STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155721	A. BUILDING -- B. WING	05/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LAWRENCE MANOR HEALTHCARE CENTER	8935 E 46TH ST INDIANAPOLIS, IN 46226

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/21/19 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Emergency Preparedness survey, Lawrence Manor Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 55 certified beds. At the time of the survey, the census was 29. Quality Review completed on 05/24/19	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/21/19 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Life Safety Code survey, Lawrence Manor	K 0000	Preparation and or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required. The facility requests the plan of correction be considered the allegation of compliance effective 6-20-19.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 55 and had a census of 29 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 05/24/19			
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of			

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	the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure the corridor doors to 8 of 8 hazardous storage rooms or room with fuel fired equipment was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect all residents in all smoke compartments. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 from 11:00 a.m. to 1:15 p.m., the following was noted:: a) The front hopper room with trash/dirty linen storage did not completely self-close and latch into the door frame. b) The dirty side door to the laundry room did not completely self-close and latch into the door frame.	K 0321	K321 1) The self-closing hardware for the front hopper room (a), the soiled side of laundry door (b), the housekeeping storage room door (c), the ice room door (e), and the rear hopper room door (f), will be adjusted or replaced to ensure self-closing and latch into the door frame. The door to the main storage room (h) will be adjusted to clear the floor and self-close and latch into the door frame. The combustible storage in room 28 (d) will be removed. Self-closing hardware will be installed on the activity room door (g) to ensure self-closing and latch into frame. 2) The unsealed holes and gap around drywall patch will be closed and or sealed to prevent	06/20/2019

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	c) The house keeping storage room which contained hazardous chemicals and storage did not completely self-close and latch into the door frame. d) Room 28 was greater than 50 square feet and contained large amounts of combustible storage did not contain a self-closing door. e) The ice room contained fuel fired equipment and the door did not completely self-close and latch into the door frame. f) The rear hopper room with trash/dirty linen storage did not completely self-close and latch into the door frame. g) The activities room was greater than 50 square feet and contained large amounts of combustible storage did not contain a self-closing door. h) When the door to the main storage room was fully opened, it would not self-close due to the door sticking on the floor. Based on interview at the time of observation, the Maintenance Director agreed all aforementioned doors were hazardous areas and did not self-close or latch into the frame. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 furnace rooms which contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 10 residents in one smoke compartment Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 at 1:00 p.m., in the celling of the furnace room which contained fuel fired equipment had two unsealed one inch holes, two unsealed four inch holes, and		any penetrations in the furnace room. All hazardous storage rooms or rooms with fuel fired equipment were assessed for self-closing/latching and penetrations and there were no additional findings. The maintenance person and all staff were inserviced on 5-23-19 regarding identifying doors that do no self-close and or latch, and wall/ceiling penetrations; and reporting their observations to the administrator and maintenance person. The preventative maintenance checklist will include monthly observations for self-closing/latching doors and any wall/ceiling penetrations. Maintenance will monitor door self-closing/latching and wall penetrations weekly for one month and monthly for six months and ongoing, and document findings on the TELS/PM log. The audit logs will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	1/8 inch gap around a drywall patch that was covering a hole. Based on interview at the time of the observation, the Maintenance Director agreed there were unsealed penetrations in the ceiling of the furnace room which contained fuel fired equipment and provided the measurements of the unsealed penetrations. 3.1-19(b)			
K 0355 SS=B Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to maintain 1 of 1 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 5.5.5 states fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 5.5.5.3 states a placard shall be placed near the extinguisher that states that the protection system shall be actuated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using the portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect five staff in the kitchen. Findings include:	K 0355	K355 A placard was placed near the portable fire extinguisher stating the Ansul system should be activated prior to using the extinguisher. There is only one kitchen area and thus the only area affected. Maintenance person and dietary staff inserviced on 5-22-19 regarding use of the Ansul system and the fire extinguisher and the necessity for keeping the placard in view at all times. Use of the Ansul system and fire extinguisher added to the dietary employee orientation check list. Dietary will add “placard in view” on the daily kitchen cleaning schedule.	06/20/2019

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	Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 at 1:10 p.m., a portable K Class fire extinguisher was located in the kitchen and a placard was not conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Based on interview at the time of observation, the Maintenance Director stated the extinguisher has been moved and the sign was not replaced in the new location. 3.1-19(b)		Dietary supervisor to monitor placement of placard in relation to fire extinguisher by observation weekly for six months and document findings on cleaning log. The audit logs will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 28 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in room 19. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 at 12:53 p.m., the corridor door to resident room 19 did not latch into the frame when tested due to the latch sticking inside the door. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame because the latch was sticking in the door. 3.1-19(b)	K 0363	K363 The sticky latch which prevented resident room door 19 from closing and latching was replaced. All resident room doors were tested for positive closing and latching, and adjustments were made if needed. Maintenance person inserviced on 5-22-19 regarding resident rooms doors and positive latching. Maintenance will add positive door latching to the room inspection check list which is performed monthly. Maintenance person will check resident room doors for positive latching weekly for one month and monthly for six months and	06/20/2019

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			ongoing. Results including adjustments and repairs will be documented on the room inspection log. The audit logs will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 15 residents in two smoke compartments.	K 0374	K374 The coordinating device on the door frame holding the smoke barrier doors open by room 5 open will be replaced to allow for doors to close restricting the movement of smoke. All smoke barrier doors and hold open/close devices were tested for closure restricting the movement	06/20/2019

