

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155384	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  06/23/2014
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-LINCOLN HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 402 19TH ST TELL CITY, IN 47586
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/23/14</p> <p>Facility Number: 000411 Provider Number: 155384 AIM Number: 100275100</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Lincoln Hills was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility with a lower level was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and in spaces open to the corridors, plus battery operated smoke</p>	K010000	Please accept this as our credible plan of correction. Preparation and submission of this Plan of Correction does not constitute any admission or agreement of any kind by the facility of the truth of any conclusion set forth in this allegation. Accordingly, the facility has prepared and submits this Plan of Correction solely as a requirement under State and Federal Law that mandates a submission of a Plan of Correction as a condition to participate in Title 18 and Title 19 programs.	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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K010025 SS=E	<p>detectors in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 74 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except a metal shed containing facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/26/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two 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>Based on observation and interview, the facility failed to ensure smoke partitions,</p>	K010025	What corrective action will be accomplished for those residents found to have been affected by	07/23/2014

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	<p>such as drop in ceiling tiles, were provided to limit the transfer of smoke in 3 of 10 smoke compartments. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke. This deficient practice could affect mostly staff in the lower level and up to 5 residents while using the Personal Care room (Beauty Shop) which was in the same smoke compartment as several storage rooms.</p> <p>Findings include:</p> <p>Based on observations on 06/23/14 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following areas in the lower level were missing ceiling tiles:</p> <ol style="list-style-type: none"> <li>Five in the corridor leading to the kitchen</li> <li>Six in the sprinkler riser room and connecting empty room</li> <li>Eight in the dry food storage room</li> <li>One in room 44 (storage room)</li> <li>One in east hall storage (last storage room on right near the north exit door)</li> </ol> <p>This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p>		<p>the deficient practice? The ceiling tiles in the areas affected will be corrected by July 23, 2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by the deficient practice. Ceiling tiles will be audited for placement. Affected areas will be corrected by July 23, 2014. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct audits five times per week for two months, four times per week for one month, three times per week for one month, two times a week for one month and one time per week for one month to ensure tiles are properly placed. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further issues are identified.</p>	

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K010029 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 20 hazardous area room doors, such as a room over 50 square feet containing combustible material, would automatically close with no impediment to closing the door. This deficient practice could affect mostly kitchen and other staff while in the kitchen service hall.</p> <p>Findings include:</p> <p>Based on observation on 06/23/14 at 11:25 a.m. and again at 1:40 p.m. during a tour of the facility with the Maintenance Supervisor, the Dietary Office/storage room was over 50 square feet in size and contained at least fifteen large cardboard boxes full of supplies. The door to this room was equipped with</p>	K010029	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Door closures will be applied to the medical waste room, Room 42, Room 43, Room 44, the maintenance shop, and both lower level shower rooms by July 23, 2014. The door to the Dietary Office/Sotrage room will remain closed. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Audits will be conducted to ensure doors requiring door closures have the closures in place and installed as required by July 23, 2014. The Dietary Office/Storage room door will be audited to ensure door remains closed. What measures will be</p>	07/23/2014

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	<p>a self closing device, however, the door was held wide open with a chair, furthermore, there was no one in the room either time it was observed. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 7 of 20 hazardous area room doors, such as rooms over 50 square feet containing combustible material, were equipped with self closing devices on the doors. This deficient practice could affect 5 or more residents, as well as staff and visitors while using the Personal Care room (Beauty Shop) which was in the same smoke compartment as several storage rooms.</p> <p>Findings include:</p> <p>Based on observations on 06/23/14 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following hazardous area rooms in the lower level were over 50 square feet each in size and contained a large amount of combustible material such as cardboard boxes, furniture, beds, wheelchairs, and other</p>		<p>put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct audits five times per week for two months, four times per week for one month, three times per week for one month, two times a week for one month and one time per week for one month to ensure door closures are properly placed and the Dietary Office/stroage room remain closed. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be reviewed in the monthly QAPI committee meeting for six months or until no further issues are identified.</p>		

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K010038 SS=E	<p>equipment:</p> <ul style="list-style-type: none"> <li>a. The Medical Waste Room</li> <li>b. Room 42</li> <li>c. Room 43</li> <li>d. Room 44</li> <li>e. Maintenance Shop</li> <li>f. Both lower level shower rooms</li> </ul> <p>The doors to these rooms were not provided with self closing devices. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 3 of 10 exit access doors which were equipped with delayed egress locks were provided with signs stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. 7.2.1.6.1, requires approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised</p>	K010038	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The three exit access doors, Station 1 west hall exit door, front exit/entrance door, and lower level east corridor, north exit door will have signs indicating, "Push until Alarm Sounds Door Can Be Opened in 15 Seconds" applied by July 23, 2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this	07/23/2014

