STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155234	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTRIDGE HEALTH CARE CENTER	125 W MARGARET AVE TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	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). Survey Date: 02/12/14 Facility Number: 000139 Provider Number: 155234 AIM Number: 100266410 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Westridge Health Care 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. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces	K010000	Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under State and Federal law.Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802	

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	open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 66 and had a census of 56 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except the detached laundry and maintenance storage areas. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/18/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K010018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 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 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 3 of 4 smoke compartments could automatically latch and hold doors tightly in their door frames and prevent the passage of smoke. This deficient practice affects staff, visitors and 10 or more residents in the north south and east smoke compartments. Findings include: Based on observation with the maintenance director and administrator on 02/12/14 between 10:30 a.m. and 2:30 p.m., doors protecting openings to the corridor: a. for the south medicine room did not	K010018	1. a. The latch for the south medication room was properly repaired and remains latched when closed on 02/21/14.b. The latches for resident rooms 116 and 220 were properly repaired and remain latched when closed on 02/13/14.c. A latch was applied to the extra supply room door and the two inch diameter hole was repaired on 02/24/14.2. All residents have the potential to be affected. If a door latch is discovered that does not automatically latch and/or hold the door tightly, maintenance will be notified for needed repair.3. Maintenance will add an audit of latched doors to the weekly preventative maintenance routine to identify any doors that are in need of repair.4. Maintenance will inspect doors to ensure proper latch closure and that the	02/24/2014

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	latch reliably into the door frame. The door was closed and latch engaged but the door could be opened. The maintenance director relocked the door and the door was secure. A second attempt to open the door allowed it to open by pushing on the door; b. for resident rooms 116 and 220 had latches which did not work. The doors could be pushed open without using the door knob to disengage the latch; c. for the extra supply room behind the north hall nurses station had no latch to keep the door closed and had a two inch diameter hole in the door where a lock had been removed. The maintenance director acknowledged at the time of observations, the doors could not latch tightly into their door frames and prevent the passage of smoke. 3.1-19(b)		door holds tightly when closed; Weekly for the next 90 days during routine preventative maintenance rounds, then quarterly thereafter. The inspection will be added to the Preventative Maintenance Book.5. Completion Date: February 24, 2014	

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K010029 SS=E	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 Based on observation and interview, the facility failed to ensure openings through ceiling smoke barriers in 1 of 4 smoke compartments were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 10 or more residents in the east smoke compartments. Findings include:	K010029	1. The twelve inch duct penetrating the boiler room ceiling was sealed with flame retardant caulk to maintain smoke resistance on 02/27/14.The expandable foam and gray caulk was removed and filled with flame resistant caulk to maintain smoke resistance on 02/27/14.The expandable foam located at the meeting edge of the ceiling drywall was properly repaired to completely cover and seal the ceiling on 02/27/14.All drywall was completed with drywall tape and flame resistant caulk to seal the gaps on 02/28/14.2. All residents have the potential to be affected.3. During routine preventative maintenance rounds, any openings discovered through smoke barriers will be repaired.4. Maintenance will inspect ceiling penetrations during routine preventative maintenance inspections and ensure the	02/28/2014

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	Based on observation with the maintenance director and administrator on 02/12/14 at 11:10 a.m., one twelve inch duct penetrating the boiler room ceiling was unsealed leaving a one half inch gap around the duct. A second twelve inch duct penetrating the ceiling had been sealed with expandable foam and covered with a gray caulk. The foam was exposed because some of the caulk had fallen away. Additionally, a ceiling repair had been made by piecing sheets of dry wall together. The drywall did not cover the area completely exposing a one inch by ten inch area of expandable foam at the meeting edge between the ceiling drywall and wall. The other drywall had not been taped and gaps of 1/4 to 3/8 inch into the attic above were visible. The maintenance director agreed at the time of observations, the openings had not been properly sealed. 3.1-19(b)		openings are sealed with proper smoke resistant material.5. Completion Date: February 28, 2014	

