

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 01/27/2015
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825
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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: 01/26/15 and 01/27/15</p> <p>Facility Number: 000459 Provider Number: 155567 AIM Number: 100289700</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist; Scott Wytosick, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, University Park Health and Rehabilitation Center 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and</p>	K010000		

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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K010018 SS=D	<p>battery operated smoke detectors in the resident rooms. The facility has a capacity of 104 and had a census of 58 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The facility had a garage providing facility services including the storage of maintenance supplies that was not sprinklered.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 02/04/15.</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 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>			
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K010029 SS=D	<p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 53 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/27/15 at 12:00 p.m., the Maintenance Supervisor acknowledged the corridor door to resident room 302 had a loose rubber threshold that prevented the corridor door from closing and latching into the door frame. threshold.</p> <p>3.1-19(b)</p> <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>Based on observation and interview, the</p>	K010018	<p>Corrective action: Room 302 rubber threshold was fixed 1/27/15 during survey. Other residents affected: No other resident were found to be affected. Systemic changes: During TELS rounds daily for each room reviewed the door threshold will be examined for needed repairs and that the door will close and latch into door frame. Angel rounds will also monitored for needed repairs. Corrective actions monitored: TELS rounds will be reviewed weekly to assure compliance, and then any compliance issues will be reviewed at monthly QA meeting.</p>	01/27/2015
	Based on observation and interview, the	K010029	Corrective action: Kitchen door	02/06/2015

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K010038 SS=D	<p>facility failed to ensure the corridor door to 1 of 1 kitchens, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/27/15 at 12:59 p.m., the Maintenance Supervisor confirmed the corridor door entering the kitchen from the service hall caught on a raised area of the floor and remained in the open position.</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>1. Based on observation, record review, and interview, the facility failed to ensure 53 of 58 residents without a clinical diagnosis were allowed access to 1 of 10 locked exit doors. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of</p>	K010038	<p>has been adjusted so that door opens and closes without any obstruction. Other residents affected: No resident were found to be affected. Systemic changes: Door was adjusted so that door opens and closes with any obstruction. Corrective actions monitored: Doors will be added to the TELS rounds so that doors are reviewed weekly for correct operation of the doors. Any doors found to be out of compliance will be adjusted and those doors will be reviewed at monthly QA meetings.</p> <p>Corrective action: 1. Exit code has been placed at the door indicated in survey. 2. All doors requiring signage that states "Push until alarm sounds door can be opened in 15 seconds" Have been put in place at each of these doors. Other residents affected: No residents were found to be affected. Systemic changes: 1. Exit code has been placed at the door indicated in survey. 2. All doors requiring signage that states "Push until alarm sounds door can be</p>	02/11/2015

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	<p>health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect 53 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 01/27/15 at 1:31 p.m., the main entrance/exit door was held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was not posted at the entrance/exit door. Based on an interview with the Administrator on 01/27/15 at 2:00 p.m. during the exit conference, she confirmed there were five residents with a diagnosed clinical behavior residing throughout the facility.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 10 exit doors was accessible. Health care occupancies permit delayed-egress locks if all the conditions of LSC, Section</p>		<p>opened in 15 seconds" Have been put in place at each of these doors. Corrective actions monitored: Signage will be monitored through daily TELS rounds and then reviewed at monthly QA/Safety meetings for compliance.</p>	

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K010050 SS=F	<p>7.2.1.6.1 are met. LSC 7.2.1.6(d) requires on the door adjacent to the release 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 width on a contrasting background that reads as follows: "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" This deficient practice could affect 2 resident in the south hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 01/27/14 at 12:31 p.m., the exit door from the south hall community room was equipped with electromagnetic locks that released after pushing the door for 15 seconds. The Maintenance Supervisor acknowledged the door lacked a sign adjacent to the release device.</p> <p>3.1-15(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p>			

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K010052 SS=C	<p>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>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 3 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the "Fire Drill Report" with the Maintenance Supervisor on 01/26/15 at 11:30 a.m., there was no record of a third shift fire drill for the second quarter of 2014 and a first shift fire drill for the third quarter of 2014. Based on an interview with the Maintenance Supervisor at the time of record review, no other documentation was available for review to verify this drill were conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an</p>	K010050	<p>Corrective action: Fire Drills will be conducted in accordance to the TELS schedule to ensure that each shift has a drill for the quarter. Other residents affected: No residents were found to affectedSystemic changes:Fire Drills will be conducted in accordance to the TELS schedule to ensure that each shift has a drill for the quarter. Corrective actions monitored: Fire drills will be reviewed each month during QA and Safety meetings to assure compliance and to review any issues found during the drill.</p>	02/11/2015

