

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 04/28/2014
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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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: 04/28/14</p> <p>Facility Number: 000027 Provider Number: 155690 AIM Number: 100266180</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Meadow Brook Rehabilitation Centre & Suites was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery powered smoke detectors in</p>	K010000		
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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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K010018 SS=E	<p>resident rooms. The facility has a capacity of 97 and had a census of 62 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas which provide facility services were sprinklered except for one detached garage used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 05/12/14.</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 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</p>						

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	<p>with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of 3 sets of double leaf corridor doors could latch independently into their door frames. This deficient practice could affect 9 residents on Hall 2 and 8 residents on Hall 6 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 04/28/14 during the tour between 1:00 p.m. and 2:00 p.m. with the Maintenance Supervisor, the following sets of double leaf corridor doors required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame.</p> <p>a. Double door set leading into Therapy. b. Double door set leading into Maintenance office. c. Double door set leading into the Kitchen.</p> <p>Based on interview on 04/28/14 concurrent with the observations it was acknowledged by the Maintenance Supervisor, the aforementioned sets of corridor doors would not latch</p>	K010018	<p>·No residents were affected by the deficient practice. Spring loaded bolts were installed on each set of double doors to ensure each door is secured independently of the other, directly into the door frame.</p> <p>·All residents had the potential to be affected by the deficient practice. Springloaded bolts were installed on each set of double doors to ensure each door is secured independently of the other, directly into the door frame.</p> <p>·Springloaded bolts will remain in place on each set of double doors, and Maintenance Director designee, will ensure they are in proper working order during monthly Preventative Maintenance monitoring. Any issues with proper closure of double doors will be immediately corrected.</p> <p>·Results of the Monitoring will be reviewed during the facility's quarterly Quality Assurance meeting for ensured compliance, monitoring will be ongoing.</p>	05/28/2014

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K010029 SS=E	<p>independently into their door frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 doors leading to hazardous areas on Hall 6 such as rooms with combustibile items was provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 6 residents on Hall 6 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/28/14 at 1:45 p.m. with the Maintenance Supervisor, the paper shredder room on Hall 6 contained twenty two cardboard boxes inside the room which was greater than</p>	K010029	<p>·No resident were affected by the deficient practice.</p> <p>·All residents that reside on the 600 Hall had the potential to be affected by thedeficient practice. A self-closing device was installed on storage area, toensure that the door will automatically close.</p> <p>·The self-closing device will remain in place to ensure the automatic closure of thedoor to the storage area. All doors were checked to ensure all doors requiringa self closing device were in place and working properly with no other issuesfound. The Maintenance Director ordesignee will monitor all doors requiring a self closure are in place and areworking properly during monthly</p>	05/28/2014
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K010038 SS=E	<p>fifty square feet in size and did not have a self closing device on the corridor door. Based on interview on 04/28/14 at 1:48 p.m. with the Maintenance Supervisor, it was acknowledged the aforementioned door leading into the paper shredder room containing combustible items was not equipped with a self closing device on the door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 16 nonresident rooms do not require the unlocking of two locks on the door to exit from a room. This deficient practice could affect 6 residents on the Hall 4 as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 04/28/14 during the tour between 1:16 p.m. to 1:33 p.m. with the Maintenance Supervisor,</p>	K010038	<p>Preventative Maintenance monitoring. Any negative findings during monitoring will be reported to the administrator and corrected immediately.</p> <p>·Results of the Monitoring will be reviewed during the facility's quarterly Quality Assurance meeting for continued compliance, monitoring will be ongoing.</p> <p>·No residents were affected by the deficient practice. The knob lock was removed from the Business Office and the key lock was removed from the soiled utility.</p> <p>·All residents had the potential to be affected by the deficient practice. The knoblock was removed from the Business Office and the key lock was removed from the soiled utility. All doors throughout the facility were inspected for secondary locks, no other areas were found to have secondary locks.</p> <p>·Maintenance Director or</p>	05/28/2014

