

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155389	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/21/2015
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NAME OF PROVIDER OR SUPPLIER  WESTPARK A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222
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K 0000  Bldg. 01	<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: 07/21/15</p> <p>Facility Number: 000473 Provider Number: 155389 AIM Number: 100290410</p> <p>At this Life Safety Code survey, Westpark a Waters Community 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 consisted of two sections: the original section determined to be Type III (200) construction and the Addition was determined to be Type V (000) construction. The facility is fully sprinklered except for the women's restroom by the west nurses station. The facility has a fire alarm system with</p>	K 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.</p> <p><b>Facility is requesting paper compliance for all deficiencies in this POC.</b></p>	
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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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K 0018 SS=E Bldg. 01	<p>smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The entire facility was surveyed as Type V (000) construction. The facility has a capacity of 89 and had a census of 58 at the time of this visit.</p> <p>The facility has elected to utilize a Categorical Waiver pertaining to clean waste and patient record recycling containers.</p> <p>All areas where the residents have customary access were sprinklered. The facility has two detached storage sheds which were not sprinklered.</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 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. Based on observation and interview, the</p>	K 0018		08/20/2015

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K 0025	<p>facility failed to ensure 1 of over 75 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing and latching and would resist the passage of smoke. This deficient practice could affect 20 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:35 a.m. to 12:15 p.m. on 07/21/15, the corridor door to the Main Dining Room by the west entrance to the kitchen was propped in the fully open position with a door wedge on the floor. Based on interview at the time of observation, the Administrator acknowledged the aforementioned corridor door failed to resist the passage of smoke and provided an impediment to closing and latching.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>It is the intent of this facility to ensure that all doors are provided with a means suitable for keeping the door closed.</p> <p><b>A. Actions Taken:</b></p> <p>1 One magnetic door holder will be ordered and purchased by compliance date. The magnetic door holder will be installed upon receipt.</p> <p><b>B. Others Identified:</b></p> <p>1 No residents were affected</p> <p><b>C. Measures Taken:</b></p> <p>1 All doors were inspected and tested to meet set standards. The maintenance director/designee will inspect and audit all doors as part of the monthly preventative maintenance program to ensure proper closure.</p> <p><b>D. How Monitored:</b></p> <p>1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing.</p>	

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SS=E Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> 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 openings through 2 of 14 smoke barrier walls were protected to maintain the fire resistance rating of the smoke barrier wall. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect 75 residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the facility from 10:35 a.m. to 12:15 p.m. on 07/21/15, the following was noted: a. a two inch by two inch hole in the attic smoke barrier wall for the passage of</p>	K 0025	<p>It is this facilities intent to ensure that smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3.</p> <p>A. ACTIONS TAKEN:</p> <p>1 The two inch by two inch hole in the attic smoke barrier wall for the passage of twenty data cables has been closed with appropriate dry wall and fire caulk on 8/3/15.</p> <p>2 The two inch by two inch hole in the attic smoke barrier wall for the passage of ten data cables has been closed with appropriate dry wall and fire caulk on 8/3/15.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1 No residents were affected</p>	08/20/2015
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K 0029 SS=E Bldg. 01	<p>twenty data cables was noted above the corridor door set by Room 7.</p> <p>b. a two inch by two inch hole in the attic smoke barrier wall for the passage of ten data cables was noted above the corridor door set by the east nurses' station. Based on interview at the time of the observations, the Maintenance Director acknowledged the openings in the aforementioned smoke barrier walls did not maintain the fire resistance rating of the smoke barrier walls.</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 facility failed to ensure 1 of 6 hazardous areas such as paint and repair shops were separated from other areas by self closing</p>	K 0029	<p>C. MEASURES TAKEN:</p> <p>1 Following any work by contractor the maintenance director/designee will observe as well as audit the work space and ensure that there is no breach in any firewalls.</p> <p>D. HOW MONITORED:</p> <p>1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing</p> <p>It is the intent of this facility for doors to latch in the door frame when closed to keep the door tightly closed and for doors to hazardous</p>	08/20/2015

