

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

The plan of corrections is a requirement of federal law, but not necessarily an acknowledgement of any violation of federal laws and regulations

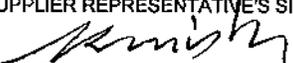
PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - RIBEIRO B. WING _____	RECEIVED JAN 10 2014	(X3) DATE SURVEY COMPLETED 12/17/2013
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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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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 1¾ 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, it was determined the facility failed to maintain the doors protecting the corridors.</p> <p>The finding included:</p> <p>Observation of the 2nd floor storage room on 12/17/13 at 9:10 AM, revealed the door was held open with a box.</p> <p>This finding was verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.</p>	K 018	<p>K 018 SS=D</p> <p>A. The box holding open the 2nd floor storage room door was removed immediately. (See Attachment FF)</p> <p>B. All residents could be affected by this practice. No residents were harmed.</p> <p>C. Propped doors will be monitored during The Facilities Management Director's weekly rounds and Facilities Management's quarterly preventative maintenance rounds.</p> <p>D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting.</p>	1/18/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/9/14
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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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K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the exit access.</p> <p>The finding included:</p> <p>Observation and interview of three staff members of the memory care unit on 12/17/13 at 1:50 PM, revealed the staff did not know the patio's key pad exit code. There were other staff present who did know the code.</p> <p>This finding was verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.</p>	K 038	<p>K 038 SS=E</p> <p>A. All staff will be in-serviced on the exit code for the patio on the secured unit by January 17, 2014. Also all door codes have been put on stickers and attached to the employees name badge.</p> <p>B. All residents could be affected by this practice. No residents were harmed.</p> <p>C. The Facilities Management Director or designee will review and quiz staff on the exit code during the monthly fire drills and document staffs performance.</p> <p>D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management meeting.</p>	1/18/14	
K 104 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the smoke barriers.</p>	K 104	<p>K104 SS=D</p> <p>A. Removed low voltage wire and seal hole with 3M Fire Caulk at duct above fire door on south hall on December 18, 2013. (See Attachment GG)</p> <p>B. All patients could be affected by this practice. No residents were harmed</p> <p>C. Penetrations will be checked during the quarterly preventive maintenance program for the inspection and repair of smoke and fire partitions.</p>	1/18/14	

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K 104	Continued From page 2 The findings included: Observation of the fire damper above the fire wall next to room 426 on 12/17/13 at 8:19 AM, revealed low voltage wires not sealed. This finding was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 12/17/13.	K 104	D. Documentation will be kept on file in the Facilities Management Office and reviewed by the Facilities Management Director or designee and a standing report made to the Risk Management Committee.	1/18/14	

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JAN 10 2014

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K 018 SS=E	<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 observations, it was determined the facility failed to maintain the doors protecting the corridors.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Observations of the central supply room 12/17/13 at 9:19 AM, revealed wooden door wedges in use. Observations of the physical therapy room on 12/17/13 at 9:27 AM, revealed the door was held open with a wooden rack. 	K 018	<p>K 018 - (1)</p> <ol style="list-style-type: none"> The wooden door wedge in Central Supply was removed immediately. (See Attachment KK) All residents could be affected by this practice. No residents were harmed. Propped doors will be monitored during The Facilities Management Director's weekly rounds and Facilities Management's quarterly preventative maintenance rounds. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management meeting. 	1/18/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 1/19/14

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K 018 SS=E	<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 1¾ 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 observations, it was determined the facility failed to maintain the doors protecting the corridors.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Observations of the central supply room 12/17/13 at 9:19 AM, revealed wooden door wedges in use. Observations of the physical therapy room on 12/17/13 at 9:27 AM, revealed the door was held open with a wooden rack. 	K 018	<p>K 018 - (2)</p> <ol style="list-style-type: none"> The wooden rack in Physical Therapy was removed immediately. (See Attachment LL) All residents could be affected by this practice. No residents were harmed. Propped doors will be monitored during The Facilities Management Director's weekly rounds and Facilities Management's quarterly preventative maintenance rounds. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting. <p>K 018-3</p> <ol style="list-style-type: none"> The wooden door wedges in the multiple shops were removed immediately. All residents could be affected by this practice. No residents were harmed. Propped doors will be monitored during The Facilities Management Director's weekly rounds and Facilities Management's quarterly preventative maintenance rounds. 	1/18/14

