

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185132</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/15/2013</b>
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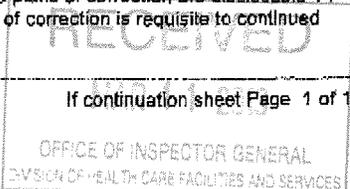
NAME OF PROVIDER OR SUPPLIER  <b>FRANCISCAN HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3625 FERN VALLEY ROAD LOUISVILLE, KY 40219</b>
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F 000	INITIAL COMMENTS  A recertification survey was initiated on 02/13/13 and concluded on 02/15/13 and a Life Safety Code survey was initiated on 02/14/13 and concluded on 02/15/13 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.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  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 maintain resident equipment in a safe and sanitary manner for one (1) of seventeen (17) Sampled Residents (Resident #8) and two (2) of the four (4) Unsampled Residents (Unsampled Residents C & D). The covering on the bilateral arms of three wheelchairs were cracked and split.  The findings include:  Interview with the Director of Plant Operations, on 02/14/13 at 4:30 PM, revealed there were no specific policies regarding the maintenance of wheelchairs.  Observations during the environmental tour, on 02/14/13 at 3:23 PM, with the Director of Plant Operations revealed the bilateral arms of three wheelchairs were cracked and split. The personal	F 253	1. The wheelchair arms for Resident #8 were replaced by the Director of Plant Operations (DPO) on 2-20-13. Resident C and D wheelchair arms replaced by Plant Operations on 2-20-13. 2. Plant Operations assessed all wheelchairs on 2-28-13 to determine any other wheelchairs that had cracked or split arms. Any identified were corrected by Plant Operations. 3. Plant Operations and Facility Staff were in serviced by Executive Director on 03-08-13 related to maintaining resident equipment in a safe and sanitary manner with emphasis on wheelchair arms. Work orders were reviewed so staff can complete when repairs are necessary. 4. Ongoing monitoring will be maintained by DPO and ED when making daily rounds throughout the facility. Work orders are to be completed by any staff who identify this. Random audits of each unit will be completed weekly times 3 months by DPO and ED, then monthly times 6 months to insure compliance. Results of the audits will be reviewed in monthly QA meeting. Observations will also occur during routine visits by DPO Support and during Peer Reviews twice annually.	3-28-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Henry Adkins</i>	TITLE <i>Exec. Dir.</i>	(X6) DATE <i>3-10-13</i>
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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.

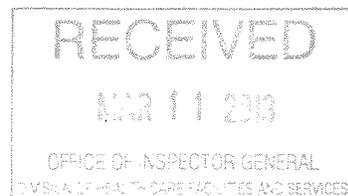


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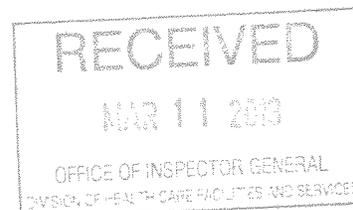
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F 253	Continued From page 1 wheelchair for Resident #8 had a 2 1/2 inch opened area on the right arm rest exposing the interior foam which could not be disinfected. Both arm rests had split and cracked coverings. The wheel chairs identified for the two (2) Unsampld Resident's C and Resident D, had cracked and split areas to the bilateral arm rests.  Interview with the Director of Plant Operations, on 02/14/13 at 4:30 PM, revealed the wheelchair for Resident #8 had been the resident's personal wheelchair and was brought from home. He stated the wheelchairs identified for Resident's C and D did belong to the facility and staff were to notify him of any repairs needed by completing a work order and this was not done. He stated it was important to maintain the integrity of the wheelchair arms to prevent skin tears or injury to the residents.	F 253		
F 371 SS=F	483.35(i) 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 the facility's policies and procedures, it was determined the facility failed to ensure staff	F 371	F 371 1. The undated cottage cheese, sour cream, honey nectar thick chocolate milk, thick and easy tea and honey thick cranberry juice were discarded when identified. Dietary Aide #1 and volunteer were educated by DFS immediately on handwashing and use of hair restraints. Volunteer was also reminded to seek dietary staff assistance for drinks when needed. 2. On 2/13/13, no residents showed any signs of food related illness, therefore no residents affected. on 2/13/13, staff were informed to cover all exposed hair. DFS observed dietary staff to determine if appropriate beard and hair covers in place. He also observed staff to to insure the use of hand sanitizer and handwashing in place. No more undated food found.	3-28-13