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	<p>automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting</p>		<p>deficient practice. Audits will be conducted to ensure all doors requiring signage indicating delayed egress are applied by July 23, 2014. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct audits five times per week for two months, four times per week for one month, three times per week for one month, two times per week for one month and one time per week for one month to ensure signage is properly placed. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be presented to the QAPI committee monthly for review for six months or until corrective actions are no longer required.</p>	

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K010050 SS=F	<p>background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect up to 10 residents in the Station 1 west hall, plus any number of residents, as well as staff and visitors while exiting the front entrance and lower level east corridor north exit.</p> <p>Findings include:</p> <p>Based on observations on 06/23/14 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the following exit doors were equipped with delayed egress locks and were not provided with signs indicating, PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS:</p> <ul style="list-style-type: none"> <li>a. Station 1 west hall exit door</li> <li>b. Front exit/entrance door</li> <li>c. Lower level east corridor, north exit door</li> </ul> <p>This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>				

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	<p>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 alarms. 19.7.1.2</p> <p>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Fire Drill book on 06/23/14 at 10:15 a.m. with the Maintenance Supervisor present, the facility lacked written documentation a fire drill was conducted during the second shift (evening) of the second quarter (April, May, and June) of 2013. This was acknowledged by the Maintenance Supervisor at the time of record review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3</p>	K010050	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Fire drills will be held at unexpected times under varying conditions at least quarterly on each shift. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. Fire drills will be held at unexpected times under varying conditions at least quarterly on each shift. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct audits five times per week for two months, four times per week for one month, three times per week for one months, two times per week for one month and one time per week for one months to ensure fire drills are being conducted</p>	07/23/2014	

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K010051 SS=F	<p>employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's fire drills in the Fire Drill book on 06/23/14 at 10:15 a.m. with the Maintenance Supervisor present, three of three second shift (evening) fire drills were performed at 2:05 p.m., 2:10 p.m., and 2:20 p.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source</p>		properly. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be presented to the QAPI committee monthly for review for six months or until corrective actions are no longer required.		

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	<p>of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems to provide effective warning of the fire in any part of the building in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/23/14 at 1:15 p.m. during a tour of the facility with the Maintenance Supervisor, the fire alarm control panel had a yellow trouble light illuminated. The Maintenance Supervisor pushed the reset button three separate times and the fire alarm control panel went back into a yellow trouble each time. When the fire alarm system was tested between 2:25 p.m. and 2:35 p.m. from three different pull stations, the smoke barrier doors did close each time and the exit doors did release from the magnetic holders each time, however, the audible alarm and strobes did not activate. This was acknowledged by the Maintenance Supervisor at the time of fire alarm system testing, furthermore,</p>	K010051	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A fire watch was put into place immediately upon notification of the failure of the fire alarm system. The state fire marshall was contacted, the local fire department fire chief was contacted and the vendor that services the alarm system was contacted. The fire chief and vendor arrived at the facility. The vendor checked the fire alarm box and placed the wires in the proper outlet. The alarm system was tested and was in working order at 4:00 p.m. on June 23, 2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The alarm system was placed back into service and tested on June 23, 2014. There have been no further system failures identified. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance</p>	07/23/2014

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K010064 SS=F	<p>the Maintenance Supervisor said the fire alarm control panel was not in a trouble mode the last time he observed it on Friday (06/20/14).</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to inspect 24 of 24 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 4-3.4.2 requires fire extinguisher inspections at least monthly with the date of inspection and the initials of the person performing being recorded. In addition, NFPA 10, Section 4-2.1 defines inspection as a "quick check" to ensure the fire extinguisher is available and will operate. It is intended to give reasonable assurance the fire extinguisher is fully charged and operable, verifying it is in its designated place, it has not been actuated or tampered with and there is no obvious</p>	K010064	<p>supervisor/designee will conduct audits five times per week for two months, four times per week for one month, three times per week for one month, two times per week for one month and one time per week for one months to ensure the fire alarm system is in proper working order. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be presented to the QAPI committee monthly for review for six months or until corrective actions are no longer required.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The fire extinguishers will be inspected monthly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The fire extinguishers will be inspected monthly. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct</p>	07/23/2014	

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K010130 SS=E	<p>or physical damage or condition to prevent its operation. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/23/14 between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, the tags on all 24 fire extinguishers indicated they were not inspected monthly during April and May of 2014. This was acknowledged by the Maintenance Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, interview and observation; the facility failed to ensure the proper maintenance of 51 of 54 battery operated smoke detectors in resident rooms to ensure the smoke detectors are continually operable. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect 70 residents, as well as staff, and visitors in the facility.</p>	K010130	<p>audits five times per week for two months, four times per week for one month, three times per week for one month, one time per week for one month and one time per week for one month to ensure fire extinguishers are being inspected. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be presented to the QAPI committee monthly for review for six months or until corrective actions are no longer required.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The smoke detectors will be maintained properly to ensure proper operation. The Boiler Inspectors office was contacted and the facility was informed the inspections are performed every two years, rather than every year. The five fuel fire water heaters will be inspected and certificates maintained to ensure the water heaters are in safe</p>	07/23/2014

