

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2016
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NAME OF PROVIDER OR SUPPLIER KENDALLVILLE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1802 E DOWLING ST KENDALLVILLE, IN 46755
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 02/10/16</p> <p>Facility Number: 000529 Provider Number: 155482 AIM Number: 100267140</p> <p>At this Life Safety Code survey, Kendallville Manor 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, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 60 and had a census of 31 at the time of this survey.</p>	K 0000	<p>This plan of correction is to serve as Kendallville Manor's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Kendallville Manor or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of life safety and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. In lieu of a revisit, we respectfully request a Desk Review.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0025 SS=D Bldg. 01	<p>All areas where the residents have customary access are sprinklered. The facility does have a barn and a shed providing facility services that were not sprinklered.</p> <p>Quality Review on 02/18/16 by Lex Brashear, LSC Specialist</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space</p>	K 0025	<p>1. a. The one-half inch unsealed penetration around a water line at the 200 hall attic smoke barrier wall has been caulked using fire barrier sealant CP 25WB. The three-quarter inch unsealed penetration above a conduit at the 100 hall attic smoke barrier wall has been caulked using a fire barrier sealant CP 25WB. This could have potentially affected all residents. b. The Maintenance Director toured the facility and found no other areas in need of fire barrier sealant within the smoke barrier walls. c. In the</p>	03/11/2016
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	<p>between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observations on 02/10/16 at 3:55 p.m., the Maintenance Director acknowledged there was a one half inch unsealed penetration around a water line at the 200 hall attic smoke barrier wall. Based on observation at 4:01 p.m., the Maintenance Director acknowledged there was a three quarter inch unsealed penetration above a conduit at the 100 hall attic smoke barrier wall.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half 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 was not in a resident care area but could affect facility staff.</p>		<p>event a project may involve wiring that would cause an opening in a smoke barrier wall, a fire barrier sealant will be used to seal the opening. d. In the event a project is scheduled that will affect a smoke barrier wall, at the completion of the project the Maintenance Director will ensure the fire barrier sealant has been applied correctly. Completed 3/4/2016. 2. a. The four inch by twelve inch hole in the ceiling drywall near the 100 hall attic access panel has been replaced with drywall. The three unsealed ceiling penetrations measuring one fourth inch along side conduit and IT wiring in the electrical room have been caulked using a fire barrier sealant CP 25WB. This could have potentially affected all residents. b. The Maintenance Director toured the facility and found no other areas in need of fire barrier sealant within the smoke barrier walls. c. In the event a project may involve wiring that would cause an opening in a smoke barrier wall, a fire barrier sealant will be used to seal the opening. d. In the event a project is scheduled that will affect a smoke barrier wall, at the completion of the project the Maintenance Director will ensure the fire barrier sealant has been applied correctly. Completed 3/4/2016.</p>		

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K 0029 SS=F Bldg. 01	<p>Findings include:</p> <p>a. Based on an observation on 02/10/16 at 4:00 p.m., the Maintenance Director acknowledged there was a four inch by twelve inch hole in the ceiling drywall near the 100 hall attic access panel.</p> <p>b. Based on an observation on 02/10/16 at 1:55 p.m., the Maintenance Director acknowledged there were three unsealed ceiling penetrations measuring one fourth inch alongside conduit and IT wiring in the electrical room.</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 the corridor door to 2 of 31 resident rooms with combustibles, measuring over 50 square feet in size, were provided with a self</p>	K 0029	1. Rooms 114 and 206 lacked a self-closing device and were being temporarily used as storage during renovations of the facility. The extra materials were moved to an offsite storage unit.	03/11/2016	