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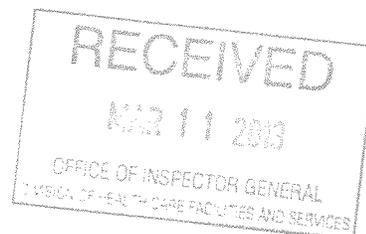
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F 371	Continued From page 2 followed their policy for dating opened food, failed to ensure staff and volunteers washed their hands at appropriate times and failed to ensure staff utilized hair restraints and in the proper manner in the kitchen.  The findings include:  Review of the facility's undated policy titled, Date Marking, revealed the staff were to identify when food was prepared and when it was to be discarded. The policy further revealed commercially prepared items when opened, when potentially hazardous foods are stored, and ready to eat food are opened are to be dated. Continued review of the policy revealed foods are to be discarded when the expiration date by the manufacturer guaranteed the food would no longer meet quality standards.  Review of the facility's policy titled Hair Restraint, not dated, revealed employees would be required to wear hair restraints, as required by the 2009 Federal Food Code; (A) food employees shall wear hair restraints such as hats, hair coverings that are designed and worn to effectively keep their hair from contacting exposed food. Continued review of the facility's policy revealed employees that have hair that extrudes out of the cap will be required to have hair wrapped into a bun style or tucked under the hat.  Review of the facility's policy titled Sequence of Meals/Tray, not dated, revealed the facility had one (1) serving tray line for the building which served both the Assisted Living (AL) Dining room and the Health Care Center Dining Room.	F 371	F 371 continued 3. Dietary staff were inserviced on 3-8-13 by ED and DFS related to storage, preparation and service of food under sanitary conditions. Emphasis was placed on dating of opened food and handwashing requirements. Dietary staff return demonstrated proper handwashing, use of hair restraints and dating of food when opened. Competencies were signed off on by DFS and ADFS, Uniform requirements will also be posted in the department. 4. Handwashing and hair restraint competency audits will be completed once a month times six months and will be maintained and reviewed in monthly QA meeting. DFS and ADFS will check for foods being dated as part of daily rounding in kitchen. These items will also be reviewed in monthly QA as well as during visits by Dietary Support and Dietician.	



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F 371	<p>Continued From page 3</p> <p>Review of the facility's policy, release date 10/2004, titled Guidelines for Handwashing, revealed health care workers shall wash hands before/after preparing/serving meals or drinks. No policy regarding volunteers serving drinks was provided.</p> <p>Observation, on 02/13/13 at 8:50 AM, with the Dietary Director during the initial tour of the kitchen's walk in refrigerator, revealed the following items opened and undated: one (1) container of cottage cheese; one container of dairy fresh sour cream; and a glass crate covered in clear plastic with a hole in it and labeled honey nectar thick chocolate milk. Continued observation of the kitchen's reach-in refrigerator revealed two (2) open containers of Thick and Easy tea and two (2) containers of honey thick cranberry juice.</p> <p>Interview with the Dietary Director, on 02/13/13 at 9:10 AM, revealed kitchen staff who used the food items were responsible to date and label that food item. He further stated the evening staff are to monitor that items are labeled and dated. He continued to state he was ultimately responsible to ensure food items were labeled, dated and sealed properly to ensure the safety of the food.</p> <p>Interview with the Assistant Living Server/Dietary Aide #1, on 02/13/13 at 9:15 AM, revealed she was responsible to ensure all items in the walk-in refrigerator were labeled and dated. She stated that sometimes items may not get dated due to being in a hurry. She further stated there was no way to ensure the integrity of the food quality without proper labeling and an open date.</p>	F 371			



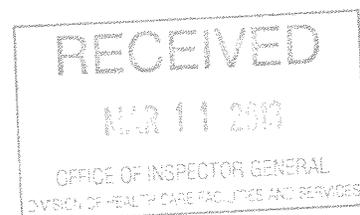
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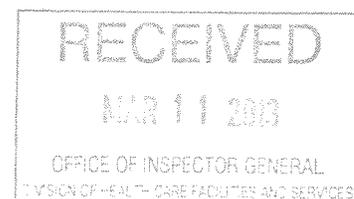
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F 371	<p>Continued From page 4</p> <p>Observation during the trayline service, on 02/14/13 at 11:15 AM, revealed the Assistant Living Server/Dietary Aide #1 entered from the Assisted Living area and proceeded to the trayline, applied gloves and obtained a resident's meal. Further observation revealed no hand washing or hygiene was preformed. Continued observation of the Assistant Living Server/Dietary Aide revealed hair bangs and each side of the hair was dangling from under the hair restraint (net) as she was obtaining food from the trayline.</p> <p>Interview with the Assistant Living Server/ Dietary Aide #1, on 02/15/13 at 2:30 PM, revealed her job was to prepare and serve the assistant living resident's meal from the trayline. She further stated she was trained on proper hair restraints; however, she was unaware of her hair and bangs dangling from under the hair net. She continued to state the importance of proper hair restraints was to prevent the spread of germs.</p> <p>Observation of the kitchen, on 02/14/13 at 11:20 AM, revealed an assistant living volunteer with a beard enter from the assistant living entrance into the kitchen, obtain a drink from the soda fountain, without a hair/beard covering and without washing their hands.</p> <p>Interview with the Assisted Living Volunteer, on 02/14/13 at 11:22 AM, revealed he obtained beverages from the fountain daily, during meals service, without wearing a hair/beard restraint or washing his hands.</p> <p>Interview with the Dietary Director, on 02/15/13 at 2:40 AM, revealed all kitchen and dietary staff are trained in handwashing, hair restraints and</p>	F 371		