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K010056 SS=F	<p>the Business office corridor door had a deadbolt lock and a knob lock and the soiled utility room both on Hall 4 had a knob lock plus a key lock and latch which could not be unlocked without assistance from maintenance who were the only ones with a key. Based on interview on 04/28/14 concurrent with the observations, it was acknowledged by the Maintenance Supervisor the deadbolt on the Business office on Hall 6 should be removed and the key lock and latch on the Soiled utility room corridor door should be removed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 1 steel</p>	K010056	<p>designee will monitor all doors for secondary locks, to ensure thatno door has a secondary lock installed during monthly Preventative Maintenance monitoring. Any negative findings during monitoring will be reported to the administrator and corrected immediately.</p> <p>·Results of the Monitoring will be reviewed during the facility's quarterly Quality Assurance meeting for continued compliance, monitoring will be ongoing.</p> <p>·No residents were affected by the deficient practice. A visual inspection of the steel sprinkler</p>	05/28/2014

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	<p>armover sprinkler pipes observed outside the laundry on Hall 4 was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/28/14 at 2:15 p.m. with the Maintenance Supervisor, a steel sprinkler pipe armover outside the laundry on Hall 4 which, when measured, extended thirty six inches in length and was unsupported. Based on interview on 04/28/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was unsupported.</p> <p>3.1-19(b)</p>		<p>pipe revealed one additional location that required an additionarmover hanger, this location as well as the location outside of laundry hadthe appropriate armover hanger installed to meet the requirement of notexceeding 24 inches from the end of the steel pipe.</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the deficient practice. A visualinspection of the steel sprinkler pipe revealed one additional location thatrequired an addition armover hanger, this location as well as the location outside of laundry had the appropriate armover hanger installed to meet therequirement of not exceeding 24 inches from the end of the steel pipe. ·The armover hangers will remain in place. The Maintenance Director or designee will observe the steel sprinklerlines during monthly Preventative Maintenance monitoring to ensure all armoverhangers remain in place per regulations. Any negative findings duringmonitoring will be reported to the administrator and corrected immediately. ·Results of the Monitoring will be reviewed during the facility's quarterly QualityAssurance meeting for continued compliance, monitoring will be ongoing. 				

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K010062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler systems was maintained 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 all residents as well as visitors and staff should the sprinkler pipe break and require repair.</p> <p>Findings include:</p> <p>Based on observation on 04/28/14 at 1:45 p.m. with the Maintenance Supervisor, a four inch diameter steel sprinkler pipe located in the riser room on Hall 4 was used to support two, one inch diameter plastic water lines which were nonsprinkler components. Based on interview on 04/28/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned sprinkler pipe was used to support nonsprinkler components.</p>	K010062	<ul style="list-style-type: none"> ·No residents were affected by the deficient practice. The one inch plastic water lines were removed. ·All residents have the potential to beaffected by the deficient practice. The one inch plastic water lines wereremoved. ·Visual inspection will occur to ensure the sprinkler system is not supporting non-system components during monthly Preventative Maintenance monitoring. Any negative findings during monitoring will be reported to the administrator and corrected immediately. ·Results of the Monitoring will be reviewed during the facility's quarterly QualityAssurance meeting for continued compliance, monitoring will be ongoing. 	05/28/2014			

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K010066 SS=E	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 1 of 3 areas where smoking was permitted. This deficient practice could affect 8 residents on Hall 6 as well as visitors and staff.</p>	K010066	<p>·No residents were affected by the deficient practice. Proper receptacles have been placed at each entrance that is utilized by either the public or staff.</p> <p>·All residents have the potential to be affected by the deficient practice. Properreceptacles have been placed at each entrance that is utilized by either thepublic</p>	05/28/2014

