

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

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FORM APPROVED
OMB NO. 0938-0391

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/06/2015
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 50 ADAMS STREET NEW CASTLE, KY 40050
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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 000	INITIAL COMMENTS A Recertification Survey was initiated on 08/04/15 and concluded on 08/06/15. The facility was found not meeting the minimum requirements for recertification and deficiencies were cited at the highest scope and severity of a "F".	F 000	Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
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 observations, interviews, and review of the facility's policy, it was determined the facility failed to store, prepare, and distribute and serve food under sanitary conditions. Observation of the facility's kitchen during tour revealed three (3) glasses filled with fluid were stored in the refrigerator uncovered, undated, and unlabeled. Continued observation revealed dishes, with food particles on them, were stored with other clean dishes. Further observation revealed cartons of thickened liquids were stored in the refrigerator past their recommended open date, "magic cups" stored in the freezer, undated, and one dented can was stored in the dry storage area with other	F 371	F 371 F <i>Residents Affected</i> Upon observation, it was revealed that a kitchen pan and lid with dried food substances on them, which were immediately cleaned, were stored away as clean. After continuous observation, it was revealed that several "magic cups" were stored in the freezer undated, which were thrown away. Additionally, two cartons of thickened orange juice dated 6/11/15 and 6/25/15, two boxed containers of Apple Juices dated 7/16/15, and one boxed container of Prune Juice dated 7/2/15 were also stored in the freezer, which were also was immediately discarded. Three glasses of a liquid substance were stored in the refrigerator uncovered, undated, and not labeled, which were	

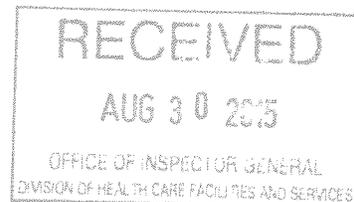
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jenna Davis</i>	TITLE X Administrator	(X6) DATE X 8-28-15
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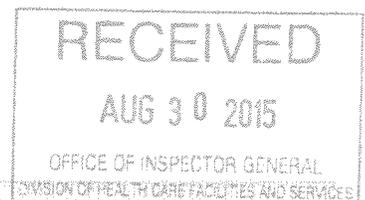
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F 371	Continued From page 1 usable cans. The findings include: Review of the facility's policy, titled "Refrigerated Storage", undated, revealed it was the policy for the facility to store, prepare, and serve foods in accordance with federal, state, and local sanitary codes. Continued review of the policy revealed that all foods would be properly wrapped and/or stored in sealed containers and dated, tabled and monitored so they were used by the specified "use-by date". Further review of the policy revealed the food would be discarded within appropriate shelf life. Review of the facility's policy titled "Purchasing/Receiving/Storage", undated, revealed damaged canned food containers would be stored together in the store room in a separate and distinct area away from other food items. Continued review of the policy revealed damaged containers were defined as all dented containers. Review of the facility's policy titled, "Leftover Foods", undated, revealed it was the policy of the facility to store leftovers in a safe and sanitary manner in compliance with federal, state, and local sanitation codes. Continued review of the policy revealed all refrigerated leftover foods were to be used within seventy-two (72) hours or discarded. Review of the facility's guidelines for "Thick and Easy", dated 08/05/15, revealed Thickened Orange Juice shelf life after opening would be up to ten (10) days at thirty-four (34) degrees to forty (40) degrees. Continued review of the guidelines revealed the Thickened Dairy Nectar had a shelf	F 371	thrown away. One dented can of Cheddar Cheese, which was thrown away, was stored with other cans for resident use. <i>Identification of Other Residents</i> The deficiency had the potential to affect residents with P.O. diets. The inappropriately stored items identified were immediately thrown away and pans washed. <i>Systemic Changes</i> All dietary staff has been re-trained on storing, preparing, and serving foods and kitchenware in accordance with federal, state, and local sanitary codes on 8-6-15 by the Dietary Manager. A new Food Storage Policy addressing proper labeling and dating food and drink; storing pots, pans and other kitchenware; and proper storage of food and drink compliant with federal, state, and local sanitary codes was created on 8-25-15 by the Dietary Manager. All dietary staff will be in-serviced by the Dietary Manager on the new Food Storage Policy by 9-10-15. A new daily QA audit was developed by the Dietary Manager and consultant Registered Dietician on 8-25-15. The audit requires the Dietary Manager or designee to audit stored food and drink items to ensure they are stored, labeled, and dated in compliance with federal, state, and local sanitary codes. The audit also requires the Dietary Manager or designee to audit stored kitchenware to ensure it is stored in		



