### K 038
#### SS=D
**NFPA 101 LIFE SAFETY CODE STANDARD**

Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1

This **STANDARD** is not met as evidenced by:
- Based on observation, it was determined the facility failed to provide an exit access was readily accessible at all times.

The findings included:

- Observations on 6/1/10 at 10:45 AM, revealed the exit from the laundry corridor in the basement consisted of a concrete pad outside of the exit door. There was no hard path or surface to a public right of way. In weather conditions including rain, the surface of the exit path to the public way would impede ambulatory residents and be impassible for non-ambulatory residents.

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### K 045
#### SS=D
**NFPA 101 LIFE SAFETY CODE STANDARD**

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, it was determined the facility failed to provide illumination at all exit discharge.

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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**TITLE**

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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 safeguards provide sufficient protection to the patient. (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.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 045</td>
<td>Continued From page 1</td>
<td>K 045</td>
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</tbody>
</table>

**The findings included:**

During a fire drill conducted on 6/1/10 at 1:35 PM at resident room 221, the following were observed.

a. The maintenance director had to instruct staff member #1 to pull the fire alarm.

b. Staff member #1 was unable to pull the fire alarm and the maintenance director pulled the fire alarm.

c. After the fire alarm was activated, staff member #2 finished mopping the floor of resident room 220 and failed to completely close the door of...
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>K 050</td>
<td>Continued From page 2 resident room 220. d. A medication cart was left in the corridor by resident room 221 obstructing the corridor.</td>
<td></td>
<td>K 064</td>
<td>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</td>
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<tr>
<td>K 064</td>
<td><strong>SS=F</strong></td>
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<td>1. No residents were identified as being affected by alleged deficient practice.</td>
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<td>2. Maintenance Director conducted an audit to verify which fire extinguishers needed servicing.</td>
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<td>3. Fire extinguishers were labeled and given an “in house” number. A secondary log sheet has been created to insure that all extinguishers are checked monthly as well as yearly. State Systems was contacted with the issues on fire extinguish located by resident room #404. The extinguisher was inspected and a new tag for 2010 was place on the extinguisher.</td>
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<td>4. Maintenance Director / designee will monitor fire extinguishers monthly during pm rounds to ensure extinguishers are maintained. Any issues noted will be addressed immediately and forwarded to the QA&amp;A Committee for follow-up.</td>
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