

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155325	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/26/2014
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NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/26/14</p> <p>Facility Number: 000218 Provider Number: 155325 AIM Number: 100274800</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meadow View Health and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated</p>	K010000	<p>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. The facility would like to request a Desk/Paper review of this Plan of correction.</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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K010017 SS=F	<p>smoke detectors in all resident sleeping rooms. The facility has a capacity of 98 and had a census of 83 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except one detached wood framed storage shed.</p> <p>Quality Review by Dennis Austill, Life Safety Code Specialist on 08/29/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend 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 the 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,</p>						

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	<p>19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 5 of 6 open use areas were separated from the corridor by walls constructed with at least a thirty minute fire resistance rating extending from the floor to the roof/floor above or met an Exception. LSC 19.3.6.1, Exception #1: Smoke compartments protected throughout by an approved, supervised automatic sprinkler system shall be permitted to have spaces unlimited in size open to the corridor, provided the following criteria are met:</p> <p>(a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. (b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, or the smoke compartment in which the space is located is protected throughout by quick response sprinklers. (c) The open space is protected by an electrically supervised automatic smoke detection system, or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses' station or similar space. (d) The space does not obstruct access to required exits. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p>	K010017	<p>K017 No specific residents were cited or required corrective action due to this practice. Smoke detectors will be installed in the main entrance lobby, the Copy Room, the main entrance reception room, the North Hall lounge, and the South Hall Bistro. An audit was conducted of other open, unsupervised areas in the facility to ensure compliance. The maintenance staff has been educated on the requirement that open spaces be protected by an electrically supervised automatic smoke detection system or be arranged and located to allow direct supervision by facility staff. The maintenance supervisor and/or designee will complete an environmental tour to ensure that smoke detectors are in required open areas. This audit will be completed monthly for 6 months, then quarterly for 2 quarters. Results of this audit will be presented to the Quality Performance Improvement Committee (QPI) for review. Any further action will be determined by the QPI committee.</p>	09/25/2014			

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K010027 SS=E	<p>Findings include:</p> <p>Based on observations on 08/26/14 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant #1, and Administrator in Training (AIT), the following areas and rooms were open to the corridor: The main entrance lobby, the Copy Room, the main entrance reception room, the North Hall lounge, and the South Hall Bistro dining room. Exception #1 requirement (c) of LSC 19.3.6.1 was not met as follows: The main entrance lobby, the Copy Room, the main entrance reception room, the North Hall lounge, and the South Hall Bistro dining room were not protected by an electrically supervised automatic smoke detection system, or the entire spaces were not arranged and located to allow direct supervision by the facility staff from nurses' stations or similar staffed space. This was acknowledged by the Maintenance Supervisor, Maintenance Assistant #1 and AIT at the time of each observation.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are</p>						

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	<p>at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors that close in the same direction were equipped with the appropriate hardware to allow the door which must close first, always close first so both doors always close completely. Smoke barrier doors equipped with an astragal are required to have a coordinator to ensure the door that must close first always closes first. This deficient practice could affect up to 57 residents, as well as staff and visitors in the North Hall.</p> <p>Findings include:</p> <p>Based on observation on 08/26/14 at 1:25 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant #1, and the Administrator in Training (AIT), the west North Hall set of smoke barrier doors swung in the same direction and was equipped with an astragal on one of the doors. These smoke barrier doors lacked a coordinator to allow the astragal side to close second,</p>	K010027	<p>K027</p> <p>No specific residents were cited or required corrective action due to this practice. A coordinator will be installed on the west North Hall set of smoke barrier doors. An audit was conducted of all smoke barrier doors in the facilities that are equipped with an astragal to ensure compliance. The maintenance staff has been educated on the requirement that smoke barrier doors equipped with an astragal must be equipped with a coordinator to ensure that the doors close in the correct sequence. The maintenance supervisor and/or designee will test each set of smoke barrier doors that is equipped with an astragal to ensure that the coordinator is functioning properly. This audit will be completed weekly for 2 months, then monthly as per policy and procedure. Results of this audit will be presented to the Quality Performance Improvement Committee (QPI) for review. Any further action will be determined by the QPI committee.</p>	09/25/2014