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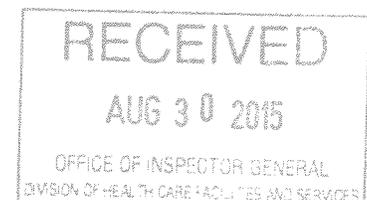
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F 371	<p>Continued From page 2</p> <p>life after opening up to four (4) days at thirty-four (34) degrees to forty (40) degrees.</p> <p>Observation of the Kitchen during tour, on 08/04/15 at 9:05 AM, revealed a kitchen pan, stored with other cleaned dishes, was observed to have dried red substance on the bottom of the pan. Continued review of the cleaned kitchen pans revealed a lid, stored away as clean, was observed to have dried white substance on the lid. Observation of the freezer revealed there were several "magic cups" that was stored in the freezer, undated. Additionally, two (2) cartons of thickened orange juice dated 06/11/15 and 06/25/15. There were two (2) boxed containers of Apple Juices dated 07/16/15 and one (1) boxed container of Prune Juice dated 07/02/15.</p> <p>Continued tour of the kitchen revealed one (1) dented can of Cheddar Cheese was stored with the other cans for residents use and three (3) glasses of a liquid substance was stored in the refrigerator that was uncovered, undated, and was not tabled.</p> <p>Interview with Dietary Aide #5, on 08/06/15 at 10:30 AM, revealed the dishes should not have been stored with food particles left on them. She stated that if they found food particles left on the dishes, then the dishes would have to be re-washed. She reported it was important to re-wash the dishes due to contamination and bacteria would build up on the food that was left on the dishes. Continued interview with Dietary Aide #5 revealed that the juices should have been covered, tabled, and dated. Additionally, she reported this was to prevent cross contamination with juice or milk. She reported you would want to make sure no bacteria got in them. Continued interview with Dietary Aide #5 revealed everything</p>	F 371	<p>compliance with federal, state, and local sanitary codes. These daily QA audits are turned into the Administrator daily for review and compliance.</p> <p>Monitoring The Administrator will submit the results of the QA audits completed to the monthly Quality Assurance and Safety Committee meeting for review and recommendations.</p> <p>Date of Correction 9-11-15</p>		



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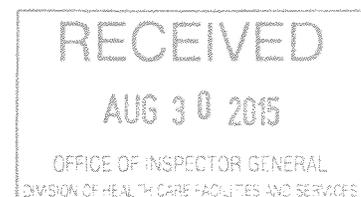
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F 371	<p>Continued From page 3</p> <p>in the refrigerator should be labeled to let staff know what the product was and items should be dated to make staff aware of what items should be tossed. Dietary Aide #5 reported all items should be thrown away after three (3) days, so that bacteria does not set up in the items. Further interview with Dietary Aide #5 revealed the kitchen staff should not use "dented" cans. She reported it was important to get rid of those cans because bacteria can set up in the cans and contaminate the food.</p> <p>Interview with the Food Service Assistant Manager, on 08/06/15 at 11:00 AM, revealed the dishes should not have been stored with food particles on them. She reported she was sure this might have occurred before, but reported it should not be done for cross contamination. She further revealed the dishes should not have been put away with the clean dishes if it was still dirty. Continued interview with the Food Service Assistant Manager revealed it was her job to label and date everything. The Food Service Assistant Manager reported the three (3) glasses in the refrigerator should have been covered, tabled, and dated. She reported this was an oversight by her and she would continue to educate the staff. Additionally, she revealed it was her job to pull dented cans as they come into the facility's kitchen. She stated the dented cans could carry food borne illnesses, adding, "something could come off the can." Further interview with the Food Service Assistant Manager revealed it was the policy that after opening a product, it should be used within three (3) days and the carton of juices/dairy thickened product should be used within the recommended guidelines. The Food Service Assistant Manager reported it was an oversight on her part and added the cartons</p>	F 371			