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TITLE

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K 018	Continued From page 1 3. Observations of the multiple shops on 12/17/13 at 9:35 AM, revealed wooden door wedges in use. These findings were verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.	K 018	D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Safety Committee meeting which in turn reports to the Quality Improvement Committee.	
K 038 SS=E	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 observations, it was determined the facility failed to maintain the exit access. The findings included: 1. Observations of the 1st floor interior stair way on 12/17/13 at 9:12 AM, revealed the no exit barrier to the basement was not in use. 2. Observations of the 4th floor center stair way door on 12/18/13 at 10:28 AM, revealed no 15 second delay egress sign posted on the door. 3. Observations of the 4th floor interior stair way on 12/18/13 at 10:28 AM, revealed the no exit barrier to the attic was not in use. These findings were verified by the director of maintenance and acknowledged by the	K 038	K 038 - (1) A. The no exit barrier on the 1 st floor stairwell was placed back in use immediately. (See Attachment MM) B. All residents could be affected by this practice. No residents were harmed. C. The exit barrier will be monitored during Facilities Management Director's weekly rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting.	1/18/14

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K 038	Continued From page 2 administrator during the exit conference on 12/18/13.	K 038	K 038 - (2)	
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the corridors clear and unobstructed serving as exit access The finding included: Observations of the corridor access next to room 206 on 12/17/13 at 10:30 AM, revealed carts and a blood pressure monitor were obstructing the last 4 feet. This findings was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 12/17/13.	K 039	A. The 15 second delay egress sign was placed on the 4 th floor center stairwell door on January 13, 2014. (See Attachment NN) B. All residents could be affected by this practice. No residents were harmed. C. The delayed egress signage will be monitored during Facilities Management Director's weekly rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee. K 038 - (3)	1/18/14
K 062 SS=E	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 observations, record review and	K 062	A. Exit barrier to the attic was put up on December 18, 2013. (See Attachment OO) B. All residents could be affected by this practice. No residents were harmed C. The Facilities Management Director or designee will check on weekly rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting.	

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K 038	Continued From page 2 administrator during the exit conference on 12/18/13.	K 038		
K 039 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the corridors clear and unobstructed serving as exit access The finding included: Observations of the corridor access next to room 206 on 12/17/13 at 10:30 AM, revealed carts and a blood pressure monitor were obstructing the last 4 feet. This findings was verified by the maintenance supervisor and acknowledged by the administrator during the exit conference on 12/17/13.	K 039	K 039 A. The carts and blood pressure monitor near room 206 were moved immediately. (See Attachment PP) B. All residents could be affected by this practice. No residents were harmed. C. Items blocking the means of egress will be monitored during Facilities Management Director's weekly rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting.	1/18/14
K 062 SS=E	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 observations, record review and	K 062	K 062- (1) A. The plastic covering the sprinkler head in paint shop was removed on December 17, 2013. (See Attachment QQ) B. All residents could be affected by this practice. No residents were harmed. C. Sprinkler heads will be checked quarterly by Fire Sprinkler LLC for foreign materials and noted on the inspection report. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. All deficiencies will be fixed before the next quarterly inspection.	1/18/14

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K 062	Continued From page 3 interview, it was determined the facility failed to maintain the sprinkler system The findings included: 1. Observations of the paint shop paint booth on 12/17/13 at 8:26 AM, revealed the sprinkler was covered with plastic. 2. Observations of the clean laundry room on 12/17/13 at 8:53 AM, revealed different type of sprinklers at the entrance and office. 3. Observations of the laundry loading dock on 12/17/13 at 9:02 AM, revealed rusty sprinklers. 4. Record review on 12/17/13 at 1:30 PM, revealed the facility was unable to provide documentation for the 5 year replacement or calibration of the sprinkler system gages. 5. Record review on 12/17/13 at 1:52 PM, revealed the facility has two fire pumps with only one weekly test log sheet. During an interview on 12/17/13 at 1:52 PM, the director of maintenance confirmed the log sheet did not described which pump was tested. These findings were verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.	K 062	K 062 - (2) A. Sprinkler heads were changed by Fire Sprinkler LLC to correct orientation on December 30, 2013. (See Attachment RR) B. All residents could be affected by this practice. No residents were harmed. C. Sprinkler heads will be checked quarterly by Fire Sprinkler LLC for correct orientation and noted on the inspection report. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. All deficiencies will be fixed before the next quarterly inspection. K 062 - (3) A. Rusty sprinkler heads on laundry loading dock have been ordered and will be replaced by January 17, 2014. (See Attachment SS) B. All residents could be affected by this practice. No residents were harmed. C. Sprinkler heads will be checked quarterly by Fire Sprinkler LLC for corrosion and noted on the inspection report. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. All deficiencies will be fixed before the next quarterly inspection.	1/18/14	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066			