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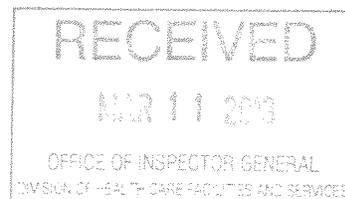
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F 371	Continued From page 5 trayline service. He further stated he monitored the sanitation of the food prep area and held staff to be accountable to each other. He continued to state volunteers were not to be in the kitchen area because they are not a part of Trilogy.	F 371		
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  <b>(a) Infection Control Program</b> The facility must establish an Infection Control Program under which it - <b>(1)</b> Investigates, controls, and prevents infections in the facility; <b>(2)</b> Decides what procedures, such as isolation, should be applied to an individual resident; and <b>(3)</b> Maintains a record of incidents and corrective actions related to infections.  <b>(b) Preventing Spread of Infection</b> <b>(1)</b> When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. <b>(2)</b> The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. <b>(3)</b> The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	<b>1.</b> Resident # 5 suffered no ill effects from nurse not completing handwashing between glove changes. Wound was assessed on 2-14-13 by Shaunte Johnson, DHS and no signs of infection observed. Resident has been discharged. <b>2.</b> Residents with dressing changes were observed by DHS and ADHS during treatment changes to insure nurses are following Infection Control policies related to handwashing. Ice chests were cleaned and sanitized on 2-15-13 by Cathy Ferguson, CNA and family and visitors were notified that staff will obtain ice from ice chest for them. <b>3.</b> Nursing staff will be educated on 03-15-13 by DHS/ADHS related to infection Control with emphasis on handwashing and gloving during treatments. Handwashing competency will be a part of annual training and staff will be required to return demonstrate practice. ED will inform families/visitors and residents that facility staff will obtain ice from ice chests. <b>4.</b> All employees are trained on Infection Control upon hire and annually. DHS and ADHS will randomly audit 5 treatments weekly times 3 months and then quarterly times 6 months to insure nurses are properly gloving and washing hands. Results of audits will be reported by DHS and ADHS to monthly QA meeting where compliance will be monitored and action plans required for non-compliance. ED/DHS will monitor visitors attempting to get ice from ice chest during daily rounds. They will be reminded as necessary.	3-28-13



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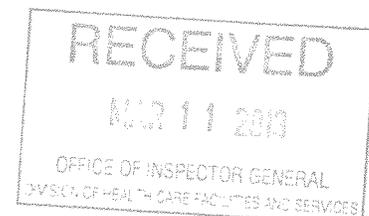
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F 441	<p>Continued From page 6</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure the staff followed their policy and practiced appropriate hand hygiene after removal of gloves for one (1) of seventeen (17) Sampled Residents and four (4) Unsampled Residents. The staff failed to complete handwashing between glove change for Resident #5. In addition, staff allowed one (1) of four (4) Unsampled Residents and seventeen (17) Sampled Residents to obtain ice from the one hundred (100) hallway ice chest. (Unsampled Resident B).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Guidelines for Hand Washing, release date 10/2004, did not address residents' obtaining their own ice.</p> <p>Review of the facility's policy regarding Guidelines for Hand Washing, release date 10/2004, stated health care workers shall wash hands upon removal of gloves, worn per standard precautions for direct contact with excretions or secretions.</p> <p>Review of the facility's policy regarding Handwashing/Hand Hygiene, revised 08/2009, revealed the purpose of this procedure was to</p>	F 441		



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F 441	<p>Continued From page 7</p> <p>provide guidelines for effective hand washing and hygiene techniques that would aid in the prevention of the transmission of infections. An appropriate ten (10) to fifteen (15) second handwashing with antimicrobial or non-antimicrobial soap and water must be performed after contact with blood, body fluids, secretions, mucous membranes or non-intact skin and after removing gloves. An alcohol-based hand rub may be used before handling clean or soiled dressings, after handling used dressings or contaminated equipment and after removal of gloves. The use of gloves did not replace handwashing/hand hygiene.</p> <p>Review of the facility's policy regarding Guidelines to Standard Precautions, updated 01/2010, revealed the purpose was to prevent the transmission of infectious organisms. The staff was to wash hands after removal of gloves and wash hands often and well, per the handwashing guidelines. It directed the staff to wash their hands before applying gloves and after the removal of gloves.</p> <p>Observation of a skin assessment and a sacral dressing change on Resident #5, on 02/14/13 at 1:05 PM through 1:37 PM, with Registered (RN) #1, revealed hand hygiene was not practiced after removal of gloves and prior to the next glove use. RN #1 removed her gloves twice during the upper and lower body skin assessment without hand hygiene completed prior to reapplying gloves. A soiled adult brief was changed by the RN, again gloves were changed without hand hygiene. Gloves were donned and she proceeded with a sacral dressing change. Again, gloves were applied, removed and reapplied without hand</p>	F 441			