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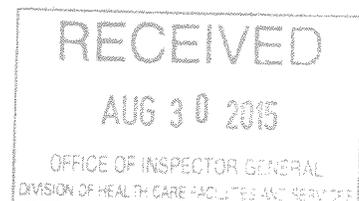
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F 371	Continued From page 4 should have been removed from the refrigerator. Interview with the Food Service Director, on 08/04/15 at approximately 9:06 AM and 08/05/15 at approximately 4:00 PM, revealed the pan used to cook food in should not have had food substance on it. She reported she believed the substance to be spaghetti sauce. Continued interview revealed the lid to the pan had dried water and some food particles, but was not certain of what the food particle might have been. She reported the pan and the lid was not washed properly and needed to be re-washed. Further interview with the Food Service Director revealed she believed that there were over seventy-five (75) magic cups (nutrition shakes) in the freezer that should have been dated. The Food Service Director revealed she was not certain of the expiration date of the juices and the dairy product, but added she thought it was okay because of the expiration date on the carton, not the date that the carton was opened. Additionally, the Food Service Director reported the dented can should not have been stored with the regular cans for distribution because the dented can could carry food bourne illness and if severe enough, it could cause an outbreak. Continued interview with the Food Service Director revealed the three (3) glasses with liquid in them was poured for the day. It contained a red substance, light brown substance, and bright yellow substance. The Food Service Director reported the glasses should have been covered and reported she just placed the juices in the refrigerator as this surveyor should "take her word for it". An additional interview with the Food Service Director revealed she thought the time a product could rest in the refrigerator after opening was seventy-two (72) hours.	F 371			



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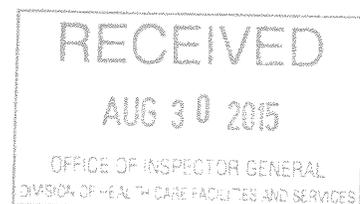
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F 371	Continued From page 5 Interview with the Dietitian Consultant, on 08/05/15 at approximately 3:30 PM, revealed it would be her expectation that the juice in the cartons in the refrigerator would be kept no longer than six (6) days after opening. She reported she was not sure how long the milk could sit in the refrigerator after opening, but thought it was a shorter period. The Dietitian Consultant reported that while she was not sure of the exact expiration date of the items after opening them, she would rely on the policy and the recommendation for holding the juice/dairy products after opening. Further interview with the Dietitian Consultant revealed, it would have been her expectation that the items in the refrigerator would have been covered, dated, and labeled. She reported it was the facility's policy, as well as, within the regulations.	F 371			
F 455 SS=F	483.70(b) EMERGENCY ELECTRICAL POWER SYSTEM An emergency electrical power system must supply power adequate at least for lighting all entrances and exits; equipment to maintain the fire detection, alarm, and extinguishing systems; and life support systems in the event the normal electrical supply is interrupted. When life support systems are used, the facility must provide emergency electrical power with an emergency generator (as defined in NFPA 99, Health Care Facilities) that is located on the premises. This REQUIREMENT is not met as evidenced by:	F 455	F 455 F <i>Residents Affected</i> Upon observation, it was revealed that the facility failed to have a system in place to provide uninterrupted access to continuous oxygen therapy as well as use of the facility's six mechanical lifts. Four residents care planned for continuous oxygen usage received and have continued to receive oxygen without any disruptions to their MD orders for oxygen. Residents care planned for mechanical lift usage were transferred with the assistance of a mechanical lift per MD orders and there has not been any disruption to following the MD orders. The generator was restored to working condition compliant with Life Safety Code on 8-18-15.		