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K 0043 SS=D Bldg. 01	<p>closing device. This deficient practice could affect all resident.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/10/16 during a tour of the facility from 2:24 p.m. to 4:10 p.m., the corridor doors entering resident rooms 114 and 206 lacked a self closing device. Both resident rooms measured over 50 square feet in size and were used for the storage of combustible items such as resident beds, furniture and decorations. This was confirmed by the Maintenance Director at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.) 19.2.2.2</p> <p>Based on observation, the facility failed to ensure 1 of 6 resident room restrooms in the 100 hall was arranged such that the residents can open the door from inside without using a key or a special tool. This deficient practice would affect 2 of 31 residents.</p>	K 0043	<p>Room 114 is now a resident's room. Room 206 is scheduled to have the floor tiling replaced on March 11, 2016. 2. The Maintenance Director toured the facility and found no other areas in need of self-closures for rooms being used for storage. 3. In the event that additional renovations take place at the facility, Maintenance Director will ensure that only rooms with self-closures will be used. 4. Completed 3/4/16.</p> <p>1. Resident rooms 104 and 106 which share a restroom had both door knobs replaced unlockable door knobs. This could have affected 2 residents. 2. The Maintenance Director toured the facility and found no other restroom doors with lockable door knobs. 3. Both restroom door knobs were replaced with unlockable door knobs. 4. In the</p>	03/11/2016			

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K 0046 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/10/16 at 2:11 p.m., the restroom doors shared by resident rooms 104 & 106 had lockable door knobs that allowed both doors to be locked from the outside requiring a special tool to unlock either door from inside the restroom. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 emergency light fixtures of at least 1½ hour duration were tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for</p>	K 0046	<p>event a project is scheduled that will affect a resident restroom door knob, at the completion of the project, the Maintenance Director will ensure that only door knobs with no locks will be used. 5. Completed 2/29/16.</p> <p>1. There was no written record of a monthly function test for the battery operated emergency light at the generator, the laundry room emergency light, and the kitchen emergency light. This could have affected all occupants. 2. The Maintenance Director toured the facility and found no other battery operated emergency lights. 3. Form Electrical Light Fixture Test will be used to document the monthly 30-second and annual 90 minute function test required. The form has been added to the checklist for the quarterly QA meetings and will be monitored by the Administrator for the monthly and annual tests.</p>	03/11/2016

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	<p>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. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observations during the tour of the facility with the Maintenance Director on 02/10/16 from 1:20 p.m. to 4:30 p.m., battery operated emergency lights were observed at the emergency generator, in the kitchen and the laundry room. Based on an interview with the Maintenance Director during record review at 1:05 p.m., there was no written record of a monthly function test for the battery operated emergency light at the generator since 12/2015, the laundry room battery operated emergency light since 08/2015 and the kitchen since 11/2015. Additionally, the Maintenance Director confirm a annual ninety minute test was not conducted on any of the battery operated emergency lights for the previous year.</p> <p>3.1-19(b)</p>			

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K 0051 SS=F Bldg. 01	<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 record review and interview, the facility failed to ensure documentation for the testing of 1 of 1 fire alarm system's components and devices was available for review. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors, heat sensors, fire alarm pull stations, and fire alarm control equipment be tested annually. The inspection should include locations and serial numbers, the test/inspection done and whether each device passed or failed. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K 0051	The fire alarm system with approved components, etc. are inspected annually. The documentation was not immediately located by the Maintenance Director. A deficit in this issue would affect all occupants. The Annual Test and Inspection as performed timely by SafeCare on 7/2/2015 is attached. The Maintenance Director has the website link to access all work performed and tests and inspections to provide as required.	03/11/2016

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K 0062 SS=F Bldg. 01	<p>Based on interview during the record review process on 02/10/16 at 12:45 p.m., the Maintenance Director acknowledged he was unable to provide documentation of a inspection for the facility's fire alarm system.</p> <p>3-1.19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers for the automatic sprinkler system in accordance with NFPA 25, 1998 Edition 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents if the sprinkler system had to be shut down because a proper sprinkler wasn't available as a replacement.</p>	K 0062	The facility failed to provide a complete supply of spare sprinklers specifically for a "quick response" sprinkler head. This practice could have affected all occupants. The Maintenance Director will add this set to the replacement cabinet. The Maintenance Director will ensure replacements heads are maintained in the cabinet. Ordered and to be completed by 3/11/2016.	03/11/2016

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K 0067 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director on 02/10/16 at 3:15 p.m., there were no quick response sprinkler heads in the spare sprinkler cabinet. Based on observation during the tour from 1:55 p.m. to 3:15 p.m., there was a quick response sprinkler head in the building overhang outside of the facility at the resident smoke area. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 dampers in the ceiling vents were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A,</p>	K 0067	The facility failed to ensure 2 of 2 dampers in the ceiling vents were inspected and provided necessary maintenance every four years. This deficit could have impacted all residents, staff and visitors. Maintenance Director has contacted SafeCare and has an inspection planned for 3/7/2016 for the facility. We have requested SafeCare to prompt this facility for the next inspection to be conducted in 4 years.	03/11/2016

