.2.3.1(2) is provided as a result of a requirement that corridor walls or smoke barriers be of 1-hour fire resistance-rated construction, the opening protectives shall be permitted to have not less than a 20-minute fire protection rating when tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, without the hose stream test. Exception No. 2: The requirement of 8.2.3.2.3.1(2) shall not apply where special requirements for doors in 1-hour fire resistance-rated corridor walls and 1-hour fire resistance-rated smoke barriers are specified in Chapters 18 through 21. Exception No. 3: Existing doors having a 3/4-hour fire protection rating shall be permitted to continue to be used in vertical openings and in</p>	K 011		
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K 011	<p>Continued From page 5</p> <p>exit enclosures in lieu of the 1-hour rating required by 8.2.3.2.3.1(2).</p> <p>(3) 1/2-hour fire barrier - 20-minute fire protection rating</p> <p>Exception: Twenty-minute fire protection-rated doors shall be exempt from the hose stream test of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.</p> <p>4.6.1.1 The authority having jurisdiction shall determine whether the provisions of this Code are met.</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 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. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 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. <p>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall</p> <ol style="list-style-type: none"> 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 	K 011		
K 022	NFPA 101 LIFE SAFETY CODE STANDARD	K 022		

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K 022 SS=D	<p>Continued From page 6</p> <p>Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure NO exit signs were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of two (2) smoke compartments, twenty three (23) residents, staff and visitors. The facility has the capacity for thirty four (34) beds and at the time of the survey, the census was thirty one (31).</p> <p>The findings include:</p> <p>Observation, on 06/25/14 at 10:02 AM, with the Maintenance Director revealed an exterior door in the Therapy Room that could be mistaken for an exit door to have improper No Exit signage. The letters on the sign were only a half inch (1/2") high.</p> <p>Interview, on 06/25/14 at 10:03 AM, with the Maintenance Director revealed he was not aware the letters of a No Exit sign had to be of a certain height.</p>	K 022	<p>There were no residents said to be affected by the deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice as they could mistake the door as an exit.</p> <p>The required sign was replaced by the Administrator on 6/25/14 using letters in the word NO 2 in high with a 3/8 high stroke. The word EXIT being 1 inch high, aligned right below the word NO. The Maintenance staff were in-serviced on the regulations of the sign lettering sizes.</p> <p>The Administrator/designee will monitor compliance through weekly rounds.</p>	8/8/14

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K 022	Continued From page 7 The census of thirty one (31) was verified by the Administrator on 06/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/25/14. Actual NFPA Standard: Reference: NFPA 101 (2000 edition) 7.10.8 Special Signs. 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs.	K 022	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 maintain emergency lighting in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to	K 046	8/8/14

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K 046	<p>Continued From page 8</p> <p>affect two (2) of two (2) smoke compartments, thirty four (34) residents, staff and visitors. The facility has the capacity for thirty four (34) beds and the census was thirty one (31) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 06/25/14 at 10:22 AM, with the Maintenance Director revealed the facility failed to document the annual ninety (90) minute test for battery powered emergency lighting.</p> <p>Interview, on 06/25/14 at 10:23 AM, with the Maintenance Director revealed he was not aware that documentation was to be provided for the ninety (90) minute test.</p> <p>The census of thirty one (31) was verified by the Administrator on 06/25/14. The survey findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/25/14.</p> <p>Actual NFPA Standard:</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</p>	K 046	<p>No residents were said to be affected by the deficient practice.</p> <p>All residents have the potential to be affected by the deficient practice if the lighting fails to function.</p> <p>Maintenance Director was in-serviced by the Administrator on the correct format to document accurate testing of the lighting. This will include exact time frames of testing. They will be at least 30 seconds no less than every 30 days and at least 1 1/2 hours annually.</p> <p>The Administrator will audit monthly/ annually the documentation of testing to insure compliance.</p>	
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K 046	Continued From page 9 maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. 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 1 1/2 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 046		
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	K 050	No residents were said to have been affected by the deficient practice. All residents have the potential to be affected deficient practice as the staff must be prepared on how to manage a fire. The Maintenance staff were in-serviced by the Administrator on the interpretation of regulation of	8/8/14

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K 050 Continued From page 10

This STANDARD is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect two (2) of two (2) smoke compartments, thirty four (34) residents, staff and visitors. The facility has the capacity for thirty four (34) beds and at the time of the survey, the census was thirty one (31).

The findings include:

Review of the facility's Fire Drill documentation, on 06/25/14 at 10:10 AM, with the Maintenance Director, revealed the fire drills were not being conducted at random times on all shifts. Fire drills on first shift were conducted routinely at 1:15 PM and between 9:16 AM and 9:57 AM. Fire drills on second shift were conducted routinely around 7:20 PM and 3:30 PM. Fire drills on third shift were routinely conducted around 5:50 AM. The fire drills reviewed were over the last four (4) quarters.

Interview, on 06/25/14 at 2:00 PM, with the Maintenance Director, revealed he was unaware the fire drills were not being conducted as required.

The census of thirty one (31) was verified by the Administrator on 06/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/25/14.

Actual NFPA Standard:

K 050

random fire drills. Each shift, throughout the quarter will be held at least 2 hours a part from each other.
The Administrator will audit the fire drill times each month to insure compliance, comparing times throughout the quarter.

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K 050	Continued From page 11	K 050		
K 056 SS=F	<p>Reference: NFPA 101 (2000 edition) 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>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, blueprint review and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect two (2) of two (2) smoke compartments, thirty four (34) residents, staff and visitors. The facility has the capacity for thirty four (34) beds and at the time of the survey, the census was thirty five (35). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.</p>	K 056	<p>No residents were said to be affected by the deficient practice.</p> <p>All residents have the potential to be affected by the deficient if a fire were to occur there is the potential that were would not be enough sprinklers to assist in manging the fire.</p> <p>New sprinklers were ordered to be installed by Fire Protection Services approximately on or before August 15, 2014. All areas of the facility were assessed by the Maintenance Director to insure compliance of state and federal regulations on required sprinklered areas.</p>	8/8/14

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K 056	<p>Continued From page 12</p> <p>The findings include:</p> <p>Observation, on 06/24/14 at 2:00 PM, with the Maintenance Director revealed two (2) exterior roofs outside the exit doors by rooms #324 and #307 to not have sprinkler protection installed.</p> <p>Blueprint review, on 06/24/14 at 2:20 PM, with the Maintenance Director revealed on page A-39 of the blueprint dated 01/28/88 that the two (2) exterior roofs outside the exit doors by rooms #324 and #307 to be constructed of combustible wood materials.</p> <p>Interview, on 06/24/14 at 2:22 PM, with the Maintenance Director, revealed he had not been aware the exterior roofs were constructed of combustible wood materials.</p> <p>The census of thirty one (31) was verified by the Administrator on 06/25/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 06/25/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p>	K 056	The Regional Maintenance Director will review sprinkler placement through out facility to insure compliance.		