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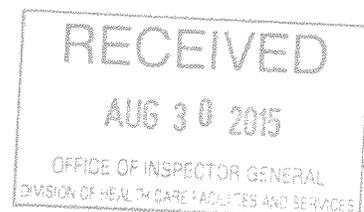
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F 455	<p>Continued From page 6</p> <p>Based on interview and facility policy review it was determined the facility failed to have a system in place to provide uninterrupted access to continuous oxygen therapy as required to four (4) residents out of fifty (50) in the event of a power failure and the generator of the facility had to be activated. In addition, residents could not be transferred using any of the facility's six (6) mechanical lifts in the event of a facility power failure.</p> <p>The findings include:</p> <p>Review of facility policy titled "Auxiliary Power for Life-Support Systems," with a revision date of August 2008 revealed if the normal power supply was disrupted the emergency generator would provide auxiliary power to established areas within the building. Continued review of the facility policy revealed life support equipment was located at each nurse's station and was to be used only during an emergency.</p> <p>Interview with the facility Maintenance Director on 08/06/15 at 11:03 AM revealed he had identified the generator would not automatically transfer power on 07/09/15 and had contacted the generator vendor to assess the generator to determine the problem. Continued interview with the facility Maintenance Director revealed the generator vendor had incorrectly identified the problem with the generator and that the Maintenance Director discovered on 07/16/15 after the generator vendor had replaced the transfer switch that the generator did not automatically transferring power to the facility. Further interview with the facility Maintenance Director revealed that according to the generator vendor the emergency power generator needed a</p>	F 455	<p><i>Identification of Other Residents</i></p> <p>The deficiency had the potential to affect the 4 residents who are care planned for continuous oxygen therapy and residents who utilize the mechanical lifts for transfers.</p> <p>All residents who have MD orders for continuous oxygen and use of the mechanical lifts are receiving these services as ordered by their physician and there has not been any disruption to these services. The generator was restored to working condition compliant with Life Safety Code on 8-18-15.</p> <p><i>Systemic Changes</i></p> <p>The Director of Maintenance arranged for Nixon Power to expedite the shipping for a new control board for the facility generator on 8-10-15. Nixon Power replaced the control board on the facility generator on 8-18-15 to restore it to working status and in compliance with Life Safety Code standards.</p> <p><i>Monitoring</i></p> <p>The generator's new control board has been programmed by Nixon Power to automatically start the generator weekly on Friday. Additionally, the Maintenance Director will manually start the generator monthly under load for 30 minutes to ensure the transfer switch is transferring power from the generator to the facility and confirm the generator is in proper working condition in compliance with Life Safety Code standards.</p>		



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F 455	Continued From page 7 new controller in order for the system to automatically transfer power. Continued interview with the facility Maintenance Director revealed he had to get bids on getting the controller replaced because it was over a certain amount of money. The facility Maintenance Director stated he got final pricing on replacing the controller on 07/16/15 and conveyed the information to the former Facility Administrator. Interview with the Regional Director of Operations on 08/06/15 at 1:00 PM revealed he was not made aware of the generator issue until he was contacted on 07/27/15 about getting approval from the corporate office to purchase a new controller for the generator. Continued interview with the Regional Director of Operations revealed he was under the impression that the facility had emergency power available in the event of a power failure. Interview with the Facility Administrator on 08/06/15 at 1:21 PM revealed he had been the administrator of the facility for four (4) days and was under the impression that the facility could do a manual power transfer in the event of a facility power failure.	F 455	Correction Date: 9-11-15		



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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/11/15 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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: 1971</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: Four (4) 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, 85KW generator. Fuel source is natural gas.</p> <p>A Recertification Life Safety Code Survey was initiated on 08/04/15 and concluded on 08/05/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has sixty (60) certified beds and the census was fifty (50) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p>K 025 D</p> <p><i>Residents Affected</i> Upon observation it was revealed that the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards above the ceiling located by Room 106 and another above the ceiling by the conference room.</p> <p><i>Identification of Other Residents</i> The deficiency had the potential to affect all the residents in the facility. The Director of Maintenance checked all smoke barriers in the facility on 8-7-15 to identify any other areas of concern; no others identified.</p> <p><i>Systemic Changes</i> On 8-25-15 the Director of Maintenance repaired the two unsealed penetrations; one</p>	
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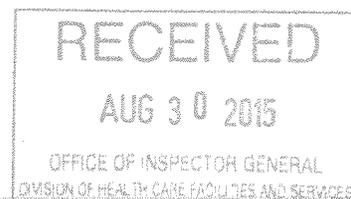
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X Jevon Davis</i>	TITLE <i>Administrator</i>	(X6) DATE <i>X 8-28-15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be 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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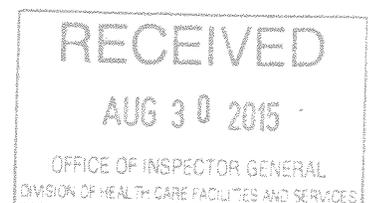
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185362	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - HOMESTEAD NURSING CENTER B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2015
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K 000	Continued From page 1	K 000	in the smoke barrier above the ceiling located by Room #106 and another above the ceiling located by the conference room. The Director of Maintenance sealed both penetrations with fire rated caulking that is capable of maintaining the smoke resistance of the smoke barrier so there are no longer penetrations in the facility's smoke barriers.	
K 025 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation 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 National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty (50).</p> <p>The findings include:</p> <p>1. Observation, on 08/04/15 at 10:08 AM, with the Maintenance Director revealed an unsealed penetration in the smoke barrier extending above the ceiling located by Room #106. The</p>	K 025	<p>A new monthly QA audit was developed 8-26-15 by the Administrator to ensure that the penetrations remain sealed. The Director of Maintenance will check once a month to ensure that the smoke barriers do not have any penetrations and remain sealed. These audits are turned into the Administrator monthly for review and compliance.</p> <p>Monitoring The Administrator will submit the results of the QA audits completed monthly by the Maintenance Director to the monthly Quality Assurance and Safety Committee meeting for review and recommendations.</p> <p>Date of Correction 9-11-15</p>	