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	<p>doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire alarm system. This deficient practice could affect 14 residents, staff and visitors in the vicinity of the former Therapy Gym.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:35 a.m. to 12:15 p.m. on 07/21/15, the former Therapy Gym had been converted to a paint storage room and maintenance repair shop. The corridor entry door to the aforementioned room was not equipped with a self closing device. Based on interview at the time of observation, the Maintenance Director stated the room was being utilized as a paint storage room and maintenance repair shop and acknowledged the entry door from the corridor was not equipped with a self closing device.</p> <p>3.1-19(b)</p>		<p>areas be closed automatically</p> <p>A. ACTIONS TAKEN:</p> <p>1 The corridor entry door to the aforementioned room has been equipped with a self- closing device as an automatic door closure has been installed.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1 A 100 percent audit was completed on doors with no other findings. No residents were affected.</p> <p>C. MEASURES TAKEN:</p> <p>1 The Maintenance director/designee will complete a monthly audit on all doors as a part of the monthly preventative maintenance program and any issues will be immediately addressed.</p> <p>D. HOW MONITORED:</p> <p>1 QA committee will be responsible for the oversight of maintenance documentation</p>	

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K 0046 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on record review, observation and interview; the facility failed to document testing of emergency lighting in accordance with LSC 7.9 for 5 of 12 battery powered lights for the most recent 12 month period. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test to be conducted at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ -hr duration.</p> <p>Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Battery Operated Emergency Lights - Test Log for 2014 and 2015" documentation with the Maintenance Director during record</p>	K 0046	<p>monthly and ongoing.</p> <p>It is the intent of this facility to provide periodic testing of Emergency lighting equipment at 30 day intervals for not less than 30 seconds and an annual test to be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration.</p> <p>A. ACTIONS TAKEN:</p> <p>1 Annual testing for not less than 1 ½ hour duration for the battery powered emergency light located at the emergency generator was conducted along with monthly testing of all battery powered emergency lights.</p> <p>B. OTHERS IDENTIFIED:</p> <p>1 A 100 percent audit was completed on all battery operated emergency lights with no findings. No residents were affected.</p>	08/20/2015

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	<p>review from 9:05 a.m. to 10:35 a.m. on 07/21/15, the following was noted:</p> <p>a. documentation of annual testing for not less than 1 ½ -hr duration for the battery powered emergency light located at the emergency generator for the most recent twelve month period was not available for review. The most recent documented annual testing was on 05/07/14.</p> <p>b. documentation of monthly functional testing documentation for battery powered emergency lights located at the emergency generator, by Room 42, by Room 43, by Room 46-47 and the nurses station room for the six month period of January 2015 through June 2015 was not available for review.</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:35 a.m. to 12:15 p.m. on 07/21/15, battery powered emergency lights were noted in the facility at the aforementioned locations and each battery powered emergency light operated when its respective test button was depressed.</p> <p>Based on interview at the time of record review and of the observations, the Maintenance Director acknowledged documentation of annual testing for not less than 1 ½ -hr duration for the most recent twelve -month period for the emergency generator and monthly functional testing documentation for the</p>		<p>C. MEASURES TAKEN:</p> <p>1 The Maintenance director/designee will complete monthly and annual testing on all battery operated emergency lights and document per policy. A complete audit on all battery operated emergency lights will be a conducted monthly and annually as part of the monthly preventative maintenance program.</p> <p>D. HOW MONITORED:</p> <p>1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing</p>	

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K 0050 SS=F Bldg. 01	<p>aforementioned battery powered emergency lights for the six month period of January 2015 through June 2015 was not available for review.</p> <p>3.1-19(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 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 document fire drills conducted on the third shift for 1 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of "Fire Drill Report" documentation with the Maintenance Director during record review from 9:05 a.m. to 10:35 a.m. on 07/21/15, documentation of a fire drill conducted on the third shift in the first quarter of 2015 was not available for review. Based on interview at the time of record review,</p>	K 0050	<p>The facility's intent is to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. A. <b>ACTIONS TAKEN:</b> 1. Fire drills will be conducted at unexpected times under varying conditions. Fire drills that are conducted will be documented. B. <b>OTHERS IDENTIFIED:</b> No residents were affected. C. <b>MEASURES TAKEN:</b> 1. Maintenance director/designee will document fire drills and ensure they are conducted on all shifts at unexpected times under varying conditions. D. <b>HOW MONITORED:</b> 1 QA committee will be responsible for the oversight of maintenance documentation monthly and</p>	08/20/2015