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K010029 SS=E	<p>however, this set of smoke barrier doors did close in the correct sequence when tested. During an interview at the time of each observation, the Maintenance Supervisor, Maintenance Assistant #1, and the AIT acknowledged the lack of a coordinator on the set of smoke barrier doors in the west North Hall.</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>1. Based on observation and interview, the facility failed to ensure 3 of 15 hazardous area room doors, such as rooms over 50 square feet containing combustible material, were equipped with self closing devices on the doors. This deficient practice could affect any number of residents and staff while in or passing through the 200 west hall.</p>	K010029	<p>K029</p> <p>No specific residents were cited or required corrective action due to this practice. A self closing device was installed on the doors in the Medical Records room, the Education Room, and the Housekeeping Room. A positive latch will be installed on the door to the North Hall shower room. An audit was completed of all other</p>	09/25/2014

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	<p>Findings include:</p> <p>Based on observations on 08/26/14 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant #1 and the Administrator in Training (AIT), the following was noted:</p> <p>a. The Medical Records room was over 50 square feet and had over 30 cardboard boxes full of paper records. There was no self closing device on the door.</p> <p>b. The Educational Room was over 50 square feet and was half full of beds, old furniture, cardboard boxes, and other items. There was no self closing device on the door.</p> <p>c. The Housekeeping Room was over 50 square feet and was full of toilet paper rolls, paper towels, cleaning chemicals, and other items. There was no self closing device on the door.</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor, Maintenance Assistant #1 and the AIT acknowledged the lack of self closing devices on the previously mentioned hazardous area room doors.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 shower rooms which contained soiled linen</p>		<p>rooms in the facility that is over 50 square feet and contain combustible material or soiled linen containers to ensure compliance. The maintenance staff was educated about the requirement that rooms over 50 square feet that contain combustible material must be equipped with a self closing device on the door. Maintenance staff was also educated on the requirement that rooms containing soiled linen containers over 32 gallons must be equipped with a positive latch on the door. The maintenance supervisor and/or designee will complete an environmental tour to ensure that all rooms over 50 square feet have doors equipped with a self closing device and that all rooms containing soiled linen containers over 32 gallons have doors equipped with a positive latch. This audit will be completed monthly for 6 months, then quarterly for 2 quarters. Results of this audit will be presented to the Quality Performance Improvement Committee (QPI) for review. Any further action will be determined by the QPI committee.</p>	

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K010038 SS=E	<p>containers over 32 gallons, was equipped with a positive latch on the door. This deficient practice could affect up to 57 residents, as well as staff and visitors in the North Hall.</p> <p>Findings include:</p> <p>Based on observation on 08/26/14 at 1:22 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant #1, and the Administrator in Training (AIT), the North Hall shower room contained two large soiled linen bins each over half full of soiled linen, and two large trash bins each over half full. The door to the North Hall shower room was not equipped with a positive latch. This was acknowledged by the Maintenance Supervisor, Maintenance Assistant #1, and AIT at the time of observation, furthermore, when asked, the Maintenance Supervisor said the bins were normally stored in the shower room when not in use.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the</p>	K010038	K038 No specific residents were cited or required corrective action	09/25/2014			

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	<p>facility failed to ensure 1 of 6 exit access doors which were equipped with delayed egress locks and were provided with signs stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS did open when pushing on the door for 15 seconds. Section 7.2.1.6.1, requires approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be</p>		<p>due to this practice. The west North Hall exit door, which is equipped with a delayed egress lock, was repaired. An audit of all other exit doors in the facility was completed to ensure compliance. The maintenance staff was educated about the requirement that an irreversible process shall release the lock within 15 seconds upon application of a force that shall not be required for more than 3 seconds. The maintenance supervisor and/or designee will complete an environmental tour to ensure that exit doors with delayed egress locks are functioning properly. This audit will be completed weekly for 2 months, monthly for 4 months, then quarterly for 2 quarters. Results of this audit will be presented to the Quality Performance Improvement Committee (QPI) for review. Any further action will be determined by the QPI committee.</p>	