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K 0070 SS=E Bldg. 01	<p>1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation and interview on 02/10/16 at 3:44 p.m., the Maintenance Director confirmed a damper was installed in the ceiling vent of the 200 hall. At the time of observation, the Maintenance Director confirm there was another damper in the ceiling vent of the 100 hall. Based on an interview with the Maintenance Director at the time of observation, he confirmed the facility lacked documentation of an inspection for the ceiling vent dampers.</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 and interview, the facility failed to ensure 1 of 1 portable</p>			K 0070	1. Portable space heating devices are prohibited in all health care		03/11/2016

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K 0075 SS=F Bldg. 01	<p>space heaters in the facility was in accordance with NFPA 101, Section 19.7.8. This deficient practice could affect approximately 6 resident in the main entrance lounge.</p> <p>Findings include:</p> <p>Based on an observation on 02/10/16 at 2:42 p.m., the Maintenance Director confirmed the heating device of the portable fireplace in the main entrance lounge produced heat when the knob was turned the "on" position.</p> <p>3.1-19(b)</p> <p>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 (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</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square feet area for 1 of 2 resident room corridors. This deficient practice could affect all residents.</p>	K 0075	<p>occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. 2. The lobby has an electric fireplace for the past seven years which has served as a focal point. It can be switched to heat. The Maintenance Director has disabled the heat function of the fire place. Completed 3/4/16. It can only function as a mock fireplace (with lights illuminating plastic fire logs and not heating up).</p> <p>1. A 32-gallon soiled linen container was stored beside a 32-gallon trash container in the 100 and 200 hallways. This deficient practice would impact all residents. 2. A notice was posted for staff to keep containers in the hallway only while changing out</p>	03/11/2016			

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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
K 0144 SS=F Bldg. 01	<p>Findings include:</p> <p>Based on observations with the Maintenance Director on 02/10/16 at during a tour of the facility from 2:29 p.m. to 3:23 p.m., a 32 gallon soiled linen container was stored beside a 32 gallon trash container in the 100 and 200 hall. Based on an interview with the Maintenance Director at the time of observation, he confirmed each contain had a capacity of 32 gallons.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or</p>	K 0144	<p>the residents rooms at least one room apart. The Administrator and DON will conduct daily rounds through the month of March to ensure the practice is being followed.</p> <p>1. Generators are to be inspected weekly and exercised under load for 30 minutes per month. This deficient practice could affect all occupants. 2. The Maintenance Director will conduct the monthly generator emergency test and log it as required. To be completed by March 11, 2016. 3. This log will be added to the quarterly QA meeting checklist for Maintenance and reviewed by the Administrator for compliance. After the first quarterly QA meeting and the Administrator finding the log was completed for that quarter, the Administrator will</p>	03/11/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155482	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 02/10/2016
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	<p>not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review of the generator log "Monthly Generator Emergency Test Log" on 02/10/16 at 1:10 p.m., the Maintenance Director confirmed the only documentation include on the generator log was the date of the monthly test for January through June of 2015. The Maintenance Director confirmed he was unable to provide documentation of a monthly load test after June of 2015.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was inspected on a weekly basis. NFPA 99, 3-5.4.2 requires a written record or inspection, performance, exercise period and repairs shall be regularly maintained and</p>		<p>no longer require that log to be reviewed in the QA meetings.</p> <p>1. The Generator system needs to be inspected weekly. The Maintenance Director was unable to provide documentation of the weekly generator inspection. This deficient practice could affect all occupants. 2. The Maintenance Director will conduct the weekly generator inspection as required. Completed by March 7, 2016 and will be ongoing. 3. The log will be added to the quarterly QA meeting checklist for Maintenance and reviewed b the Administrator for compliance. After the first quarterly QA meeting and the Administrator finding the log was completed for that quarter, the Administrator will no longer require that log to be reviewed in the QA meetings.</p>	