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K 0056 SS=E Bldg. 01	<p>the Maintenance Director acknowledged documentation of a fire drill conducted on the third shift in the first quarter of 2015 was not available for review.</p> <p>3.1-19(b) 3.1-19(ff)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to ensure a sprinkler head was installed in all facility restrooms to provide coverage for all portions of the building. This deficient practice could affect 14 residents, staff and visitors in the vicinity of the women's restroom by the west nurses' station.</p> <p>Findings include:  Based on observation with the</p>	K 0056	<p>ngoing.</p> <p>It is this facilities intent that is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the installation of sprinkler systems, to provide complete coverage for all portions of the building. <b>A. Actions Taken:</b> 1 An automatic sprinkler head was installed in the women's restroom by the west nurses station. <b>B. Others Identified:</b> 1 No residents were affected. <b>C. Measures Take:</b> 1. The systemic change that the facility has made is adding an</p>	08/20/2015

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K 0062 SS=C Bldg. 01	<p>Administrator and the Maintenance Director during a tour of the facility from 10:35 a.m. to 12:15 p.m. on 07/21/15, the women's restroom by the west nurses' station was not sprinklered. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the women's restroom by the west nurses' station was not sprinklered.</p> <p>3.1-19(b)</p> <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 provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 2-4.1.4 requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types</p>	K 0062	<p>automatic sprinkler head to the women's restroom by the west nurses station. 2. 100 percent audit of all facility restrooms to ensure that each restroom has an automatic sprinkler head. No additional findings. The maintenance director/designee will inspect all rooms to ensure that there is complete coverage for all portions of the building as part of the monthly preventative maintenance program. <b>D. How Monitored:</b>. 1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing.</p> <p>It is the intent of this facility to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25.</p> <p>A. ACTIONS TAKEN:</p> <p>1 Sidewall sprinkler complete supplies have been delivered to this building for back up and stored appropriately.</p>	08/20/2015

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K 0064 SS=F Bldg. 01	<p>and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents, staff and visitors if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:35 a.m. to 12:15 p.m. on 07/21/15, two sidewall sprinklers were installed in the maintenance storage room by the southeast exit for the facility. No spare sidewall sprinklers were located on the premises in the spare sprinkler cabinet in the sprinkler riser room. Based on interview at the time of observation, the Maintenance Director acknowledged no spare sidewall sprinklers were located on the premises in the spare sprinkler cabinet.</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</p>		<p>B. OTHERS IDENTIFIED:</p> <p>1 No residents were affected</p> <p>C. MEASURES TAKEN:</p> <p>2 The systemic change that the facility has made is ordering sidewall sprinkler complete supply to have for back up.</p> <p>3 100 percent audit of all facility sprinkler heads to ensure there are spares for each. No additional findings. The maintenance director/designee will inspect all sprinkler head supplies and ensure that there are back up sprinkler head supplies for each type of sprinkler head as part of the monthly preventative maintenance program.</p> <p>D. HOW MONITORED:</p> <p>1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing</p>	

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NAME OF PROVIDER OR SUPPLIER  WESTPARK A WATERS COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 1316 N TIBBS AVE INDIANAPOLIS, IN 46222
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	<p>Based on observation and interview, the facility failed to inspect 11 of 14 portable fire extinguishers in the facility 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 that it is in its designated place, it has not been actuated or tampered with and there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observations with the Administrator and the Maintenance Director during a tour of the facility from 10:35 a.m. to 12:15 p.m. on 07/21/15, the following was noted:</p> <p>a. the annual maintenance tag attached to the portable fire extinguishers located in the Assist Dining Room and in the kitchen by the range hood each indicated a monthly inspection was not</p>	K 0064	<p>It is the intent of this facility to inspect all portable fire extinguishers in the facility each month. A. ACTIONS TAKEN: 1 All facility portable fire extinguishers have been inspected and documented per policy. B. OTHERS IDENTIFIED: 1 No residents were affected C. MEASURES TAKEN: 1 A 100 percent audit of the facilities fire extinguishers have been audited to ensure that all fire extinguishers have been inspected and documented. No additional findings. The Maintenance director/designee will complete a monthly audit on all fire extinguishers as a part of the monthly preventative maintenance program and any issues will be immediately addressed D. HOW MONITORED 1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing</p>	08/20/2015