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K010046 SS=F	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. 1. Based on record review and interview, the facility failed to provide complete documentation of 30 second periodic testing at 30 day intervals and annual testing for 1 1/2 hours of 12 of 12 battery powered emergency lighting fixtures. LSC 7.9.3 requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for not less than 30 seconds and an annual test shall be conducted for not less than 1 1/2 hours. Written records of visual inspections and tests shall be kept. This deficient practice could affect all occupant. Findings include: Based on review of the Monthly Preventive Maintenance Calendar and the maintenance director's maintenance notebook log with the maintenance director and administrator on 02/12/14 between 2:15 p.m. and 2:35 p.m., the last monthly note on the preventive maintenance calendar for battery powered emergency light fixture testing was dated 11/15/13 and read, "all 12	K010046	1. All twelve battery powered emergency lighting fixtures were tested to ensure compliance on 02/26/14. For each fixture, the location and test results were noted.The battery powered emergency lighting provided for the emergency generator will be replaced. The generator was ordered on 02/25/14.2. All residents have the potential to be affected.3. The battery powered emergency lighting for the emergency generator will be tested weekly as part of the Preventative Maintenance Emergency Generator testing. Any malfunction noted will be immediately reported to the administrator and repaired.4. Maintenance will include weekly testing and the results will be presented to the Quality Assurance Committee for review. Any non-compliance will be immediately corrected.5. Completion Date: March 14, 2014	03/14/2014

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	emergency lites OK." There was nothing to identify the location of each fixture and the test results for each fixture. A calendar entry noted a ninety minute test for all the devices on 1/31/14. The maintenance director acknowledged at the time of record review, there was no way to tell if every fixture had been individually tested, what the test consisted of, and the results for each device. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 12 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect all occupants if the generator task lighting were needed to maintain and repair the generator during a power outage. Findings include: Based on observation with the maintenance director and administrator on 02/12/14 at 12:30 p.m., the battery powered emergency lighting provided for the emergency generator site was tested three times. The bulbs would			

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	flicker each time but could not remain illuminated. The maintenance director said at the time of observation, "I wrote a work order on it." He said he was the person to repair or replace the fixture and he thought ice fell from a gutter above the fixture and damaged it. 3.1-19 (b)			

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K010051 SS=F	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 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 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice affects all occupants. Findings include: Based on observation with the maintenance director and administrator	K010051	1. The emergency power circuit panel will be properly secured and identified by the new generator that was ordered on 02/25/14. The fire alarm system circuit breaker was identified with red marking legend on 02/13/14.The emergency power circuit breaker panels will be secured.2. All residents have the potential to be affected.3. Maintenance will ensure all emergency power circuit breaker panels are secured and identified during routine preventative maintenance rounds.4. Maintenance will include an audit of power circuit breaker panels for identification and security at the next Quality Assurance	03/14/2014

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	on 02/12/14 at 1:00 p.m., the maintenance director identified the emergency power circuit breaker panel in the east hall corridor. It was covered by a framed decoration. The panel was otherwise unsecured and unidentified. The fire alarm system circuit breaker located in the identified emergency power breaker box lacked identification. The maintenance director said at the time of observation, the fire alarm circuit breaker was on this panel. The legend for the circuit breakers did not identify a fire panel circuit and none was marked with a red marking. He agreed there was no means to identify the circuit and the panel was easily accessible for unauthorized persons. 3.1-19(b)		Committee meeting. Any non-compliance will be reported and immediately corrected.5. Completion Date: March 14, 2014	

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K010052 SS=F	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 approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to properly test and maintain 1 of 1 fire alarm systems in accordance with NFPA 72. NFPA 72, 3-8.1 allows fire alarm system components to share control equipment or operate as stand alone systems, but in any case, they shall be arranged to function as a single system. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all occupants. Findings include: Based on observation with the maintenance director and administrator on 02/12/14 at 1:10 p.m., the automatic dialer component was disconnected to simulate trouble from phone line failure. No local trouble signal was initiated on the fire panel located at the nurses'	K010052	1. A new generator has been ordered and will be installed. The new generator will allow the fire alarm system components to provide trouble signals on the fire panel located at the nurses station.2. All residents could be affected. The new generator will be capable to initiate trouble from phone line failure at the fire panel located at the nurses station.3. Maintenance will ensure the generator alerts the fire alarm system components during weekly routine preventative maintenance rounds.4. Maintenance will include an audit of test results of the fire alarm system components to provide trouble signals at the next Quality Assurance Committee meeting. Any non-compliance will be reported and immediately corrected.5. Completion Date: March 14, 2014 Addendum 1. What measures have been put in place or what systemicchanges have been made to ensure the trouble signal from the dialer will besent to a monitored location? The phone system has been serviced and repaired. The troublesignal from	03/14/2014