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K 062	Continued From page 3 interview, it was determined the facility failed to maintain the sprinkler system The findings included: 1. Observations of the paint shop paint booth on 12/17/13 at 8:26 AM, revealed the sprinkler was covered with plastic. 2. Observations of the clean laundry room on 12/17/13 at 8:53 AM, revealed different type of sprinklers at the entrance and office. 3. Observations of the laundry loading dock on 12/17/13 at 9:02 AM, revealed rusty sprinklers. 4. Record review on 12/17/13 at 1:30 PM, revealed the facility was unable to provide documentation for the 5 year replacement or calibration of the sprinkler system gages. 5. Record review on 12/17/13 at 1:52 PM, revealed the facility has two fire pumps with only one weekly test log sheet. During an interview on 12/17/13 at 1:52 PM, the director of maintenance confirmed the log sheet did not described which pump was tested. These findings were verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.	K 062	K 062 - (4) A. All gauges were replaced on January 7, 2014. (See Attachment TT) B. All residents could be affected by this practice. No residents were harmed C. Sprinkler gauges will be checked annually by Fire Sprinkler LLC for five year replacement and noted on the inspection report. separately. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. K 062- (5) A. A separate churn test log was developed for each fire pump on December 20, 2013. (See Attachment UU) B. All residents could be affected by this practice. No residents were harmed C. Fire pump logs will be reviewed monthly by the Facilities Management Director to insure both fire pump churn test are performed and documented separately.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066	D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee.	1/18/14

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

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BIRMINGHAM B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2013
NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218		
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K 062	Continued From page 3 interview, it was determined the facility failed to maintain the sprinkler system The findings included: 1. Observations of the paint shop paint booth on 12/17/13 at 8:26 AM, revealed the sprinkler was covered with plastic. 2. Observations of the clean laundry room on 12/17/13 at 8:53 AM, revealed different type of sprinklers at the entrance and office. 3. Observations of the laundry loading dock on 12/17/13 at 9:02 AM, revealed rusty sprinklers. 4. Record review on 12/17/13 at 1:30 PM, revealed the facility was unable to provide documentation for the 5 year replacement or calibration of the sprinkler system gages. 5. Record review on 12/17/13 at 1:52 PM, revealed the facility has two fire pumps with only one weekly test log sheet. During an interview on 12/17/13 at 1:52 PM, the director of maintenance confirmed the log sheet did not described which pump was tested. These findings were verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.	K 062			
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066			

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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218		
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K 066	<p>Continued From page 4</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to enforce provisions of their smoking policy.</p> <p>The finding included:</p> <p>Observation of the laundry loading dock on 12/17/13 at 9:02 AM, revealed evidence of smoking in a no smoking area.</p> <p>This finding was verified by the director of maintenance and acknowledged by the administrator during the exit conference 12/17/13.</p>	K 066	<p>K 066 - (1)</p> <p>A. No smoking signs were installed at the laundry loading dock on December 13, 2013. In-services will be completed by January 17, 2014. (See Attachment VV)</p> <p>B. All residents could be affected by this practice. No residents were harmed.</p> <p>C. The Facilities Management Director will check all non smoking areas for compliance or the lack of during weekly rounds.</p> <p>D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting.</p>	1/18/14	

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K 069 K 069 SS=D	Continued From page 5 NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect the cooking facilities. The finding included: Observation of the kitchen hood system on 12/17/13 at 9:40 AM, revealed the fire suppression nozzles were not centered over the deep fat fryer. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 12/17/13.	K 069 K 069	K 069 A. Kitchen fryer was moved so that fire suppression nozzles are centered over fryer on December 19, 2013. (See Attachment WW) B. All residents could be affected by this practice. No residents were harmed. C. Kitchen equipment placement under fire suppression hood will be monitored during Facilities Management's quarterly preventative maintenance rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee.	1/18/14
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	K 076 A. The "H" cylinder in the pipe shop was secured on December 17, 2013. (See Attachment XX) B. All residents could be affected by this practice. No residents were harmed. C. Proper storage for all tank cylinders will be checked during Facilities Management Director's weekly rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting.	1/18/14