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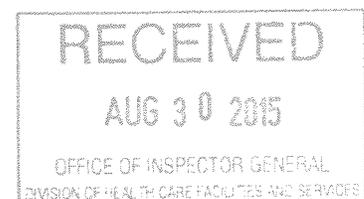
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K 025	<p>Continued From page 2</p> <p>penetration was due to a continuous ridge vent that was installed with the new roof.</p> <p>Interview, on 08/04/15 at 10:09 AM, with the Maintenance Director revealed he was not aware the smoke barrier would not resist the passage of smoke due to the new ridge vent.</p> <p>2. Observation, on 08/04/15 at 10:17 AM, with the Maintenance Director revealed an unsealed penetration in the smoke barrier extending above the ceiling located by the Conference Room. The penetration was due to a continuous ridge vent that was recently installed with the new roof.</p> <p>Interview, on 08/04/15 at 10:18 AM, with the Maintenance Director revealed he was not aware the smoke barrier would not resist the passage of smoke due to the new ridge vent.</p> <p>The census of fifty (50) was verified by the Administrator on 08/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/05/15.</p> <p>Actual NFPA Standard:</p> <p>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</p>	K 025			



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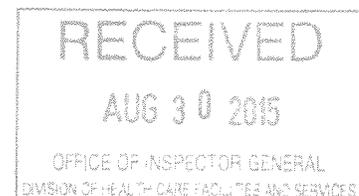
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K 025	Continued From page 3 in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments 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 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. 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	K 025			



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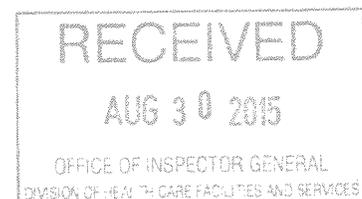
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K 025	Continued From page 4 of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose. NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 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 affect four (4) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty (60) beds and the census was fifty (50) on the day of the survey. The findings include: Observation, on 08/04/15 at 11:22 AM, with the Maintenance Director revealed the facility failed to document the annual ninety (90) minute test for battery powered emergency lighting. Interview, on 08/04/15 at 11:23 AM, with the Maintenance Director revealed he was not aware documentation was to be provided for the ninety (90) minute test for battery powered emergency lighting.	K 025			
K 046 SS=F		K 046	K 046 F <i>Residents Affected</i> Upon observation, it was revealed the facility failed to maintain emergency lighting in accordance with NFPA standards in which the facility failed to document the annual ninety minute test for battery powered emergency lighting. Emergency egress lighting was installed in the facility in accordance with NFPA standards on 8-13-15 by the Director of Maintenance. <i>Identification of Other Residents</i> The deficiency had the potential to affect all the residents in the facility. <i>Systemic Changes</i> Emergency egress lighting was installed in the facility in accordance with NFPA standards on 8-13-15 by the Director of Maintenance. The installed lights are arranged to provide initial illumination that is not less than an average of one foot-candle (1 lux), measured along the path of egress at floor level. On 8-17-15 the egress lighting was inspected by the Director of Maintenance to ensure it satisfied both the 30 day test and the annual 90 minute test for battery powered emergency lighting in		