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	station. The maintenance director acknowledged at the time of observation, no trouble signal showed on the control panel. He commented, "we get a call from the alarm company when the phone lines are down." 3.1-19(b)		the dialer will automatically be sent to a monitored location. 2. How the corrective action will be monitored to ensure thedeficient practice will not reoccur? As a measure of ongoing compliance the Maintenance Directoror designee will check to ensure the trouble signal from the dialer is sent toa monitored location monthly ongoing. Any problems noted will be addressedaccordingly. 3. The Maintenance Director or designee is responsible forsaid monitoring.	
K010062 SS=F	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 Based on observation and interview, the facility failed to ensure sprinkler piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants. Findings include:	K010062	1. The bundles of cables and wires will be removed from the sprinkler pipes and provided with separate hangers.2. All residents have the potential to be affected.3. Maintenance will inspect sprinkler pipes to ensure they are free of cables and wires and are not used for a means of support.4. Maintenance will include an audit of sprinkler pipes to ensure they are maintained free of external loads at the next Quality Assurance Meeting. Any	03/14/2014

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	Based on observation with the maintenance director on 02/12/14 at 11:10 a.m., attic sprinkler pipes were observed above the east wing near the smoke barrier. Bundles of cables and wires were using the sprinkler pipes for support. The maintenance director said at the time of observation, he was unaware the wire and cables were not supported by hangers in the attic. 3.1-19(b)		non-compliance will be reported to the administrator and immediately corrected.5. Completion Date: March 14, 2014	

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K010066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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, interview, and record review; the facility failed to enforce requirements for 1 of 1 facility wide smoking policies. This deficient practice affects staff, visitors and 10 or more residents in and around exits for the east and north halls where evidence of smoking was observed. Findings include: Based on observation with the maintenance director and administrator on 02/12/14 between 11:15 a.m. and	K010066	1. The trash receptacle have been clearly marked "Trash Only", for both the East and North designated smoking areas. The self-closing metal containers have been clearly marked "Cigarettes Only", for both the East and North designated smoking areas.One of the two self-closing metal containers was relocated to the North wing exit patio areas.The North exit was added to the facility Smoking Policy as a designated areas for a smoking area.Emptying of ashtrays and trash and cleaning of cigarette butts have been	02/13/2014

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NAME OF PROVIDER OR SUPPLIER WESTRIDGE HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 125 W MARGARET AVE TERRE HAUTE, IN 47802	

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	12:35 p.m., a designated smoking area outside the south, east wing exit had two self closing metal containers and a butt tower for the disposal of cigarette waste. One container had cigarette butts and paper and plastic wrappers. Another trash container in the area was identified by the administrator at the time of observation, as the receptacle for trash other than cigarette butts. It was almost full with accumulated plastic and paper waste and a collection of cigarette butts. Two cigarette butts were observed on the ridged mat on the patio outside the facility entry door. Outside the north wing exit neat the nurses station a self closing metal ashtray full of cigarette butts was observed resting on top of the trash can provided for the area. The administrator said upon this observation, this area was not a designated smoking area but smokers came to this patio when there was inclement weather on the east side of the building where smoking was designated in the facility policy. The trash can held an accumulation of plastic and paper wrappings and cigarette butts. There was no self closing metal container for disposal of the butts filling the ashtray. At 2:25 p.m. on 02/12/14, the Smoking Policy was reviewed with the administrator and maintenance director. The policy identified "Designated		added to the daily routine of the housekeeping department. The smoking areas were cleaned of cigarette butts. 2. All residents have the potential to be affected. The housekeeping department has added the smoking areas to their daily routine to ensure ashtrays, trash and cigarette butts remain picked up and emptied timely.3. The housekeeping department will include the smoking areas as part of their routine.4. The housekeeping supervisor will include an audit of smoking areas to include that cigarette butts and trash are not combined. The areas are clean of cigarette butts and self-closing metal containers are in use at the next Quality Assurance Committee meeting. Any non-compliance will be reported and immediately corrected.5. Completion Date: February 13, 2014	