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	<p>required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect up to 57 residents, as well as staff and visitors in the North Hall, while using the west North Hall exit.</p> <p>Findings include:</p> <p>Based on observation on 08/26/14 at 1:35 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant #1 and the Administrator in Training (AIT), the North Hall west exit door was equipped with a delayed egress lock and was provided with a sign stating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15</p>			

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K010051 SS=F	<p>SECONDS, however, when the door was pushed several times for 15 seconds it did not release. This was acknowledged by the Maintenance Supervisor, Maintenance Assistant #1 and the AIT at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72. 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</p>	K010051	<p>K051</p> <p>No specific residents were cited or required corrective action due to this practice. The Digital Alarm Communicator Transmitter (DACT) was repaired. The maintenance staff was educated</p>	09/25/2014			

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	<p>trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 08/26/14 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, Maintenance Assistant #1, and the Administrator in Training (AIT), the main Fire Alarm Control Panel (FACP) and the fire alarm communication panel (dialer) were both located in the Mechanical Room. When the Digital Alarm Communicator Transmitter (DACT) was placed in trouble from phone line failure at 2:20 p.m., the DACT did not actuate a local audio trouble signal, furthermore, the DACT did not activate a trouble signal at the FACP annunciator panel located at the South Hall nurses' station. Based on interview at 2:30 p.m., the Maintenance Supervisor, Maintenance Assistant #1, and the AIT acknowledged the phone line failure did not sound a trouble signal at the FACP or to the fire alarm annunciator panel at the South Hall nurses' station, furthermore, when Maintenance Assistant #1 called the fire alarm monitoring company he was told they did not receive a trouble for a phone line failure.</p>		<p>about the requirement that when a phone line failure is triggered, it should sound a trouble signal at the Fire Alarm Control Panel and at the Annex Hall nurse's station, as well as send a signal to the fire alarm monitoring company. The maintenance staff supervisor and/or designee will do a test of the DACT to ensure that a phone line failure triggers the proper signals. This audit will be completed weekly for 1 month, monthly for 5 months, then quarterly for 2 quarters. Results of this audit will be presented to the Quality Performance Improvement Committee (QPI) for review. Any further action will be determined by the QPI committee.</p>		

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K010062 SS=F	<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>1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic dry sprinkler piping systems was inspected internally every five years. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 10-2.2 states sprinkler systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally of obstructions every 5 years. NFPA 25, in A-10-2.2 explains a dry pipe system using noncoated ferrous piping shall be thoroughly investigated for obstruction from corrosion after they have been in service for 15 year, 25 years and every 5 years thereafter. This deficient practice could affect all residents, as well as staff</p>	K010062	<p>K062</p> <p>No specific residents were cited or required corrective action due to this practice. An internal dry pipe inspection was completed. The sprinkler system's gauges were replaced / recalibrated. An audit of all other sprinkler system gauges in the facility was conducted to ensure compliance. The maintenance staff was educated on ensuring the facility's sprinkler systems are maintained in reliable operating condition and inspected internally every 5 years and that sprinkler system gauges should be replaced or recalibrated every 5 years. The maintenance staff supervisor will submit a report of the last dates of an internal dry pipe inspection and of sprinkler gauge inspection. This report will be submitted to the QPI committee monthly for 3 months, then quarterly for 3 quarters. Any further action will be determined by the QPI committee.</p>	09/25/2014

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NAME OF PROVIDER OR SUPPLIER MEADOW VIEW HEALTH AND REHABILITATION CENTE				STREET ADDRESS, CITY, STATE, ZIP CODE 900 ANSON ST SALEM, IN 47167			
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	<p>and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's sprinkler system inspection reports in the Inspections book on 08/26/14 at 12:05 p.m. with the Maintenance Supervisor and Maintenance Assistant # 1 present, there was no internal dry pipe inspection documentation available after June of 2009. The quarterly sprinkler inspection dated 04/02/14 stated the internal pipe inspection was due. During an interview at the time of record review, the Maintenance Supervisor and Maintenance Assistant # 1 acknowledged there was no internal dry pipe inspection for the sprinkler system's pipes available after June of 2009.</p> <p>3.1-19(b)</p> <p>2. Based on record review, interview, and observation; the facility failed to ensure 1 of 1 sprinkler system's gauges were replaced or recalibrated within the past 5 years. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-3.2 requires gauges to be replaced every 5 years or tested every 5 years by comparison with a calibrated</p>						