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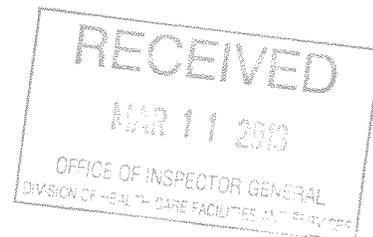
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F 441	<p>Continued From page 8 hygiene completed.</p> <p>Interview, with RN #1, on 02/14/13 at 1:37 PM, reported it was not required to wash hands between glove change on the same resident. She stated it was acceptable to do hand sanitizer or handwashing after every third glove change.</p> <p>Interview, with the Director of Nurses, on 02/15/13 at 3:45 PM, reported the staff were to wash their hands after each glove change. She stated the facility policy on Handwashing/Hand Hygiene did state the staff were to wash hands before and after the use of gloves. She reported gloves are not a substitute for handwashing.</p> <p>Observation of the 100 hallway, on 02/15/13 at 8:55 AM, revealed a License Practical Nurse (LPN) # 6 and the Human Resource/ Payroll Manager (HR) standing in front of the nurse's desk. Further observation revealed Unsampled Resident B opened the ice chest, handled the ice scoop and reached into the ice chest to obtain ice.</p> <p>Interview with Unsample Resident B, on 02/15/13 at 10:35 AM, revealed the facility was treating him/her with IV antibiotics. He/she further stated the facility had allowed him/her to obtain ice whenever he/she desired.</p> <p>Review of the History and Physical for Unsample Resident B revealed the facility admitted the</p>	F 441	
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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	
F 441	Continued From page 9 resident on 01/29/13 with diagnoses of Strep, Pneumonia, Bacteremia and a low grade fever. Continued review of the resident's Acute Visit, dated 02/12/13, revealed the neurological status was grossly intact.  Interview with LPN #6, on 02/15/13 at 9:05 AM, revealed only staff should obtain ice for residents. She further stated the purpose was to prevent cross contamination.	F 441			



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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, 1975, 2001</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: one (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was initiated on 02/14/13 and concluded on 02/15/13. Franciscan Health Care Center was found to be not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for eighty five (85) beds with a census of eighty four (84) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Nancy Adkins RWED*

TITLE

*Exec. Dir.*

(X6) DATE

*3-20-13*

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.

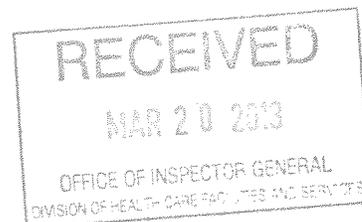
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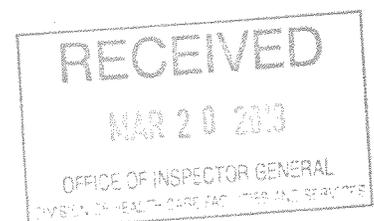
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000	Residents in these areas were assessed and displayed no symptoms of exposure to hazards.	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the</p>	K 018	<p>Corridor doors to Rooms 3-29-13, 118, 301, 305, 314, 315, 316, 322, 410, and 418 will be raised up and realigned to close so there is no gap at the top of the door that would allow the passage of smoke. The Director of Plant Operations (DPO) or DPO assistant will complete this. DPO or DPO assistant will check all the doors in the campus to ensure that there are no gaps at the tops of the doors each month to ensure that this deficient practice does not recur. These findings will be reported by the DPO monthly in QAA and safety meetings to ensure that our solutions are sustained.</p>	3-29-13



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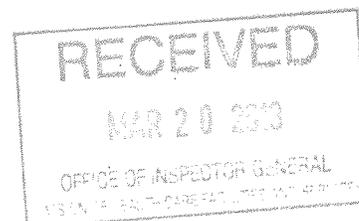
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K 018	<p>Continued From page 2</p> <p>potential to affect three (3) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for eighty five (85) beds with a census of eighty four (84) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/15/13 between 9:00 AM and 3:00 PM, with the Maintenance Director revealed the corridor doors to rooms 118, 301, 305, 314, 315, 316, 322, 410, and 418 had a gap at the top of the door that would not resist the passage of smoke.</p> <p>Interview, on 02/15/13 between 9:00 AM and 3:00 PM, with the Maintenance Director revealed he was not aware the doors had a gap too large.</p> <p>Interview, on 02/15/13 at 3:43 PM, with the Administrator revealed she was aware of the requirement for corridor doors; however, she was not aware of the doors that had too large of a gap at the top and would not resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than</p>	K 018		



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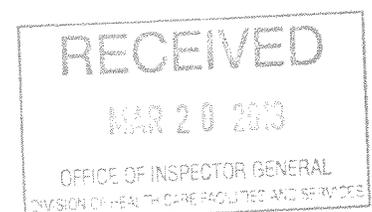
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K 018	Continued From page 3 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018			
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 025			



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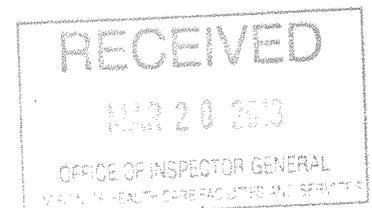
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K 025	<p>Continued From page 4</p> <p>separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 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 two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for eighty five (85) beds, with a census of eighty four (84) on the day of the survey. The facility failed to ensure smoke partitions were accessible.</p> <p>The findings include:</p> <p>Observation, on 02/15/13 at 9:33 AM, with the Maintenance Director revealed the smoke partition, extending above the ceiling located next to room #310, was not accessible at the time of the survey.</p> <p>Interview, on 02/15/13 at 9:33 AM, with the Maintenance Director revealed he was not aware the smoke partition had to be accessible.</p> <p>Interview, on 02/15/13 at 3:43 PM, with the Administrator revealed she was not aware the smoke partition had to be accessible.</p>	K 025	<p>No residents were affected related to smoke partitions not being accessible. No adverse symptoms displayed by residents that were assessed. 3-29-13</p> <p>The smoke partition cited will be made accessible by the DPO by 3/29/13.</p> <p>The DPO will put a hatch in the ceiling by 3/29/13 to have access to smoke wall. The DPO will check monthly that all smoke partitions are accessible and to ensure that this deficient practice does not happen again.</p> <p>This information will be reported by the DPO in QAA and Safety meeting monthly to ensure that our solutions are sustained .</p>	3-29-13	