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	area(s) for smoking: Outside on patio east hall nurses' station. Severe Weather Conditions 3." noted the smoking site could be relocated but there was nothing to say where the relocation site would be or the protocol for emptying ashtrays. 3.1-19(b)			
K010072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 1. Based on observation and interview, the facility failed to ensure egress for 1 of 10 exits was maintained. This deficient practice could affect residents, staff and 10 or more residents on the east wing. Findings include: Based on observation with the maintenance director and administrator on 02/12/14 at 11:30 a.m., a curtain rod with three floor to ceiling curtains hung across the corridor access to the east emergency exit from the east wing. The curtains obstructed visibility and access	K010072	1. The curtains were removed from the east emergency exit of the East Wing.All emergency exit discharges were cleared of ice and snow.2. All residents have the potential to be affected.3. Maintenance will ensure all egress exits are not obstructed and that all exterior exit discharges remain free of hazards during daily routine preventative maintenance.4. Maintenance will audit all egress exits and exterior exits for any signs of obstruction and hazards during routine preventative maintenance rounds. The results will be presented at the next Quality Assurance Committee meeting. Any non-compliance	02/13/2014

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	to the panic hardware for the exit door. The maintenance director acknowledged at the time of observation, the curtains had to be moved to open the doors. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 3 of 10 exterior exit discharges were maintained to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7. LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff and all residents on the three sleeping room wings Findings include: Based on observation with the maintenance director and administrator on 02/12/14 between 1:45 p.m. and 2:30 p.m.., emergency exit discharges were covered with areas of ice and snow for the south exit from the east wing, east exit from the north wing, and south exit from the south wing. The maintenance director acknowledged at		will be immediately reported to the administrator and immediately corrected.5. Completion Date: February 13, 2014	

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	the time of observations, the surfaces should have been cleared. 3.1-19(b)			
K010130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program in accordance with the manufacturer's recommendations for cleaning and replacement of battery operated smoke detectors in 56 of 56 resident sleeping rooms. LSC 4.6.12.2 requires any like safety code features obvious to the public, if not required by the Code, shall be maintained or removed. This deficient practice could affect visitors, staff and all 56 residents. Findings include: a. Based on review of the Monthly Preventive Maintenance Calendar, the maintenance director's maintenance notebook log, and maintenance and testing guidelines for the installed battery operated smoke detectors on 02/12/14 at 2:15 p.m. with the maintenance director and administrator,	K010130	1. Maintenance inspected all battery operated smoke detectors on 02/26/14.The battery operated smoke detector in resident room 214 was repaired but will also be replaced.2. All residents have the potential to be affected. Any smoke detector found to be malfunctional will be immediately replaced.3. An audit has been added to the Preventative Maintenance Program to log the inspection of all battery operated smoke detectors and noting the location and result of the inspection.4. Maintenance will audit the inspections of all battery operated smoke detectors and present the findings at the next Quality Assurance Committee meeting. 5. Completion Date: 02/26/2014	02/26/2014

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	no record of battery operated smoke detector maintenance or inspection was found. The maintenance director said at the time of observation, he pushed the test button to check the detectors in resident sleeping rooms but had never documented the task. The maintenance and testing guidelines for the installed battery operated smoke detectors noted the smoke alarms installed in each resident room were to be tested "weekly" and cleaned annually. The maintenance director said his checks had been done monthly and he did not know if the detectors had ever been cleaned since their installation in 2012. b. Based on observation with the administrator and maintenance director on 02/12/14 at 11:15 a.m., the cover for the battery operated smoke detector in resident room 214 hung from device wires. The alarm did did not sound when tested. The maintenance director put the cover in place and the alarm test sounded but the cover would not stay in place. The maintenance guidelines for the device were reviewed with the maintenance director and administrator on 02/12/14 at 2:15 p.m. They noted, "one lithium battery, permanently sealed inside the alarm, powers the unit." The maintenance director agreed at the time of record review, this device was no longer permanently sealed and could			

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	affect effective function as was demonstrated during the observation. 3.1-19(a)			
K010144 SS=F	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 observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply	K010144	1. The emergency generator will be replaced and will include an alarm annunciator in a location readily observed by operating personnel, at the nurses station. It will also contain an audible and visual derangement signal, be labeled and established at a continuous monitoring station.2. All residents have the potential to be affected.3. A new generator will be installed to have the capabilities to meet the standard set forth. Maintenance will audit the generator system as part of routine Preventative Maintenance Program according to manufacturers instructions.4. Maintenance will audit all testing results as set forth in the Preventative Maintenance Program and present the findings at the next Quality Assurance Committee meeting. Any non-compliance will be	03/14/2014