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	<p>Findings include:</p> <p>Based on review of the Monthly Battery Operated Smoke Detector Testing Results on 06/23/14 at 11:00 a.m. with the Maintenance Supervisor present, only three of fifty four battery operated smoke detectors in resident sleeping rooms have not been replaced during the past twelve months. Based on interview at the time of record review, the Maintenance Supervisor acknowledged only three of fifty four batteries in resident room smoke detectors were replaced within the past twelve months. Based on observations between 12:30 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Supervisor, battery operated smoke detectors were observed in all resident sleeping rooms.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review, and interview; the facility failed to ensure 5 of 5 fuel fired water heaters had an inspection certificate that was current to ensure the water heaters were in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This</p>		<p>operating condition. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. The smoke detectors will be maintained properly and ensured to be in proper working order for all residents. The five fuel fire water heaters will be inspected and certificates maintained to ensure the water heaters are in safe operating condition. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct audits five times per week for two months, four times per week for one month, three times per week for one month, two times a week for one month, and one time per week for one month to ensure the smoke detectors are being inspected and the boilers inspected and in proper working order. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be presented to the QAPI committee monthly for review for six months or until corrective actions are no longer required.</p>		

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K010144 SS=F	<p>deficient practice could affect mostly kitchen and other staff because the two locations of all five gas fired water heaters were in the kitchen area and the elevator equipment room off of the kitchen service hall.</p> <p>Findings include:</p> <p>Based on observations on 06/23/14 at 11:30 a.m. and between 12:30 p.m. and 3:00 p.m. during a tour of the facility with Maintenance Supervisor, the inspection certificates located next to the five fuel fired water heaters had expiration dates of 02/15/13. During an interview at the time of observations, the Maintenance Supervisor acknowledged the expiration dates on the water heaters and said he was not aware of the water heaters being inspected since the expiration dates.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the</p>	K010144	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A weekly	07/23/2014

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	<p>starting batteries for 1 of 1 emergency generators was available for 21 of 52 weeks. NFPA 99, 3-4.4.1.3 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Furthermore, NFPA 110, 6-3.6 requires storage batteries, including electrolyte levels, be inspected at intervals of not more than 7 days. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly. NFPA 99, 3-4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator Log on 06/23/14 at 11:45 a.m. with the Maintenance Supervisor present, there was no weekly generator documentation available to show visual inspections of the generator's</p>		<p>written record will be maintained to ensure the starting batteries and storage batteries are maintained properly and generator is visually inspected. The generator will be monitored to ensure it is exercised under operating conditions or not less than 30% of the Emergency Power Supply nameplate rating at least monthly for a minimum of 30 minutes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this deficient practice. A weekly record will be maintained to ensure the starting batteries and storage batteries are maintained properly and generator is visually inspected. The generator will be monitored to ensure it is exercised under operating conditions or not less than 30% of the Emergency Power Supply nameplate rating at least monthly for a minimum of 30 minutes. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct audits five times per week for two months, four times per week for one month, three times per week for one month, two times per</p>	

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	<p>hoses, belts, oil level, etc., plus the generators starting batteries since 01/27/14. Based on interview at the time of record review, the Maintenance Supervisor confirmed there was no weekly documentation available to show weekly inspections of the generator starting batteries since 01/27/14.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to provide documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems during 4 of 12 months. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could</p>		<p>week for one month and one time per week for one months to ensure the starting batteries and storage batteries are maintained properly and the generator is visually inspected and the generator is exercised under operating conditions or not less than 30% of the Emergency Power Supply nameplate rating at least monthly for a minimum of 30 minutes. How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be presented to the QAPI committee monthly for review for six months or until corrective actions are no longer required.</p>				

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K010147 SS=D	<p>affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator Monthly Load Test documentation on 06/23/14 at 11:45 a.m. with the Maintenance Supervisor present, the facility lacked documentation the generator was tested monthly under load since 01/15/14. During an interview at the time of record review, the Maintenance Supervisor confirmed there was no monthly generator load testing documentation available since 01/15/14.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to maintain an electric outlets in 1 of 10 smoke compartments. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice could affect one Housekeeping staff person while in the Housekeeping Office.</p>	K010147	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The cover and face plates in the Housekeeping Office will be repaired. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The facility recognizes that all residents have the potential to be affected by this</p>	07/23/2014

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	<p>Findings include:</p> <p>Based on observation on 06/23/14 at 2:10 p.m. during a tour of the facility with Maintenance Supervisor, there were two electric outlets in the Housekeeping Office that were missing there cover or faceplates. This was acknowledged by Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>deficient practice. Cover and face plates will be repaired to ensure there are no exposed parts. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The maintenance supervisor/designee will conduct audits five times per week for two months, four times per week for one month, three times per week for one month, two times per week for one month and one time per week for one months.How will the corrective action be monitored to ensure the deficient practice will not recur? The audits will be presented to the QAPI committee monthly for review for six months or until corrective actions are no longer required.</p>		