STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	155062		06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-LAPORTE	1700 I ST LA PORTE, IN 46350

(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
K 0000 Bldg. 01	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: 06/10/16 Facility Number: 000023 Provider Number: 155062 AIM Number: 100289400 At this Life Safety Code survey, Golden Living Center-Laporte 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. This one story facility with a partial basement was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has a capacity of 87 and had a census of 64 at the time of this survey.	K 0000		

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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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a block building used to store maintenance equipment which was not sprinklered. Quality Review by Lex Brashear, Life Safety Code Specialist on 06/14/16			
K 0017 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 Receptionist room was separated from the corridors by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous	K 0017	replace half door with full door an electrically supervised automatic smoke detection system will be added to receptionist area the smoke detection in this area will be added to the regularly scheduled review system the director of maintenance is responsible for ensuring that the scheduled review system is complete	07/15/2016

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	areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and (b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect staff and up to 25 residents. Findings include: Based on observation with the Maintenance Director on 06/10/16 at 11:06 a.m., the Receptionist room had only a bottom have of a door and was open to the corridor. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met because the room was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be			

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	substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3			
	1. Based on observation and interview, the facility failed to ensure 1 of 44 resident room corridor doors and 3 of 19 basement room doors had no impediment to closing. This deficient practice could affect staff and up to 30 residents. Findings include: Based on observation with the Maintenance Director on 06/10/16 between 12:00 p.m. and 12:48 p.m., the following was discovered: a) a door stop propping the Basement Employee Break room door b) a door stop propping the Basement Medical Records room door c) a door stop propping the Basement Staff Development office door	K 0018	all door stops were removed from the building and staff was educated as to the reason for not using the door stops the door in the wheelchair washing room will be repaired so that the door is resistant to smoke Maintenance director/designee will make weekly rounds to ensure that door stops are not being used through the building July 15, 2016 to Dec 31, 2016	07/05/2016

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	d) a bed with a lift attached to it prevented resident room 13 door to close into the frame. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 Wheelchair Washing Room doors were capable of resisting smoke. This deficient practice could affect staff and up to 16 residents. Findings include: Based on observation with the Maintenance Director on 06/10/16 at 1:19 p.m., the corridor door to the Wheelchair Washing Room was not smoke resistant due to a one inch hole drilled through the door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurement. 3.1-19(b)			
K 0025 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to			

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	provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barrier was maintained to provide a one hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Director on 06/10/16 from 11:37 a.m. to 1:25 p.m., the following unsealed ceiling penetrations were discovered: a) one of four ceiling tiles were missing in the Internet room b) a ten inch by seven inch ceiling penetration in the A Wing Janitor's closet c) a two and a half inch ceiling penetration in the Television room Based on interview at the time of each observation, the Maintenance Director acknowledged and provided the measurements for each unsealed penetration.	K 0025	All sited ceiling tiles will be replaced and sealed by July 15, 2016 The maintenance director will inspect the building for ceiling smoke barrier by July 22 2016 All needed repairs will be made by July 29, 2016 The maintenance director/designee will monitor monthly for any failures to the ceiling smoke barriers beginning August 1, 2016	07/05/2016

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	3.1-19(b)			
K 0029 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Kitchen with fuel fired appliances, a hazardous area, would latch into the frame. This deficient practice was not in a resident care but could affect facility staff. Findings include: Based on observation with the Maintenance Director on 06/10/16 at 12:19 p.m., the Kitchen contained fuel fired appliances. One of the Kitchen doors got caught on the frame when tested and was not able to positively latch into the frame. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.	K 0029	1. the door will be repaired to ensure that the door latches into the frame 2. the door will be repaired to ensure that it latches into the frame A self closure will be installed The maintenance director/designee will complete weekly checks on the doors from July 15, 2016 to December 31, 2016	07/08/2016

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Food Storage room greater than 50 square feet, a hazardous area, was provided with a self-closer and would latch into the frame. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on observation with the Maintenance Director on 06/10/16 at 12:29 p.m., the Food storage room contained at least one hundred cardboard boxes of food products. The corridor door did not have any self-closing hardware. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0044 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets were arranged to positively latch into the frame. LSC 19.2.2.5 requires horizontal exits to be in accordance with	K 0044	the fire doors will be adjusted to latch completely the maintenance director/designee will complete weekly checks on the door will be make beginning 7-5-16 and	07/05/2016

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	7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 28 residents. Findings include: Based on observation with the Maintenance Director on 06/10/16 at 11:31 a.m., the fire doors near resident room 24 failed to positively latch when tested. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed the set of doors were fire doors. 3.1-19(b)		ending Dec 5, 2016	
K 0046 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Based on record review and interview, the facility failed to ensure 4 of 4 battery operated emergency lights in the facility	K 0046	a 90 minute test will be conducted and recorded. All battery operated emergency lights will be in working order July 8, 2016 Going	07/08/2016