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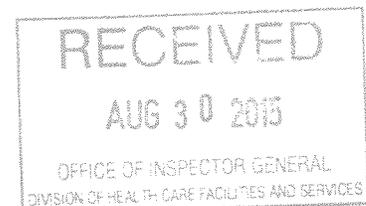
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K 046	<p>Continued From page 5</p> <p>The census of fifty (50) was verified by the Administrator on 08/05/15. The survey findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/05/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 11/2 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 11/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less</p>	K 046	<p>accordance with NFPA standards. These tests will be performed and logged every 30 days and annually by the Director of Maintenance.</p> <p><i>Monitoring</i> The Director of Maintenance will record in a log book the results of both the 30 day tests as well as the annual 90 minute test for battery powered emergency lighting in accordance with NFPA standards. The Administrator will review the maintenance log monthly to ensure compliance and submit results to the Quality Assurance Committee Meeting monthly for review and recommendations.</p> <p><i>Date of Correction</i> 9-11-15</p>		



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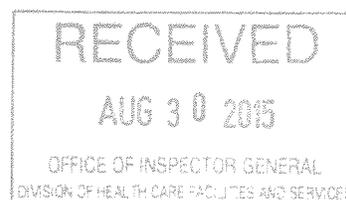
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K 046	Continued From page 6	K 046			
K 062 SS=F	<p>than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty (50).</p> <p>The findings include:</p> <p>Observation, on 08/04/15 at 10:56 AM, with the Maintenance Director revealed the full flow trip test was past due. The last full flow test was performed on 07/17/12.</p> <p>Interview, on 08/04/15 at 10:57 PM, with the Maintenance Director revealed he relied on the sprinkler contractor to keep the facility in compliance.</p> <p>The census of fifty (50) was verified by the</p>	K 062	<p>K 062 F</p> <p><i>Residents Affected</i></p> <p>Upon observation, it was revealed the facility failed to maintain the sprinkler system in accordance with NFPA standards as the full flow trip test was past due. The last full flow trip test was performed on 7-17-12. The Director of Maintenance notified Brown Sprinkler Corporation to come and perform the three year full flow test which was performed on 8-25-15 and no concerns were identified with the system.</p> <p><i>Identification of Other Residents</i></p> <p>The deficiency had the potential to affect all residents in the facility. The Director of Maintenance notified Brown Sprinkler Corporation to come and perform the three year full flow test which was performed on 8-25-15 and no concerns were identified with the system.</p> <p><i>Systemic Changes</i></p> <p>On 8-25-2015, Brown Sprinkler Corporation made a site visit to the facility to perform the three year full flow trip test in compliance with NFPA standards. The results of the full flow trip test revealed the facility's sprinkler system is in proper working condition and compliant with NFPA standards.</p>		



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K 062	<p>Continued From page 7</p> <p>Administrator on 08/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/05/15.</p> <p>Actual NFPA Standard:</p> <p>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.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <p>Item Activity Frequency Reference</p> <p>Gauges (dry, preaction deluge systems) Inspection Weekly/monthly 2-2.4.2</p> <p>Control valves Inspection Weekly/monthly Table 9-1</p> <p>Alarm devices Inspection Quarterly 2-2.6</p> <p>Gauges (wet pipe systems) Inspection Monthly 2-2.4.1</p> <p>Hydraulic nameplate Inspection Quarterly 2-2.7</p> <p>Buildings Inspection Annually (prior to freezing weather) 2-2.5</p> <p>Hanger/seismic bracing Inspection Annually 2-2.3</p> <p>Pipe and fittings Inspection Annually 2-2.2</p> <p>Sprinklers Inspection Annually 2-2.1.1</p> <p>Spare sprinklers Inspection Annually 2-2.1.3</p>	K 062	<p>The Director of Maintenance will keep record of each three year full flow trip test in a log book and document the results of the test. The Director of Maintenance will keep track of the three year inspection dates and ensure the full flow trip test is performed every three years per NFPA standards.</p> <p><i>Monitoring</i></p> <p>The Director of Maintenance will report to the administrator once the three year full flow trip test is scheduled so that the administrator can verify the next test date is within the three year window in compliance with NFPA standards.</p> <p><i>Date of Correction</i></p> <p>9-11-15</p>	