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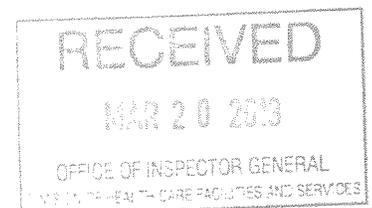
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K 025	Continued From page 5  Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier. Reference: NFPA 101 (2000 Edition).  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: (a) The space between the penetrating item and the smoke barrier 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. (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	K 025			



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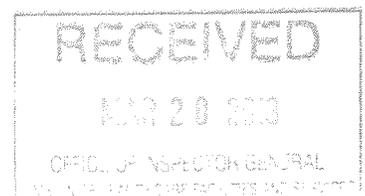
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K 025	Continued From page 6 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration 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.  19.3.7.4 Not less than 30 net ft <sup>2</sup> (2.8 net m <sup>2</sup> ) per patient in a hospital or nursing home, or not less than 15 net ft <sup>2</sup> (1.4 net m <sup>2</sup> ) per resident in a limited care facility, shall be provided within the aggregate area of corridors, patient rooms, treatment rooms, lounge or dining areas, and other low hazard areas on each side of the smoke barrier. On stories not housing bed or litterborne patients, not less than 6 net ft <sup>2</sup> (0.56 net m <sup>2</sup> ) per occupant shall be provided on each side of the smoke barrier for the total number of occupants in adjoining compartments. 19.3.7.5 Openings in smoke barriers shall be protected by fire-rated glazing; by wired glass panels and steel frames; by substantial doors, such as 13/4-in. (4.4-cm) thick, solid-bonded wood core doors; or by construction that resists fire for not less than 20 minutes. Nonrated factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door shall be permitted. Exception: Doors shall be permitted to have fixed fire window assemblies in accordance with 8.2.3.2.2.	K 025			
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 027			



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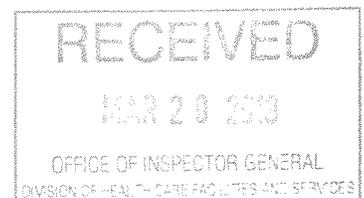
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K 027	<p>Continued From page 7</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure access doors located in smoke barriers were installed in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is certified for eighty five (85) beds with a census of eighty four (84) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/15/13 at 10:00 AM, with the Maintenance Director revealed one (1) unrated door located in the smoke partition above the ceiling in the attic next to room #211.</p> <p>Interview, on 02/15/13 at 10:00 AM, with the Maintenance Director revealed he was not aware the door was located in the attic of the smoke</p>	K 027	<p>Residents in Room 211 were not affected related to no opportunity for exposure to smoke. Other residents potentially affected were assessed with no symptoms of exposure to smoke or other hazards.</p> <p>This un-rated door that was cited will be replaced by the DPO or the DPO assistant with a new fire door by 3/29/13. The DPO will replace the wood door with a new fire rated door by 3/29/13. Monthly, The DPO or DPO assistant will check all doors ocated in the smoke barriers monthly to ensure they are all fire rated and to ensure that this deficient practice does not recur. These results will be reported by the DPO in QAA and Safety meetings monthly to ensure that our solutions are sustained.</p>	3-29-13



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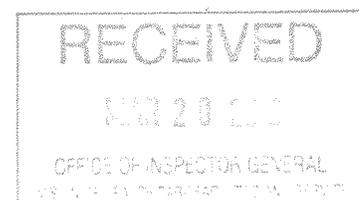
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K 027	<p>Continued From page 8 barrier, and must be rated for use.</p> <p>Interview, on 02/15/13 at 3:43 PM, with the Administrator revealed she was not aware the door was located in the attic of the smoke barrier, and must be rated for use.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>18.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.</p> <p>8.3.4 Doors. 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. 8.3.4.2* Where a fire resistance rating for smoke barriers is specified elsewhere in the Code, openings shall be protected as follows: (1) Door opening protectives shall have a fire protection rating of not less than 20 minutes where tested in accordance with NFPA 252, Standard Methods of Fire Tests of Door</p>	K 027			



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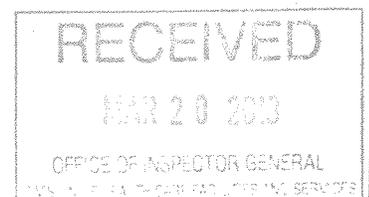
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 027	Continued From page 9 Assemblies, without the hose stream test, unless otherwise specified by Chapters 12 through 42. (2) Fire windows shall comply with 8.2.3.2.2. Exception: Latching hardware shall not be required on doors in smoke barriers where so indicated by Chapters 12 through 42. 8.3.4.3* Doors in smoke barriers shall be self-closing or automatic-closing in accordance with 7.2.1.8 and shall comply with the provisions of 7.2.1.  Reference: NFPA 101 (2000 Edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.  Reference: NFPA 101 (2000 Edition) Continuity 8.3.2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces.  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.	K 027			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour	K 029			