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	was maintained in accordance with LSC 7.9. LSC 7.9.3, Periodic Testing of Emergency Lighting Equipment, requires a functional test to be conducted for 30 seconds at 30 day intervals and an annual test to be conducted on every required battery powered emergency lighting system for not less than a 1 ½ hour duration. 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 throughout the facility. Findings include: Based on record review with the Maintenance Director on 06/10/16 at 10:34 a.m., the facility provided 30 second monthly testing documentation, however, based on interview at the time of record review, the Maintenance Director was unaware that an annual 90 minute test was suppose to be performed and acknowledged the aforementioned condition. 3.1-19(b)		forward the 90 minute test will be conducted annually	
K 0050 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire			

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	alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			
	Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all occupants. Findings include: Based on record review of the "Monthly Fire Drill Checklist" forms with the Maintenance Director on 06/10/16 at 10:07 a.m., the documentation for a third shift fire drill for the first quarter of 2016 was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged the lack of documentation. 3.1-19(b) 3.1-51(c)	K 0050	fire drills will be conducted according to life safety standards The Maintenance director/designee is responsible for all fire drills A schedule of fire drills through the next year will provided by the Maintenance director to the Executive Director and Director of Nursing The Ed or DON will sign off on all fire drills to ensure compliance	07/08/2016
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating			

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	condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect staff and up to 30 residents. Findings include: Based on observations with the Maintenance Director on 06/10/16 at 1:20 p.m. and again at 1:32 p.m., a cable was wrapped around the sprinkler pipe in the Assisted Dinning Room including three zip ties holding the wires to the sprinkler pipe, furthermore, six streamers and one banner was hung from the sprinkler pipe in the Dining Room. Based on interview at the time of observation, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 1 of 1 painted	K 0062	1. The Maintenance director/designee will check all sprinkler pipes through the building and remove all items (zip ties, wires, streamers etc) attached to the sprinker pipes through the building 2 the sprinkler head in the receptionist office will be replaced The maintenance director/designee will check to ensure no items are attached to the sprinkler pipes through out the building. Monitoring will be complete on a monthly bases beginning July 18, 2016	07/18/2016

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	sprinkler head in the Receptionist office. LSC 33.2.3.5.2 refers to LSC section 9.7. 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 staff and up to 25 residents. Findings include: Based on observation with the Maintenance Director on 06/10/16 at 11:06 a.m., one sprinkler head was covered with paint in the Receptionist area. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0064 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6			

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	1. Based on observation and interview, the facility failed to ensure 1 of 1 Laundry and 1 of 1 Kitchen portable fire extinguishers were installed correctly. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be not more than three and one half feet (42 inches) above the floor. This deficient practice could affect staff only. Findings include: Based on observations with the Maintenance Director on 06/10/16 at 12:09 p.m. and again at 12:12 p.m., the Laundry fire extinguisher measured 66 inches from the top of the extinguisher to the floor, furthermore, the Kitchen fire extinguisher measured 67 inches from the top of the extinguisher to the floor. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned condition and provided the measurements. 3.1-19(b) 2. Based on observation and interview,	K 0064	1. the portable fire extinguisher in the laundry and kitchen will be adjusted to met the standard 2 The elevator fire extinguisher will be replaced to meet the standard Maintenance Director/designee will make monthly checks on all facility fire extinguisher beginning July 13, 2016	07/08/2016

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	the facility failed to ensure 1 of 1 Elevator equipment fire extinguisher pressure gauge reading was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 06/10/16 at 12:12 p.m., the gauge on the portable fire extinguisher in the Elevator equipment room indicated the extinguisher was undercharged. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0075 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft			

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	155062		06/10/2016

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	(20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5			
	Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 1 of 5 corridors. This deficient practice could affect staff, visitors, and at least 22 residents. Findings include: Based on observations with the Maintenance Director on 06/10/16 at 1:52 p.m., a twenty gallon trash container was attached to a twenty gallon soiled linen container in the corridor near resident room 26. The two containers were first discovered at 11:35 a.m. and again at 1:52 p.m. The two containers were in the same spot both times and were not actively in use. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)	K 0075	CNA, nurses and housekeeping staff will be re-inservice on standards The trash and soiled linen containers will be separated by 59 sq m The containers will be placed so that hallways are accessible at all times The maintenance director/designee will monitor for the standard on a monthly basis beginning July 15, 2016	07/15/2016
K 0076 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with			