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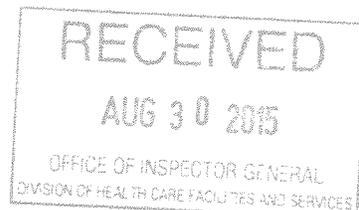
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K 062	Continued From page 8 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 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 Obstruction investigation Maintenance 5 years or as needed Chapter 10 Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection	K 062		
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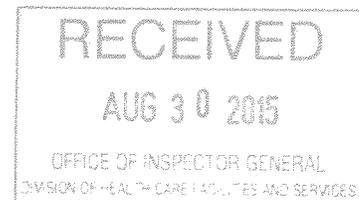
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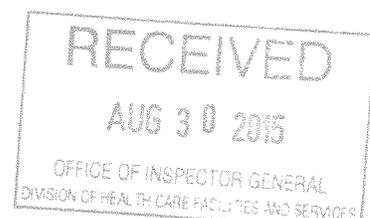
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K 062	Continued From page 9 Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2	K 062		



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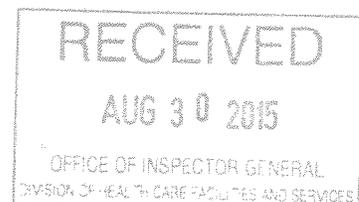
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K 062	Continued From page 10 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Praction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062			
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access in accordance with NFPA standards. The deficient practice has the potential to affect one	K 072	K 072 D <i>Residents Affected</i> Upon observation, it was revealed that the facility failed to maintain exit access in accordance with NFPA standards as two geriatric chairs and a mechanical lift were stored in the egress path at the Therapy Exit. All exits have been cleared of geriatric chairs and the mechanical lifts and remain in compliance with NFPA standards. <i>Identification of Other Residents</i> The deficiency had the potential to affect all the residents in the facility. All exits have been cleared of geriatric chairs and mechanical lifts and remain in compliance with NFPA standards. <i>Systemic Changes</i> The Director of Maintenance educated the		



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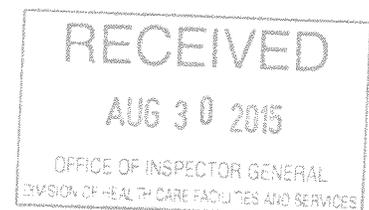
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K 072	<p>Continued From page 11</p> <p>(1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty (50).</p> <p>The findings include:</p> <p>Observation, on 08/04/15 at 11:39 AM, with the Maintenance Director revealed two (2) Geriatric Chairs and a lift stored in the egress path at the Therapy Exit. The chairs and lift were observed being unattended from 10:09 AM until 11:39 AM.</p> <p>Interview, on 08/04/15 at 11:40 AM, with the Maintenance Director revealed the chairs and lift were routinely stored in this location.</p> <p>The census of fifty (50) was verified by the Administrator on 08/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/05/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>Reference: NFPA 101 (200 Edition) 7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in.</p>	K 072	<p>Staff Development Coordinator about exit access in accordance with NFPA standards on 8-28-15. The Staff Development Coordinator is in-servicing all staff including all departments, which will be completed by 9-10-15, regarding means of egress - it must be continuously maintained free of all obstructions or impediments for immediate use in the case of fire or other emergency.</p> <p>A new QA audit was developed on 8-26-15 by the Administrator which will verify that all exits are continuously free of all obstructions and impediments. The Maintenance Director will be performing this QA audit daily and submitting them daily to the Administrator.</p> <p>Monitoring The Administrator will submit the results of the QA audits completed by the Maintenance Director to the monthly Quality Assurance and Safety Committee meeting for review and recommendations.</p> <p>Date of Correction 9-11-15</p>		



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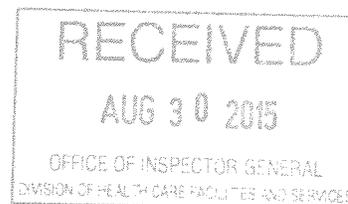
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K 072	Continued From page 12 (96 cm) and below.	K 072			
K 146 SS=F	<p>Reference: S&C-12-21-LSC NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A nursing home or hospice with no life support equipment has an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source. NFPA 99, 3.6.3.1.1</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility has the capacity for sixty (60) beds with a census of fifty (50) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the Generator testing records, on 08/04/15 at 11:12 AM, with the Maintenance Director revealed the transfer switch connected to the facility generator was not functioning. The facility generator failed to transfer power to the facility starting on 07/09/15.</p> <p>Interview, on 08/04/15 at 11:13 AM, with the Maintenance Director revealed the parts had been ordered to correct the problem with the transfer switch.</p>	K 146	<p>K 146 F <i>Residents Affected</i></p> <p>Upon observation, it was revealed that the facility failed to have a system in place to provide uninterrupted access to continuous oxygen therapy as well as use of the facility's six mechanical lifts. The Four residents care planned for continuous oxygen usage have received and have continued to receive oxygen without any disruptions to their MD orders for oxygen. Residents care planned for mechanical lift usage were transferred with the assistance of a mechanical lift per MD orders and there has not been any disruption to following the MD orders. The generator was restored to working condition compliant with Life Safety Code on 8-18-15.</p> <p><i>Identification of Other Residents</i></p> <p>The deficiency had the potential to affect the 4 residents who are care planned for continuous oxygen therapy and residents who utilize the mechanical lifts for transfers.</p> <p>All residents who have MD orders for continuous oxygen and use of the mechanical lifts are receiving these services as ordered by their physician and there has not been any disruption to these services.</p> <p><i>Systemic Changes</i></p>		