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K 0144 SS=F Bldg. 01	<p>documented for March 2015 through June 2015.</p> <p>b. the annual maintenance tag attached to the portable fire extinguishers located by Room 2, at the west nurses' station, in the Laundry room on the soiled linen side, in the kitchen for the K Class extinguisher, in the kitchen for the ABC extinguisher, by the staff restroom outside the kitchen, by Room 25, in the Salon Spa and by Room 43 each indicated a monthly inspection was not documented for June 2015. Based on interview at the time of the observations, the Maintenance Director stated no additional documentation of monthly fire extinguisher checks was available for review and acknowledged a monthly inspection for the aforementioned portable fire extinguisher locations was not documented for each month.</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.</p> <p>1. Based on record review and interview, the facility failed to ensure a monthly load test for the emergency generator was conducted for 1 of 12 months using one of the three following methods: under</p>	K 0144	It is this facilities intent that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA99.	08/20/2015

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	<p>operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. 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 affect all residents, staff and visitors.</p> <p>Findings include:</p>		<p><b>A. ACTIONS TAKEN:</b></p> <p>1. Weekly generator test and monthly load test will be completed by maintenance director/designee and documented.</p> <p><b>B. OTHERS IDENTIFIED:</b></p> <p>1. No residents were affected.</p> <p><b>C. MEASURES TAKEN:</b></p> <p>1. Weekly generator test and monthly load test will be completed by maintenance director/designee. Appropriate documentation will be maintained.</p> <p><b>D. HOW MONITORED:</b></p> <p>1 QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing.</p>	

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	<p>Based on review of "Emergency Generator - Monthly Test Log" documentation with the Maintenance Director during record review from 9:05 a.m. to 10:35 a.m. on 07/21/15, documentation of monthly load testing for June 2015 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged monthly load testing documentation for June 2015 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections of the starting batteries for the emergency generator was maintained for 5 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 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 checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection,</p>			

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K 0147 SS=E Bldg. 01	<p>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, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Weekly Inspection Checklist" documentation with the Maintenance Director during record review from 9:05 a.m. to 10:35 a.m. on 07/21/15, documentation of weekly inspections of the starting batteries for the emergency generator for the five week period of 06/01/15 through 07/03/15 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged documentation of weekly inspections of the starting batteries for the emergency generator for the aforementioned five week period was not available for review.</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 Based on observation and interview, the facility failed to ensure 1 of 1 extension</p>	K 0147	It is this facilities intent to ensure	08/20/2015

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	<p>ords including power strips were not used as a substitute for fixed wiring. NFPA 70, Article 400-8 requires, 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 14 residents, staff and visitors in the vicinity of the Housekeeping and Laundry Supply Room by Room 21.</p> <p>Findings include:</p> <p>Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 10:35 a.m. to 12:15 p.m. on 07/21/15, a refrigerator was plugged into a power strip in the Housekeeping and Laundry Supply Room by Room 21. Based on interview at the time of observation, the Administrator acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location.</p> <p>3.1-19(b)</p>		<p>that electrical wiring and equipment is in accordance with NFPA70.</p> <p><b>A. ACTIONS TAKEN:</b></p> <p>1. Power strip removed from housekeeping and laundry supply room.</p> <p><b>B. OTHERS IDENTIFIED:</b></p> <p>1. No residents were affected.</p> <p><b>C. MEASURES TAKEN:</b></p> <p>1. 100 percent audit of all electrical outlets to ensure that there are zero findings of using a power strip as a substitute for fixed wiring.</p> <p>2. Maintenance director/designee will audit all rooms as part of the monthly preventative maintenance program to ensure that electrical wiring and equipment is in accordance with NFPA70.</p> <p><b>D. HOW MONITORED:</b></p> <p>1. QA committee will be responsible for the oversight of maintenance documentation monthly and ongoing.</p>		