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	<p>approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure transmission of the fire alarm signal to the monitoring station was verified for 2 of the last 4 completed quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. NFPA 72, 1999 Edition, National Fire Alarm Code at 7-3.2.20 Testing Frequencies of Off-Premises Transmission Equipment requires quarterly testing. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor of "Fire Drill Report" on 01/26/15 p.m., the fire alarm inspection documentation, the sprinkler inspection documentation and the fire drill documentation lacked verification of the transmission of the fire alarm signal to the monitoring station for the first and fourth quarter of 2014. Based on interview at the time of review, the Maintenance Supervisor stated no other documentation was available for review.</p>	K010052	<p>Corrective action: The monitoring company will be called to verify alarm was transmitted to them during fire drill and the time recorded on the fire drill document. Other residents affected: No residents were found to be affected. Systemic changes: The monitoring company will be called to verify alarm was transmitted to them during fire drill and the time recorded on the fire drill document. Corrective actions monitored: Fire drills will be reviewed each month during QA and Safety meetings to assure compliance and to review any issues found during the drill.</p>	02/11/2015

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K010054 SS=C	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure 41 of 41 smoke detectors were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it</p>	K010054	<p>Corrective action: All smoke detectors have been check for sensitivity. Inspection was done by ASG 4/20/2014 inspection and testing document is on file. Other residents affected: No residents were affected. Systemic changes: All smoke detectors have been check for sensitivity. Inspection was done by ASG 4/20/2014 inspection and testing document is on file. Sensitivity testing will be done as regulations state. Corrective actions monitored: Inspection and sensitivity test documents will be reviewed at monthly QA/Safety meeting. Any issues with the smoke deectors will be addressed immediatly and any issues will be reviewed at the monthly QA/Safety meeting.</p>	02/26/2015

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	<p>shall be tested using any of the following methods:</p> <p>(1) Calibrated test method</p> <p>(2) Manufacturer's calibrated sensitivity test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview during the record review process at 1:05 p.m. on 01/27/15, the Maintenance Supervisor was unable to provide documentation to confirm all 41 smoke detectors throughout the facility had received a smoke detector sensitivity test.</p> <p>3.1-19(b)</p>						

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K010062 SS=D	<p>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</p> <p>Based on observation and interview, the facility failed to replace the loaded sprinkler head 8 of 15 south hall resident rooms and 1 of 3 nurses' stations. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 2 of 16 residents in the East hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 01/27/15 from 11:45 a.m. to 1:31 p.m., there was paint on the sprinkler head in the closet of resident rooms 213, 300, 306, 307, 312, 313, 314, at the south nurses' station and in the restroom of resident rooms 302 and 312. This was acknowledged by the Maintenance Supervisor at the time of</p>	K010062	<p>Corrective action: The following rooms 213, 300, 306, 307, 312, 313, 314 and the restrooms in 302 and 312 have had the sprinkler heads replaced. Sprinkler system will be inspected and tested per regulation. Other residents affected: No residents were affected. Systemic changes: The following rooms 213, 300, 306, 307, 312, 313, 314 and the restrooms in 302 and 312 have had the sprinkler heads replaced. Sprinkler system will be inspected and tested per regulation. Corrective actions monitored: Sprinkler system test and inspections will be reviewed through the QA/Safety meetings on the months that the test and inspections are done.</p>	02/13/2015			

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K010066 SS=E	<p>observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</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 Based on observation and interview, the facility failed to ensure 2 of 2 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient</p>	K010066	Corrective action: Signs have been posted at the two smoking areas that state Do Not Throw Cigarette Butts on Ground use Receptacle! Areas will be inspected every day by department heads during their	02/26/2015

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K010130 SS=E	<p>practice could affect at least 20 residents and facility staff who smoke cigarettes.</p> <p>Findings include:</p> <p>Based on observations and interview on 01/27/15 at 12:15 p.m. and then again at 1:20 p.m., the Maintenance Supervisor acknowledged there were 25 cigarette butts on the ground in the designated resident smoke area and at least 40 cigarette butts on the ground in the facility staff smoke area. Each area was provided with a "smokers oasis" which is a metal container with a long neck used for cigarette butts.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 5 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC</p>	K010130	<p>Angel rounds. Other residents affected: No residents have been affected. Systemic changes: Signs have been posted at the two smoking areas that state Do Not Throw Cigarette Butts on Ground use Receptacle! Areas will be inspected every day by department heads during their Angel rounds. Corrective actions monitored: Angel rounds are reviewed daily at morning meetings. Then monthly Angel rounds will be reviewed at QA/Safety meetings.</p> <p>Corrective action: 1. The breach in the fire wall in the attic fire barrier near resident room 300 has been sealed around cable bundle and the other noted 3/4" hole. 2. All 9 volt batteries have been replaced in single station smoke alarms, and this smoke alarms will be tested through the TELS program and documented. Other residents affected: No residents were</p>	02/26/2015