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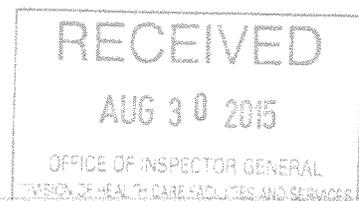
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K 146	Continued From page 13 The census of fifty (50) was verified by the Administrator on 08/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/05/15. Actual NFPA Standard: Reference: NFPA 99 (1999 Edition) 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This	K 146	The Director of Maintenance arranged for Nixon Power to expedite the shipping for a new control board for the facility generator on 8-10-15. Nixon Power replaced the control board on the facility generator on 8-18-15 to restore it to working status and in compliance with Life Safety Code standards. <i>Monitoring</i> The generator's new control board has been programmed by Nixon Power to automatically start the generator weekly on Friday. Additionally, the Maintenance Director will manually start the generator monthly under load for 30 minutes to ensure the transfer switch is transferring power from the generator to the facility and confirm the generator is in proper working condition in compliance with Life Safety Code standards. <i>Correction Date:</i> 9-11-15		



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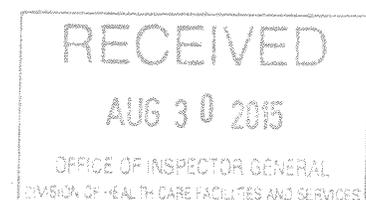
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K 146	Continued From page 14 derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2] Reference: NFPA 110 (1999 Edition) 5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch. Reference: NFPA 99 (1999 Edition) 3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.	K 146			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty (60) beds and at the time of the survey, the census was fifty (50).	K 147	K 147 D <i>Residents Affected</i> Upon observation, it was revealed that the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards as an open electrical junction was found located under the sink in the dish room. The Director of Maintenance de-energized and removed the electrical junction underneath the sink in the dish room on 8-7-15. <i>Identification of Other Residents</i> The Director of Maintenance and the Administrator conducted a facility safety rounds on 8-7-15 which included looking		



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K 147	Continued From page 15 The findings include: Observation, on 08/05/15 at 9:55 AM, with the Maintenance Director revealed an open electrical junction located under the sink in the Dish Room. Interview, on 08/05/15 at 9:56 AM, with the Maintenance Director revealed he was not aware of the open electrical junction. The census of fifty (50) was verified by the Administrator on 08/05/15. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 08/05/15. Actual NFPA Standard: Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. 370.28(c) Covers. All pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. Where metal covers are used, they shall comply with the grounding requirements of Section 250-110. An extension from the cover of an exposed box shall comply with Section 370-22, Exception.	K 147	for any other open electrical junctions. No other concerns were identified. <i>Systemic Changes</i> The Director of Maintenance located the open electrical junction in the dish room. The Director of Maintenance de-energized and removed the electrical junction underneath the sink in the dish room on 8-7-15. A new process was implemented by the Administrator on 8-31-15 which includes a weekly facility safety round which will be conducted by the Administrator and the Director of Maintenance to identify any areas of concern including open electrical junctions. These weekly safety facility rounds will be submitted to the monthly Quality Assurance Committee meetings by the Administrator. <i>Monitoring</i> The Administrator observed the area underneath the sink in the dish room on 8-7-15 and confirmed that the Director of Maintenance properly de-energized and removed the electrical junction. The Weekly safety rounds will be submitted to the monthly Quality Assurance Committee meeting by the Administrator for review and recommendations. <i>Date of Correction</i> 9-11-15		



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{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/11/15 as alleged.</p>	{K 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.