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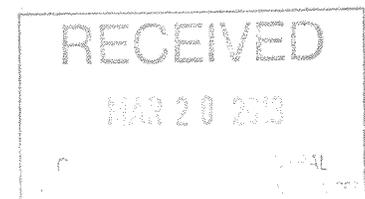
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K 029	Continued From page 10 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are 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 three (3) of seven (7) smoke compartments, residents, staff and visitors. The facility has eighty five (85) certified beds with a census of eighty four (84) on the day of the survey.  The findings include:  Observation, on 02/15/13 between 9:00 AM and 3:00 PM, with the Maintenance Director revealed doors to hazardous areas did not have a self-closing device. The rooms were identified as the Janitors Closet across from room #420, Soiled Utility Room across from room #117, Clean Linen across from room #117, and Soiled Utility across from room #307.  Interview, on 02/15/13 between 9:00 AM and 3:00	K 029	Residents in affected areas assessed and revealed no symptoms of exposure to hazardous chemicals. All doors to hazardous areas were checked by DPO on day of survey, no others affected. Self-closing devices were put on doors to Janitors closet across from Room 420, Soiled Utility Room across from Room 117 and Soiled Utility across from Room 307 on 3/7/13. The DPO or DPO assistant will check all the doors to the hazardous areas each month to ensure that the doors continue to have self-closing devices in place on the doors and to ensure that this deficient practice does not occur again. This information will be reported in the QAA and safety meeting monthly by the DPO to ensure that our solutions are sustained.	3-29-13	



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K 029	Continued From page 11 PM, with the Maintenance Director revealed he was not aware the doors identified were required to be self-closing.  Interview, on 02/15/13 at 3:43 PM, with the Administrator revealed she was aware of the requirement but not aware the doors identified were required to be self-closing.  Reference: NFPA 101 (2000 Edition).  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: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous	K 029		



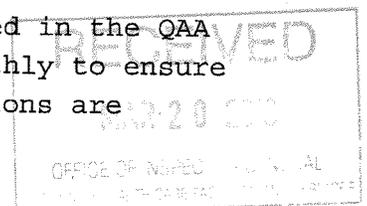
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K 029	Continued From page 12 by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 045 SS=D	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 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 lighting in accordance with NFPA standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for eighty five (85) beds with a census of eighty four (84) on the day of the survey.  The findings include:  Observation, on 02/15/13 at 1:05 PM, with the Maintenance Director revealed an exterior exit path with only one light bulb outside to light the egress path. The exit with only one light was located at the back employee exit.	K 045	No residents were affected by this cited deficiency. Residents and staff using exit were asked about the lighting and effect, no complaints voiced. The cited exit now has two lights at the exit. The DPO corrected the fixture and put two lights up on 3/8/13. DPO checked lighting at all exits on 3/8/13. No other exit lighting out of compliance. The DPO or DPO assistant will check monthly that all exits are equipped with lighting in accordance with NFPA standards to ensure that this deficient practice does not happen again.	3-29-13

This information  
(his findings)

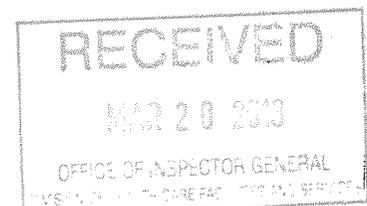
will be reported in the QAA  
and safety monthly to ensure  
that our solutions are  
sustained.



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K 045	<p>Continued From page 13</p> <p>Interview, on 02/15/13 at 1:05 PM, with the Maintenance Director revealed he was not aware the exit did not have the required illumination for egress lighting.</p> <p>Interview, on 02/15/13 at 3:43 PM, with the Administrator revealed she was not aware the exit did not have the required illumination for egress lighting.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>19.2.8 Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* 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 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</p>	K 045		



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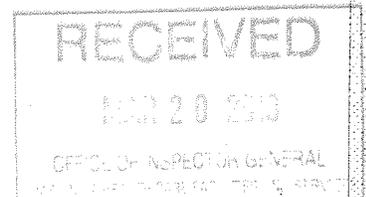
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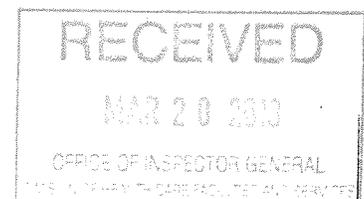
K 045	Continued From page 14 the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 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 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	K 050	No residents were affected by the cited deficiency. DPO or assistant will now randomly conduct fire drills on all shifts. See attached new schedule for fire drills for all	3-29-13



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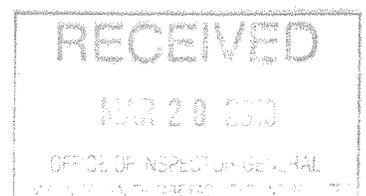
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K 050	Continued From page 15 announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on interview and fire drill record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at unexpected times, in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for eighty five (85) beds with a census of eighty four (84) on the day of the survey. The facility failed to ensure the fire drills were conducted at unexpected times on all shifts.  The findings include:  Fire Drill review, on 02/15/13 at 11:12 AM, with the Maintenance Director revealed the facility failed to conduct fire drills at unexpected times on all shifts.  Interview, on 02/15/13 at 11:12 AM, with the Maintenance Director revealed he was not aware the fire drills were not being conducted as required.  Interview, on 02/15/13 at 3:43 PM, with the Administrator revealed she was aware of the requirement but not aware the fire drills were not being conducted as required.  Reference: NFPA Standard NFPA 101 19.7.1.2.	K 050	three shifts. The schedule will be only seen by the DPO and Executive Director (ED), To ensure that the drills are random and that the deficient practice will not recur again. The DPO will report on fire drills each month in the QAA and safety meeting each month to ensure that our solutions are sustained.	