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	<p>8.2.3.2.4.2 requires 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:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 01/27/15 at 1:24 p.m., the attic fire barrier wall near</p>		<p>affected. Systemic changes: The breach in the fire wall in the attic fire barrier near resident room 300 has been sealed around cable bundle and the other noted 3/4" hole.</p> <p>2. All 9 volt batteries have been replaced in single station smoke alarms, and this smoke alarms will be tested through the TELS program and documented. Corrective actions monitored: Fire walls and battery/testing will be monitored through the TELS program and reviewed at Monthly QA/Safety meetings.</p>	

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K010144 SS=F	<p>resident room 300 had an unsealed penetration measuring one half inch around a bundle of data cables and another hole measuring three fourths inch. This was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a battery testing and replacement program was provided to ensure 53 of 53 single station smoke alarms would operate. This deficient practice affects all 58 residents.</p> <p>Findings include:</p> <p>Based on record review and interview on 01/26/15 at 1:20 p.m., the Maintenance Supervisor acknowledged the facility did not have documentation of a battery testing and replacement program for the fifty three single station smoke alarms installed in resident rooms.</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.</p>						

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	<p>3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to maintain 1 of 1 generators in proper working order. NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-3.1, states the emergency power supply system (EPSS) shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. NFPA 110, Section 6-4.7 states, the routine maintenance and operational testing program shall be overseen by a properly instructed individual. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>a. Based on observation and interview on 01/27/15 from 11:16 a.m. to 11:30 a.m., the Maintenance Supervisor acknowledged he was unable to manually start the generator. At 11:30 a.m., there were no trouble indicator lights illuminated nor audio alarms to indicate there was a problem with the emergency generator.</p> <p>b. Based on record review with the Maintenance Supervisor on 01/26/15 at 12:08 p.m., the Cummins annual generator inspection dated 12/22/14 stated "Battery 3 years old recommend</p>	K010144	<p>Corrective action: Generator has been seen by contract company and a default switch was replaced. At the January 2014 inspection it was noted that the battery was 3 years and the battery was replaced in May of 2014, the battery is not due to be replaced for another 2 years. Inspections will continue to be done as required by regulations Other residents affected: No residents were affected Systemic changes: Generator has been seen by contract company and a default switch was replaced. At the January 2014 inspection it was noted that the battery was 3 years and the battery was replaced in May of 2014, the battery is not due to be replaced for another 2 years. Inspections will continue to be done as required by regulations Corrective actions monitored: Monitoring of the Generator is done through the TELS program and will be reviewed monthly at QA/Safety meetings to assure compliance.</p>	01/30/2015			

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	<p>replacement due to age, failed battery charging alternator". Based on interview with the Maintenance Supervisor at the time of record review, he was unable to provide documentation the battery was replaced or ordered.</p> <p>3.1-19(b)\</p> <p>2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 2 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p>			

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K010147 SS=D	<p>Findings include:</p> <p>Based on record review of the generator log "Test Generator" with the Maintenance Supervisor 01/26/15 at 1:07 p.m., there was no documentation of a generator load test for the months of March and June 2014. Based on an interview with the Maintenance Supervisor at the time of record review, he was not employed with the facility at that time and was unable to provide additional documentation.</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>1. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes</p>	K010147	Corrective action: The wiring above the ceiling light fixture has been repaired in the Housekeeping office. Flexible cord was removed from residents room 200. Other residents affected: No other residents were found to be affected. Systemic changes: The wiring above the ceiling light fixture has been repaired in the Housekeeping office. Flexible cord was removed from residents	02/26/2015

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	<p>shall be provided with covers compatible with the box. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 01/27/15 at 11:38 a.m., the Maintenance Supervisor acknowledged there was exposed wiring above the ceiling light fixture in the Housekeeping office.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 1 resident in resident room 200.</p> <p>Findings include:</p> <p>Based on observation on 01/26/15 at 11:22 a.m., the Maintenance Supervisor acknowledged a refrigerator was receiving power from an extension cord</p>		<p>room 200. Corrective actions monitored: TELS rounds will be reviewed weekly to assure compliance, and then any compliance issues will be reviewed at monthly QA meeting.</p>				

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	power strip in resident room 200. 3.1-19(b)				