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K010070 SS=E	<p>Findings include:</p> <p>Based on observation on 04/28/14 at 1:15 p.m. with the Maintenance Supervisor, forty one cigarette butts were observed deposited on the ground outside the MDS exit where smoking is allowed. Based on review of the smoking policy on 04/28/14 at 3:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts into a metal container. Based on interview on 04/28/14 at 1:17 p.m. with the Maintenance Supervisor it was acknowledged the facility's employees were throwing their cigarette butts on the ground instead of into a metal container.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review; the facility failed to regulate the use of 1 of 1 portable space heaters in nonresident rooms. This</p>	K010070	<p>or staff.</p> <ul style="list-style-type: none"> ·Staff has been in-serviced about our smoking policy and the proper disposal ofcigarettes. ·Maintenance or their designee will do weekly inspections of the grounds to ensure thatcigarette butts are disposed of properly; any negative findings will bereported to the administrator and will be corrected immediately. Monitoring will be ongoing; and share the findings of the inspections with the QAcommittee for continued compliance. <p>·No residents were affected by the deficient practice. The space heater located inthe Activity office was immediately removed from</p>	05/28/2014			

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K010130 SS=E	<p>deficient practice could affect 6 residents on Hall 4 as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/28/14 at 1:45 p.m. with the Maintenance Supervisor, a portable space heater which was plugged in for use was located in the Activities office on Hall 4. Based on interview on 04/28/14 concurrent with the observation, it was acknowledged by the Maintenance Supervisor space heaters were not allowed in the facility. Based on review of the portable space heater policy on 04/28/14 at 3:30 p.m. with the Maintenance Supervisor, it stated the facility did not allow space heaters in nonresident rooms unless the heating elements of the portable heater did not exceed 212 degree F.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the care and maintenance of 2 of 2 rolling fire doors were in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section</p>	K010130	<p>the facility.</p> <ul style="list-style-type: none"> ·All residents that reside on the 400 Hall have the potential to be affected by thedeficient practice. The space heater located in the Activity office was immediatelyremoved from the facility. ·Staff members were re-educated about the space heater policy. ·Maintenance Director or designee will monitor all areas of the facility monthly to ensureno space heaters are present in the facility. Any negative findings will be reported to the administrator and will becorrected immediately. ·Results of the Monitoring will be discussed during the facility's quarterly QualityAssurance meeting for continued compliance, monitoring will be ongoing. <p>·No residents were affected by the deficient practice. Overhead Door Companyrepaired and inspected the 2 rolling doors.</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the deficient practice. OverheadDoor 	05/28/2014			

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	<p>15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 8 residents on Hall 6 adjacent to the Kitchen as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/28/14 at 12:35 p.m. with the Maintenance Supervisor, there were two metal rolling fire doors protecting the opening from the kitchen to the Main dining room next to Hall 6 which did not have an attached inspection tag. Furthermore, the Main dining room was open to the corridor and the two rolling fire doors did not close automatically when the fire alarm was activated. Based on interview on 04/28/14 at 12:37 p.m. with the Maintenance Supervisor, there was no additional documentation of an annual inspection or test to check for proper operation and full closure, and it was further stated they did not close automatically with actuation of the fire alarm system.</p>		<p>Company repaired and inspected the 2 rolling doors.</p> <p>·Maintenance Director or designee will ensure that the rolling doors are in proper workingorder during each fire drill that occurs while doors are open for service, andthat doors close when alarm is activated. Any negative findings will bereported tom the administrator and immediately corrected.</p> <p>·Resultsof the Monitoring will be discussed during the facility's quarterly Quality Assurance meeting for continued compliance, monitoring will be ongoing.</p>				

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(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
K010144 SS=F	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to provide adequate emergency task lighting in and around 1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all clients, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/28/14 at 2:25 p.m., the generator set located outside the Maintenance office on Main hall lacked</p>	K010144	<p>·No residents were affected by the deficient practice. A battery back-up emergency task light hasbeen installed.</p> <p>·All residents have the potential to be affected by the deficient practice. A battery back-up emergency task light has been installed.</p> <p>·The light will be inspected during the monthly generator testing and documentationwill be made on the generator load test form. The facility is documenting monthly the number of seconds that the generator takes to transfer load, as well as at least monthly running the generator under load for 30 minutes anddocumenting the amperage. MaintenancePersonnel have been in-serviced on proper documentation of the generatormaintenance and operation. Any negativefindings will be reported tom the administrator and immediately corrected.</p> <p>·Results of the generator</p>	05/28/2014