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	NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 cylinders in the Director of Nursing office and 2 of 2 cylinders in the A Wing Nurse's station medication room of nonflammable gases such as oxygen were properly chained or supported in a proper cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only. Findings include: Based on observation with the Maintenance Director on 06/10/16 at 12:55 p.m. and again at 12:58 p.m., the Director of Nursing office had one oxygen cylinder that was freestanding on the table, furthermore, the A Wing Nurses' station medication room had two separate oxygen cylinders that was	K 0076	all cylinder oxygen will be removed from the building or secured and properly chained and supported in a proper cylinder stand or cart The Maintenance Director/designee will monitor the building monthly ensure correct standard for cylinder oxygen usage Monitoring will begin July 15, 2016	07/08/2016

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	freestanding on the floor. Based on interview at the time of each observation, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetrations in 2 of 4 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 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: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a	K 0130	Both unsealed fire wall penetrations near room 25 and room 5 will be sealed according to standard The maintenance director/designee will monitor all fire walls for penetrations monthly beginning July 15, 2016 and ending December 31, 2016	07/15/2016

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	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: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect staff and up to 58 residents. Findings include: Based on an observation with the Maintenance Director on 06/10/16 at 1:54 p.m. and 1:57 p.m., there were two separate two inch unsealed fire wall penetrations around conduit above the drop ceiling near resident room 25, furthermore, there was one, half inch and one, three inch unsealed fire wall penetrations around wires above the drop ceiling near resident room 5. Based on interview at the time of each observation, the Maintenance Director acknowledged each aforementioned condition and provided the measurements. 3.1-19(b)			
K 0144	NFPA 101			

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SS=F Bldg. 01	LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) 1. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, the 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents. Findings include: Based on an observation with the Maintenance Director on 06/10/16 at 1:04 p.m., the generator annunciator panel was in a corridor twenty six feet away from A Wing Nurse's station and around a corner. The generator lights would not be visible and hearing the alarm would be unlikely. Based on an interview at the time of observation, the	K 0144	1 the annunciator panel will be moved to the nurses station 2 the generator will be repaired to ensure that the load test will met standard the annual load bank test will be conducted and recorded 3 During the monthly test the Maintenance Director/designee will allow a 5 min down period after load test and record the cool down time The generator will be monitor weekly, monthly and annually according to facility policies beginning July 15, 2016	07/15/2016

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	Maintenance Director acknowledged the aforementioned condition and confirmed that the Nurse's wouldn't be able to hear the alarm at the nurses' station. 3-1.19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 110, The Standard for Emergency and Standby Power Systems, Section 6-4.2.2 requires Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. This deficient practice could affect all staff, residents, and visitors. Findings include: Based on record review with the Maintenance Director on 06/10/16 at 10:55 a.m., the generator load testing paperwork indicated six of the last twelve months percentage of load was under thirty percent. Based on interview at the			

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	time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed that no documentation for an annual load bank test for the diesel generator was available for review. 3-1.19(b) 3. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's			

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	Emergency Generator monthly testing log with the Maintenance Director on 06/10/16 at 10:55 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition. 3.1-19(b)			
K 0147 SS=F Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 6 of 6 extension cords used for temporary use, 2 of 2 multiplugs, and 7 of 7 surge protectors 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 all occupants. Findings include:	K 0147	a the extension cord and coffee pots were removed from activities office One surge protector will be removed from powering the satellite television equipment b a new electrical plug will be installed to elimante the use of surge protector c A new electrical plug will be installed in the medication room for the refrigerator The extension cord powering the internet equipment will be removed d. the extension cord powering the A wing nurses station computer will be removed and replaced with a power surge strip e. the extension cord powering the B wing air conditioner will be removed and	07/15/2016

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	Based on observation with Maintenance Director on 06/10/16 between 11:22 a.m. and 1:42 p.m. the following was discovered: a) a multiplug was powering an extension cord which was powering two separate coffee pots in Activities. Additionally, a surge protector was powering another surge protector powering satellite television equipment b) a surge protector was powering another surge protector powering internet equipment in the Internet room. Additionally, an extension cord was powering internet equipment. c) an extension cord ran into the drop ceiling in the Director of Nursing office that was powering two separate refrigerators in the A Wing Nurses' station medication room. Additionally, a multiplug was powering a surge protector powering radios. d) an extension cord was powering computer equipment in the A Wing Nurses' station e) an extension cord was powering an air conditioner in the B Wing Nurses' station f) an extension cord was powering a microwave in the Assisted Dining room. g) a surge protector was powering another surge protector powering television in the TV Room h) a surge protector was powering a		placed with a power surge strip f. The extension cord powering a microwave will be removed and a new electrical plug will be installed. g. remove one surge protector h. the surge protector in the ADON office will be removed and the refrigerator will be plugged directly in the the wall beginning July 15, 2016 The Maintenance Director/designee will conduct a monthly monitoring test to insure the proper usage of electrical devices beginning July 15, 2016	

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	refrigerator in the Assistant Director of Nursing office. Based on interview at the time of observations, the Maintenance Director acknowledged each aforementioned condition. 3.1-19(b)			