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K 0147 SS=E Bldg. 01	<p>available for inspection by the authority having jurisdiction. NFPA 99, 3-4.1.1(b)1 requires generating testing be in accordance with NFPA 110, Standard for Emergency and Standby power Systems, Chapter 6. NFPA 110, 6-4.1 requires Level 1 and Level 2 EPSS including all appurtenant components shall be inspected weekly. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review of the "Weekly Generator System & Testing" generator log on 02/10/16 at 1:10 p.m., the Maintenance Director confirmed he was unable to provide documentation of the weekly generator inspection since 05/14/15.</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</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 2 multiplug adapters and 7 of 7 flexible cords were not used as a substitute for fixed wiring to provide power for either medical equipment or equipment with a high current draw. NFPA 70, National</p>	K 0147	<p>1. a) A power strip was plugged into another powerstrip which was supplying power to the IT equipment in the electrical room. a) The Maintenance Director has removed one of the power strips. b) A CPAP machine was plugged into a power strip in resident room 107. a) The CPAP has been</p>	03/11/2016	

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	<p>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 3 of 5 residents.</p> <p>Findings include:</p> <p>Based on observations on 02/10/16 during the tour from 1:58 p.m. to 3:42 p.m., the Maintenance Director acknowledged the following::</p> <p>a) a power strip was plugged into another power strip which was supplying power to the IT equipment in the electrical room</p> <p>b) a CPAP machine was plugged into a power strip in resident room 107. Additionally, the power strip was plugged into a wall receptacle at the head of the resident's bed</p> <p>c) a multiplug adapter was plugged in and providing power to a microwave, a drink dispensing machine and a compressor in the kitchen</p> <p>d) a concentrator and a CPAP machine were plugged into a power strip in resident room 202</p> <p>e) a nebulizer and a CPAP machine were plugged into a power strip in resident room 207</p> <p>f) a refrigerator was plugged into a power strip in resident room 215</p>		<p>removed as the resident does not use this anymore. A powerstrip was plugged into the wall at the resident's bed. It has been removed. c) A multiplug adapter was plugged in and providing power to a microwave, a drink dispensing machine and a compressor in the kitchen.</p> <p>a) The multiplug was removed. The drink dispensing machine and a compressor was then plugged directly into the two-outlet receptacle in the wall.</p> <p>b) The microwave was moved to another location in the kitchen and plugged directly into a wall receptacle. d) A concentrator and a CPAP machine were plugged into a power strip in resident room 202. a) The concentrator and CPAP machines have been moved and are each plugged into a socket in the wall. e) A nebulizer and a CPAP machine were plugged into a power strip in resident room 207. a) The power strip was removed, as well as the nebulizer and the CPAP machines as these residents are no longer using them. f) A refrigerator was plugged into a power strip in resident room 215. a) The refrigerator is plugged directly into the wall socket. The power strip is used for a fan as needed and for the residents cell phone chargers. g) A concentrator was plugged into a power strip in resident room 203. a) The power strip was removed and the concentrator is plugged</p>	

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	<p>g) a concentrator was plugged into a power strip in resident room 203</p> <p>h) a multiplug adapter was plugged in and providing power to electronic equipment in resident room 207</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 1 electrical receptacle in the resident room 202. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation and interview on 02/10/16 at 3:24 p.m., the Maintenance Director acknowledged the receptacle in resident room 202 restroom lacked a cover. Additionally, during a tour of the facility from 1:55 p.m. to 4:01 p.m., the Maintenance Director acknowledged there were exposed wires at the end of the baseboard heater near resident room 209 and at the end of the baseboard heater at the main entrance.</p> <p>3.1-19(b)</p>		<p>directly into a wall socket. h) A multiplug adapter was plugged in and providing power to electronic equipment in resident room 207.</p> <p>a) The multiplug adapter was removed and the television and the electronic equipment are both plugged into a power strip. 2. The receptacle in resident room 202 restroom lacked a cover. The painting in this restroom has been completed for resident room 202 and all covers have been replaced. The baseboard heater near resident room 209 and at the end of the baseboard heater at the main entrance are bent and have exposed wires. This deficient practice could affect all occupants. The Maintenance Director will bend the end caps back on these baseboard heaters to close off the exposed wires. This shall be completed no later than 3/11/2016. The Administrator will observe these for completion and compliance.</p>	