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	<p>battery powered emergency lighting. Based on interview concurrent with the observation, it was acknowledged by the Maintenance Supervisor the generator was not provided with battery powered emergency lighting.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as</p>		<p>system testing will be discussed during the facility's quarterly Quality Assurance meeting for continued compliance, monitoring will be ongoing.</p>		

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	<p>recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 04/28/14 at 3:38 p.m. with the Maintenance Supervisor, the amperage during load was documented but it could not be verified it to be 30 percent of the EPS nameplate rating for the past twelve months. Based on interview on 04/28/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator and recording the amperage, but was unaware it had to be at least 30 percent. No other equivalent method was used to comply with percentage of load capacity for the past twelve months.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to document the generator was capable of automatically restoring electrical power within 10 seconds during load testing for</p>			

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	<p>the last 10 of 12 months. 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, 3-5.3.1 requires the emergency system shall be installed and connected to the alternate power source so all functions specified herein for the emergency system will be automatically restored to operation within 10 seconds after the interruption of the normal power source. This deficient practice could affect all residents in the facility as well as visitors and staff if the generator could not supply electricity within 10 seconds of a power failure.</p> <p>Findings include:</p> <p>Based on review of Generator Log records on 04/28/14 at 3:30 p.m. with the Maintenance Supervisor, the number of seconds for the generator to transfer load was not documented since June 2013. Based on interview on 04/28/14 at 3:33 p.m. with the Maintenance Supervisor it was acknowledged the information on time of load transfer had not been recorded for the past ten months and the Maintenance Supervisor was unaware it needed to documented.</p>						

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K010147 SS=F	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords and 1 of 1 multiplug adapters was not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and multiplugs shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all residents as well as visitors and staff if the generator failed during a power outage.</p> <p>Findings include:</p> <p>Based on observations on 04/28/14 at 1:11 p.m., with the Maintenance Supervisor, an extension cord was plugged into a power source which then extended into the generator casing and was connected to a three prong multiplug which then served to power the battery charger for the battery and the block heater. Furthermore in resident room #</p>	K010147	<ul style="list-style-type: none"> ·No residents were affected by the deficient practice. The extension cord and multi-plug were removed from the generator and the generator was hard-wired to ensure proper operation if a power outage occurred. The extension cord was removed from Resident Room #408. An audit was conducted of all resident rooms and offices and one other extension cord was found and replaced with a surge protector power strip. ·All residents have the potential to be affected by the deficient practice. The extension cord and multi-plug were removed from the generator and the generator was hard-wired to ensure proper operation if a power outage occurred. The extension cord was removed from Resident Room #408. An audit was conducted of all resident rooms and offices and one other extension cord was found and replaced with a surge protector power strip. ·The Maintenance Director or designee will inspect all area of 	05/28/2014			

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	<p>408, a medical bed, fan and Christmas tree lights were plugged into a three prong multiplug. Based on interview on 04/28/14 at 1:12 p.m. it was acknowledged by the Maintenance Supervisor, an extension cord and multiplugs were used to provide power to the aforementioned appliances and it was mentioned extension cords and multiplugs were not allowed in the facility.</p> <p>3.1-19(b)</p>		<p>the facility for both extension cords and / or multi-plugs to ensure that non-are in use, during his monthly Preventative Maintenance monitoring. Residents were educated during the May 2014 Resident Council that extension cords and / or multi-plugs are not permissible for use in the facility.</p> <p>·Results of the Monitoring will be discussed during the facility's quarterly Quality Assurance meeting for continued compliance, monitoring will be ongoing.</p>	