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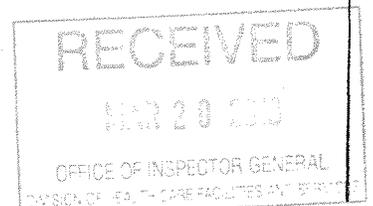
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K 050	<p>Continued From page 16</p> <p>Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.</p> <p>Reference: NFPA 101 Life Safety Code (2000 Edition).</p> <p><b>19.7* OPERATING FEATURES</b></p> <p><b>19.7.1 Evacuation and Relocation Plan and Fire Drills.</b></p> <p><b>19.7.1.1</b></p> <p>The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan 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.</p> <p><b>19.7.1.2*</b></p> <p>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.</p> <p>Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe</p>	K 050		



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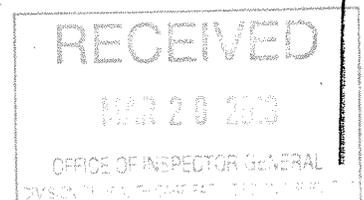
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K 050	Continued From page 17	K 050		
K 056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete 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 and interview it was determined the facility failed to ensure the building had a complete sprinkler system, installed in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for eighty five (85) beds with a census of eighty four (84) on the day of the survey. The facility failed to ensure sprinkler heads installed in a compartment were of the same temperature response type.</p> <p>The findings include:</p> <p>Observations, on 02/15/13 at 10:15 AM, with the Maintenance Director revealed mixed response sprinkler heads located next to the 300 Hall</p>	K 056	<p>3-29-13</p> <p>No residents were affected by this cited deficiency. The Nurses Station, Activity Room, Rooms 304 and 308 were checked and no damage from mixed response sprinkler heads. All sprinkler heads checked by DPO on 3/1/13 and no others out of compliance. All the sprinkler heads in the cited compartments will be changed by the RC Fire Protection company on 3/1/13. They will all match to have the same response rating. The DPO or DPO assistant will check all sprinklers each month to ensure that all the sprinklers are installed in a compartment of the same temperature response type. The DPO will report these findings in QAA and safety monthly to ensure that are solutions are sustained.</p>	



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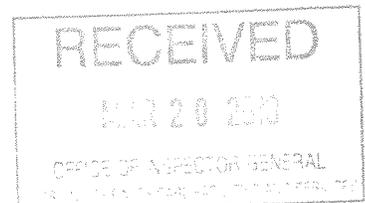
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K 056	Continued From page 18 Nurses Station, room #304, 308, and the Activities Room.  Interview, on 02/15/13 at 10:15 AM, with the Maintenance Director revealed he was not aware of the requirement for sprinkler heads being of the same response rating.  Interview, on 02/15/13 at 3:43 PM, with the Administrator revealed she was not aware of the installation requirements for sprinklers.  Reference: NFPA 13 (1999 Edition)  7-2.3.2.4 Where listed quick-response sprinklers are used throughout a system or portion of a system having the same hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all	K 056		



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K 056	<p>Continued From page 19</p> <p>sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <ol style="list-style-type: none"> <li>(1) Sprinklers installed throughout the premises</li> <li>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler</li> <li>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</li> </ol> <p>Reference: NFPA 13 (1999 edition)</p>	K 056		



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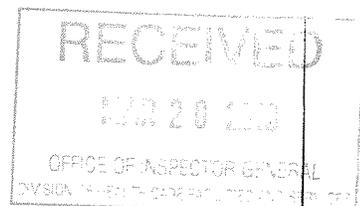
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185132	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  02/15/2013
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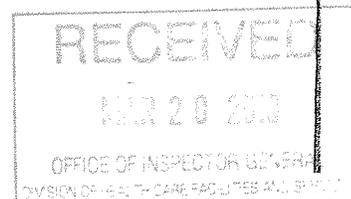
K 056	Continued From page 20 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.  Reference: NFPA 13 (1999 ed.) 5-5.5.2.2 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP)	K 056																																
	<table border="0"> <tr> <td colspan="2" style="text-align: center;">Maximum Allowable Distance</td> </tr> <tr> <td>Distance from Sprinklers to</td> <td>of Deflector</td> </tr> <tr> <td>above Bottom of</td> <td></td> </tr> <tr> <td>Side of Obstruction (A)</td> <td>Obstruction (in.)</td> </tr> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>2 1/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>3 1/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>5 1/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>7 1/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>9 1/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>16 1/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </table>	Maximum Allowable Distance		Distance from Sprinklers to	of Deflector	above Bottom of		Side of Obstruction (A)	Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	2 1/2	1 ft 6 in. to less than 2 ft	3 1/2	2 ft to less than 2 ft 6 in.	5 1/2	2 ft 6 in. to less than 3 ft	7 1/2	3 ft to less than 3 ft 6 in.	9 1/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	16 1/2	5 ft and greater	18			
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4 ft 6 in. to less than 5 ft	16 1/2																																	
5 ft and greater	18																																	
K 062 SS=F	For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). NFPA 101 LIFE SAFETY CODE STANDARD	K 062																																