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BIRMINGHAM B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2013
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K 076	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to protect medical gas storage. The finding included: Observation of the pipe shop on 12/17/13 at 8:26 AM, revealed an "H" tank of oxygen not secured. This finding was verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.	K 076		
K 147 3S=F	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 observations and interview, it was determined the facility failed to maintain the electrical equipment. The findings included: 1. Observations of the physical therapy office on 12/17/13 at 9:27 AM, revealed an extension cord plugged into a surge protector. 2. Observations of the kitchen bakery area on 12/17/13 at 9:47 AM, revealed surge protectors on the back wall not functioning properly. 3. Observations of the beauty shop on 12/17/13 at 10:05 AM, revealed multiple plug adaptors in all wall outlets, and multiple plug extension cords	K 147	K 147 – (1) A. The extension cord plugged into surge protector in physical therapy office was removed immediately. (See Attachment YY) B. All residents could be affected by this practice. No residents were harmed. C. Extension cords will be monitored during The Facilities Management Director's weekly rounds and Facilities Management's quarterly preventative maintenance rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting.	1/18/14

STATEMENT OF DEFICIENCIES & PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - BIRMINGHAM B. WING _____	JAN 10 2014	(X3) DATE SURVEY COMPLETED 12/17/2013
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K 147	Continued From page 7 in use on the counter top. 4. Observations of room 410 on 12/17/13 at 10:33 AM, revealed 2 surge protectors daisy chained together. 5. During an interview on 12/17/13 at 1:20 PM, the director of maintenance revealed the facility was not conducting the required 12 month retention force test on the electrical receptacles located in the patient care areas. These findings were verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.	K 147	K 147 - (2) A. GFCI surge protectors on the back wall of kitchen bakery area were repaired on December 23, 2013. (See Attachment ZZ) B. All residents could be affected by this practice. No residents were harmed. C. GFCI surge protectors will be monitored during Facilities Management's quarterly preventative maintenance rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting.	1/18/14
			K 147 - (3) A. The extension cord and multi plug adaptors in the beauty shop were removed on December 18, 2013. (See Attachment AAA) B. All residents could be affected by this practice. No residents were harmed. C. Extension cords and multi plug adaptors will be monitored during The Facilities Management Director's weekly rounds and Facilities Management's quarterly preventative maintenance rounds.	

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K 147	Continued From page 7 in use on the counter top. 4. Observations of room 410 on 12/17/13 at 10:33 AM, revealed 2 surge protectors daisy chained together. 5. During an interview on 12/17/13 at 1:20 PM, the director of maintenance revealed the facility was not conducting the required 12 month retention force test on the electrical receptacles located in the patient care areas. These findings were verified by the director of maintenance and acknowledged by the administrator during the exit conference on 12/17/13.	K 147	K 147 - (4) A. The two surge protectors daisy chained together in room 410 were removed on December 20, 2013. (See Attachment BBB) B. All residents could be affected by this practice. No residents were harmed. C. Improper use of surge protectors will be monitored during The Facilities Management Director's weekly rounds and Facilities Management's quarterly preventative maintenance rounds. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or designee. A standing report on all deficiencies found will be prepared and presented at the monthly Risk Management Committee meeting. K 147 - (5) A. Facilities management staff will conduct retention force test on all electrical receptacles in patient care areas by December 19, 2013. Any receptacles in patient areas that failed will be replaced by December 27, 2013. (See Attachment CCC) B. All residents could be affected by this practice. No residents were harmed. C. Facilities Management staff will test and document retention force on all electrical receptacles in patient care areas during quarterly preventative maintenance rounds.	1/18/14
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JAN 10 2014

D. Documentation will be kept on file in
the Facilities Management
Department and reviewed by the
Facilities Management Director or
designee. A standing report on all
deficiencies found will be prepared
and presented at the monthly Risk
Management Committee meeting.