K018
SS=E

NFPA 101 LIFE SAFETY CODE STANDARD

Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1/4 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

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the doors protecting the corridors.

The findings included:

Observations of the mechanical room's fire door, located in the 200 corridor, on 6/14/10 at 10:50 AM, revealed the bottom of the door was sticking to the floor. National Fire Protection Association (NFPA) 80, 15-1.2

Observations of the Restorative Therapy room's fire door on 6/14/10 at 11:17 AM, revealed the top

1) Immediate Interventions:
The mechanical room fire door
In the 200 corridor and the
Restorative Therapy room
Fire door were both corrected

2) Identification of the residents
With potential to be affected-
An audit of the facility was
Conducted on 6/14/2010 to
Ensure no other areas were
Affected.

3) Measures to prevent reoccurrence-
Audit to be completed Q month by
Maintenance director or designee to
Ensure compliance.

4) Monitoring-
Audits and findings will be reported to
Monthly Q A meeting.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE

NHA

7-2-10

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 discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to be continued program participation.
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>K018</td>
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<td>Continued From page 1 of the door was sticking to the door frame. NFPA 80, 15-1.2</td>
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<td>K018</td>
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<td>These findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 6/14/10. NFPA 101 LIFE SAFETY CODE STANDARD</td>
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<td>Emergency lighting of at least 1 1/2 hour duration is provided in accordance with 7.9.19.2.9.1.</td>
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<td>This STANDARD is not met as evidenced by: Based on record review, it was determined the facility failed to maintain the emergency lighting.</td>
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<td>The findings included: Record review on 6/14/10 at 12:15 PM, revealed the facility was unable to provide documentation that the emergency lights' 90 minute test was conducted annually. National Fire Protection Association (NFPA) 101, 7.9.3</td>
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<td>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible</td>
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1) Immediate Interventions: The emergency light 90 minute test was conducted On 6/14/2010.

2) Identification of the residents with potential to be affected: Another 90 minute test was conducted on 7/1/2010 to Ensure no other areas were Affected.

3) Measures to prevent Recurrence: The 90 minute light test to Be done annually has been Scheduled.

4) Monitoring: Audit and findings will be reported To monthly QA meeting.
K 050 Continued From page 2 alarms. 19.7.1.2

This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed the fire drill.

The findings included:

Observations during the fire drill on 6/14/10 at 12:04 PM, revealed the staff member selected to react to the drill failed to close the resident's room door and failed to announce the location of the fire. National Fire Protection Association (NFPA) 101, 19.7.1.2

This finding was acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 6/14/10. NFPA 101 LIFE SAFETY CODE STANDARD 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 record review, it was determined the facility failed to maintain the sprinkler system.

The findings included:

Record review on 6/14/10 at 12:30 PM, revealed the facility was unable to provide documentation that the sprinkler system gages were tested or

K 050

1) Immediate Interventions-Inservice was conducted on 6/14/2010 with facility staff. On proper response to a fire Drill.

2) Identification of the residents With potential to be affected- Inservice on fire drill response Was conducted with all 3 shifts On 7/1/2010 and 7/2/2010.

3) Measures to prevent reoccurrence - Monthly unannounced fire drills With all 3 staffs.

K 062 4) Monitoring- Fire drills and in services will be Reported to the monthly QA Meeting.

1) Immediate Interventions- The sprinkler system gauges were 7-9-10 Replaced on 6/14/2010 by Century Fire Alarm.

2) Identification of the residents with Potential to be affected- An audit was conducted on 7/1/2010 To ensure no other areas were affected.
**K 082**

Continued From page 3

replaced every 5 years. National Fire Protection Association (NFPA) 25, 2.2.1

This finding was acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 6/14/10.

NFPA 101 MISCELLANEOUS

OTHER LSC DEFICIENCY NOT ON 2788

**K 130**

This STANDARD is not met as evidenced by:

Penetrations and miscellaneous openings in fire barriers such as pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.

This STANDARD is not met as evidenced by:

Based on observations, it was determined the facility failed to maintain one of the three fire barriers.

The findings included:

Observations of the fire wall located above the fire doors, in the backside of a corridor, on 6/14/10 at 10:25 AM, revealed a penetration above the sprinkler pipe. National Fire Protection Association (NFPA) 101, 8.2.3.2.3.1

This finding was acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 6/14/10.

**3)** Measures to prevent:

Reoccurrence-
The sprinkler system gauges
Are on schedule to be checked
By Century Fire Alarm.

**4)** Monitoring:

Audit and findings will be reported
To monthly QA meeting.

**1)** Immediate Interventions:

Pipe located above the fire doors
In the backside of corridor a was
Corrected on 6/14/2010.

**2)** Identification of the residents with
Potential to be affected:

An audit of the facility was conducted
On 7/1/2010 to ensure no other areas
Were affected.
| ID | Prefix | Tag | Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information) | K 130 | Continued From page 4
Director at the exit interview on 6/14/10. |
---|--------|-----|-------------------------------------------------------------------------------------------------|------|----------------------------------------------------------------------------------|
| K 130 |        |     | 3) Measures to prevent reoccurrence-Audit to be completed Q month by Maintenance director or designee to Ensure compliance. | K 130 | 4) Monitoring- Audits and findings will be reported To monthly QA meeting. |