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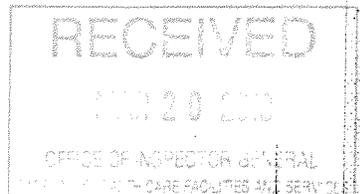
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K 062	Continued From page 21 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on sprinkler testing record review, and interview, it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for eighty five (85) beds with a census of eighty four (84) on the day of the survey. The facility failed to complete the required testing for the sprinkler system.  The findings Include:  Sprinkler Testing Record Review, on 02/15/13 at 11:20 AM, with the Maintenance Director revealed the facility did not have documentation that the gauges on the sprinkler riser had not been calibrated or replaced within the last five years.  Interview, on 02/15/13 at 11:20 AM, with the Maintenance Director revealed he was not aware of the requirement.  Interview, on 02/15/13 at 3:43 PM, with the Administrator revealed she was not aware of the requirement.	K 062	No residents were affected . DPO checked all guages on sprinkler risers on 2/15/13. The gauges on the sprinkler riser have now been calibrated, and 4 were replaced on 3/1/13. The DPO or DPO assistant will schedule this to be completed every 5 years to ensure that the deficient practice will not occur again. The DPO will review the Schedule for this testing each month in QAA and safety to ensure that our solution is sustained.	3-29-13



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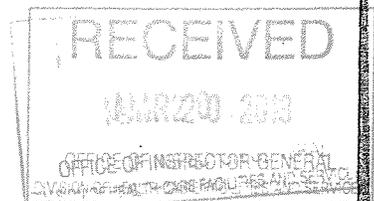
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K 062	Continued From page 22  Reference: NFPA 13 (1999 Edition)  2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type. Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.	K 062			



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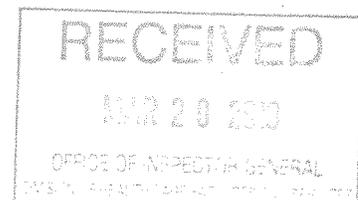
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K 062	Continued From page 23  Reference: NFPA 25 (1998 Edition).  10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.  10-2.3* Flushing Procedure. If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.  Reference: NFPA 25 (1998 Edition).  2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected,	K 062			



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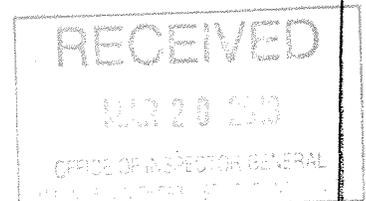
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K 062	Continued From page 24 tested, and maintained in accordance with Chapter 9.  Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance Item Activity Frequency Reference Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2 Control valves Inspection Weekly/monthly Table 9-1 Alarm devices Inspection Quarterly 2-2.6 Gauges (wet pipe systems) Inspection Monthly 2-2.4.1 Hydraulic nameplate Inspection Quarterly 2-2.7 Buildings Inspection Annually (prior to freezing weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1	K 062			



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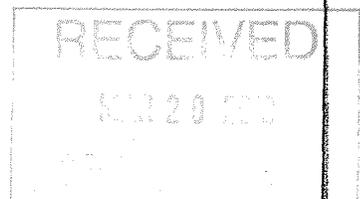
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K 062	Continued From page 25 Obstruction investigation Maintenance 5 years or as needed Chapter 10	K 062		3-29-13
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.  This STANDARD is not met as evidenced by: Based on fire damper testing record review, and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, residents, staff and visitors. The facility is certified for eighty five (85) beds with a census of eighty four (84) on the day of the survey. The facility failed to provide documentation that the smoke/fire dampers were tested within the last four (4) years.  The findings include:  Fire damper testing record review, on 02/15/13 at 11:28 AM, with the Maintenance Director revealed the facility did not have documentation that fire/smoke dampers had been tested within the last four (4) years.  Interview, on 02/15/13 at 11:28 AM, with the Maintenance Director revealed he was not aware of the requirements for fire/smoke damper testing.  Interview, on 02/15/13 at 3:43 PM, with the	K 104	No residents were affected by this cited deficiency. The fire/smoke dampers had been tested on May 11th, 2012. Please see attached documentation. We will also have them tested again this month, March 2013. The DPO or DPO assistant will have the dampers on a schedule and tested every 4 years to ensure that this deficient practice does not occur again. The DPO will bring this schedule to QAA and safety meeting Monthly to report on to ensure that our solutions are sustained.	



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K 104	Continued From page 26 Administrator revealed she was not aware of the requirements for fire/smoke damper testing.  Reference: NFPA 101 (2000 Edition)  8.3.6 Penetrations and Miscellaneous Openings in Floors and Smoke Barriers. 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: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) 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 meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that	K 104			



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K 104	Continued From page 27 is designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.  Reference: NFPA 90A (1999 edition)  3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 104			