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K010144 SS=F	<p>gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, as well as staff and visitors while in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's quarterly sprinkler system reports on 08/26/14 at 12:10 p.m. with the Maintenance Supervisor and Maintenance Assistant #1 present, the pressure gauges on the sprinkler system riser have not been replaced or recalibrated since 04/07/09. During an interview at the time of record review, the Maintenance Supervisor and Maintenance Assistant #1 acknowledged the date the sprinkler system riser gauges were last replaced was 04/07/09. Based on observation of the sprinkler system riser at 2:15 p.m. with the Maintenance Supervisor, Maintenance Assistant #1 and Administrator in Training the replacement date on all sprinkler system gauges was 04/07/14.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.</p>				

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	<p>3.4.4.1. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 emergency generators providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.4.1.1(a) requires monthly testing of the generator set shall be in accordance with NFPA 110, the Standard for Emergency and Standby Power Systems. NFPA 110, 6-4.2 requires generator sets in Level 1 and 2 service shall be exercised under operating temperature conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating at least monthly, for a minimum of 30 minutes. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's generator monthly load tests documentation on 08/26/14 at 11:00 a.m. with the Maintenance Supervisor and Maintenance Assistant #1 present, the</p>	K010144	<p>K144</p> <p>No specific residents were cited or required corrective action due to this practice. A load test will be performed on the facility's generator under operating temperature conditions or not less than 30 percent of the Emergency Power Supply (EPS) rating for a minimum of 30 minutes. The maintenance staff was educated on how to properly calculate the 30 percent of EPS and document the load tests. The maintenance staff supervisor and/or designee will perform a load test on the generator monthly as per policy and procedure and will illustrate the proper calculations. Results of this audit will be presented to the Quality Performance Improvement Committee (QPI) for review. Any further action will be determined by the QPI committee.</p>	09/25/2014			

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K010147 SS=E	<p>generator log form documented the generator was tested monthly under load, however, documentation showing the generator was exercised under operating temperature conditions or not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating for a minimum of 30 minutes during the past twelve months was always documented with a slash under the load column for the past twelve months. This was acknowledged by Maintenance Supervisor and Maintenance Assistant #1 at the time of record 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 multi adapters were not used as a substitute for fixed wiring in 3 of 64 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a</p>	K010147	<p>K147</p> <p>Power strips were removed from rooms 2, 8, and 119. A 100% facility audit was completed and all power strips were removed from resident rooms. The maintenance staff was educated about the requirement that power strips not be used for any type of medical equipment. The maintenance staff supervisor and/or designee will complete an environmental tour of 5 resident rooms per week to ensure that no</p>	09/25/2014

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	<p>structure. This deficient practice could affect 4 residents, as well as staff and visitors while in the 3 resident rooms.</p> <p>Findings include:</p> <p>Based on observations on 08/26/14 between 12:30 p.m. and 2:30 p.m. during a tour of the facility with Maintenance Supervisor, Maintenance Assistant #1, and the Administrator in Training (AIT) the following was noted:</p> <ul style="list-style-type: none"> a. Room 2 - a refrigerator and a nebulizer were plugged into a power strip b. Room 8 - a bed was plugged into a power strip c. Room 119 - an oxygen concentrator and a nebulizer were plugged into a power strip <p>At the time of each observation, the Maintenance Supervisor, Maintenance Assistant #1, and AIT acknowledged the use of the medical equipment plugged into power strips in these resident rooms.</p> <p>3.1-19(b)</p>		<p>power strips are being used. This audit will be completed weekly for 2 months, monthly for 4 months, then quarterly for 2 quarters. Results of this audit will be presented to the Quality Performance Improvement Committee (QPI) for review. Any further action will be determined by the QPI committee.</p>		