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	power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants. Findings include: Based on observations with the maintenance director and administrator on 02/12/14 between 10:30 a.m. and 2:50 p.m., a remote alarm annunciator for the emergency generator was not found. The maintenance director said at		immediately reported to the administrator and corrected.5. Completion Date: March 14, 2014	

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	2:50 p.m. on 02/12/14 there was no remote annunciator for the emergency generator. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 generators serving as an alternate source of power was maintained and capable of automatically connecting to the load within 10 seconds in the event of failure of normal power. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2 systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-5.3.2.2 requires the emergency system to be arranged so that, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load after a short delay. NFPA 99, 3-4.1.1.8 requires the the generator to start and be on line within 10 seconds. This deficient practice affects all occupants. Findings include: Based on observation on 02/12/14 at 12:25 p.m., the maintenance director made four attempts to demonstrate the			

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	operation of the generator providing emergency power to the facility. The generator turned over repeatedly but could not start. The maintenance director said he did not know why the generator failed to start since he "knew" it ran during automatic weekly load tests and he had installed a new battery in October 2013. 3.1-19(b)			
K010147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure electrical wiring and equipment was in compliance with NFPA 70, National	K010147	1. The conduit in the electrical room in the kitchen was properly secured with new conduit hangers on 02/13/14.The powerstrip was removed from the	03/14/2014

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	Electrical Code in 1 of 6 smoke compartments. NFPA 70, 1999 edition, Article 300-11(a) states raceways, cable assemblies, boxes, cabinets and fittings shall be securely fastened in place. This deficient practice could affect kitchen staff, visitors and 20 or more residents in the adjacent dining room. Findings include: Based on observation with the administrator and maintenance director on 02/12/14 at 2:15 p.m., conduit in the kitchen electrical room hung across the door opening between the electrical room and kitchen in the path of the door's swing. Upon closer inspection, one conduit hanger was broken and another did not secure the conduit. When closing the door the conduit was caught by the door. The maintenance director acknowledged at the time of observation the problem could damage the conduit. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure flexible cords were not used as a substitute for fixed wiring in 2 of 4 smoke compartments. NFPA 70 National Electrical Code, 1999 Edition, Article		employee breakroom on 02/12/14.The extension cord in room 117 was removed 02/12/14.The light fixture was replaced to a ceiling mounted fixture on 02/12/14.The junction box in the attic above the east smoke barrier will be properly covered.2. All residents have the potential to be affected. Maintenance will audit during routine Preventative Maintenance rounds. 3. Maintenance will monitor for any non-compliance during routine Preventative Maintenance rounds. All staff will monitor during their normal resident room visits. Any non-compliance will be immediately reported to the administrator and corrected.4. Maintenance will audit all corrections and present the findings at the next Quality Assurance Committee meeting. Any non-compliance will be immediately corrected.5. Date of Completion: March 14, 2014	

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	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 staff, visitors and 10 or more residents in the north and center smoke compartments. Findings include: Based on observation with the maintenance director and administrator on 02/12/14 between 10:30 a.m. and 2:20 p.m., a power strip extension cord was used to supply power to a refrigerator in room 120 and a toaster and microwave in the employee break room. An extension cord ran under the resident bed in room 117 to power a radio. The maintenance director said at the time of observation, he was unaware the cords could not be used. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure electrical wiring connections in 1 of 4 smoke compartments were maintained in a safe operating condition which included junction boxes. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient			

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	practice could affect visitors, staff and 10 or more residents in the east smoke compartment. Findings include: a. Based on observation with the maintenance director and administrator on 02/12/14 at 11:35 a.m., a light fixture was suspended by chains above one of the shower enclosures in the east wing shower room. An eight inch length of wiring ran from the ceiling to the fixture and was incompletely covered with electrical tape exposing the wires. The light switch was turned on demonstrating the wires were "live." The maintenance director acknowledged at the time of observation the installation could be unsafe. b. Based on observation with the maintenance director on 02/12/14 at 11:20 a.m., a junction box in the attic above east smoke barrier was left uncovered with multiple wires exposed. The maintenance director acknowledged at the time of observation, the box was so full it looked as though a cover would not have fit and a larger junction box was needed. 3.1-19(b)			

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