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 at 11:50 a.m., the set of smoke barrier doors by room 5 would not fully close due to the coordinating device on the door frame not correctly working and holding the doors open. Based on interview during the time of observation, the Maintenance Director stated the coordinating device needed repair and was holding the doors open. 3.1-19(b)		of smoke and there were no additional findings. The maintenance person was inserviced on 5/22/19 regarding the function of the smoke barrier doors and testing. The doors will be tested monthly per the TELS preventative maintenance program and observed for closing to restrict the movement of smoke during monthly fire drills with results documented. The administrator will monitor testing and testing results weekly for two months and monthly for six months and ongoing by reviewing TELS preventative maintenance logs for completion. The results will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical outlets were protected in 1 of 28 resident rooms according to 19.5.1. NFPA	K 0511	K511 The outlet cover by the window side resident bed in room 22 was	06/20/2019

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	70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect two residents in room 22. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 at 12:03 p.m., in room 22 the outlet cover by the window side resident bed was not completely covering the outlet, was missing the fastening screw, and was hanging on the wall by paint. Based on interview at the time of observation, the Maintenance Director agreed the outlet was not completely covered and the faceplate need to be secured. 3.1-19(b)		secured to the wall outlet with the fastening screw. All wall outlets were assessed to ensure the faceplates were installed to completely cover the opening and seated against the mounting surface. The maintenance person and all staff were inserviced on identifying and reporting hazards such as electrical outlets without protective faceplates on 5-22-19. Maintenance will add electrical outlets and protective faceplates to the room inspection check list which is performed monthly. Maintenance person will check electrical outlets weekly for one month and monthly for six months and ongoing. Results including adjustments and repairs will be documented on the room inspection log. The audit logs will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel			

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	and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 laundry rooms were provided with intake combustion air from the outside for rooms containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for all staff in the laundry room. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 at 11:30 a.m., in the laundry room there were two vents by the fuel-fired dryers but it could not be determined if the vents were for the intake of air from the outside. Based on an interview at the time of observation, when asked where the fresh air intake was located the Maintenance Director stated one of the two vents by the dryers might be the fresh air intake but was not sure. The Maintenance Director went outside and on the roof to find the air intake, but stated the air intake could not be found. 3.1-19(b)	K 0522	K522 Modifications will be made in the laundry room to provide intake combustion air from the outside. There is only one laundry room and thus the only affected area. The maintenance person was inserviced on 5-23-19 regarding the necessity for fresh air intake in the laundry room due to the fuel-fired dryers in the room. The maintenance person will check the flow of fresh air from the outside during weekly inspections of the laundry room. This task will be added to the TELS preventative maintenance log for the laundry room inspection. The maintenance person will check function of the intake air vent from the outside weekly for six months and ongoing. Findings will be documented on the laundry room inspection audit. Any adjustments or repairs will be made immediately and noted. The audit logs will be reviewed monthly by the QAPI committee and reviewed by corporate risk	06/20/2019

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			management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be 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 shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in the	K 0741	K741 A designated smoking area is established with ashtray/smoking	06/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155721	A. BUILDING 01 B. WING	05/21/2019

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	provided metal or noncombustible containers with self-closing cover devices. This deficient practice could affect 15 residents in the patio/courtyard area. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 at 12:25 p.m., in the resident smoking area outside in the patio/courtyard area there were over 60 cigarette butts disposed on the ground in and around the smoking area. Also, there were two smokers' poles with the lids sitting on the patio exposing the cigarette butts inside. Based on interview at the time of observations, the Maintenance Director agree cigarette butts were on the ground and the lids to the smokers' poles were sitting on the ground. 3.1-19(b)		tower receptacles of noncombustible material and safe design provided. A metal container with self-closing cover into which ashtrays can be emptied is readily available in the area. The smoker pole receptacles were emptied and the lids secured. Signage was prominently displayed with instructions for the disposal of cigarette butts. There are no other designated smoking areas. Housekeeping and maintenance have been assigned to empty the ashtrays daily and all staff were inserviced on 5-23-19 regarding the procedure. An audit form including compliance with the procedure for disposal of cigarette butts was implemented. The maintenance person will audit daily for one month, weekly for two months, and monthly for three months for a total of six months. If threshold of 95% compliance is not achieved an action plan will be developed. The results of these audits will be reviewed monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management.	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing			

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	155721	A. BUILDING 01 B. WING	05/21/2019

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	Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99)			
	Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 28 of 28 resident care locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct	K 0914	K914 The electrical receptacles in the 28 care locations were inspected visually for physical integrity and tested for correct polarity and retention force and results documented. The 28 locations comprise the resident bed locations in the facility and thus the only affected areas. An electrical receptacle inspection and testing log was obtained, and	06/20/2019

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	polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 from 11:00 a.m. to 1:15 p.m., the facility's 28 resident care rooms/locations contained four to six electrical receptacles in each room, most of the receptacles were not hospital grade. Based on records review at 10:30 a.m., no documentation was available to show electrical receptacles in resident rooms were tested annually nor initial testing for the hospital grade receptacles. Based on interview at the time of the observations and records review, the Maintenance Director indicated most of the electrical receptacles in the resident care areas were not hospital-grade with exception of receptacles that have been replaced. The Maintenance Director stated there was no documentation of annual testing or initial testing per NFPA 99, Receptacle Testing requirements. 3.1-19(b)		the maintenance person was inserviced 5-23-19 on the procedure for inspecting and testing non-hospital grade receptacles at intervals not to exceed twelve months. The electrical receptacle inspection and testing were added to the TELS preventative maintenance schedule. The maintenance person will check the electrical receptacles for physical integrity and note any receptacle replacements/upgrades and add them to the schedule, and document findings on the inspection testing log, weekly for one month and monthly for six months. The audit logs will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling			

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	to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen trans-filling rooms were separated from other areas in the facility in a room that is protected with a one hour fire-resistive construction in accordance with 2012 NFPA 99 11.5.2.3.1(1). This deficient practice could affect 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 05/21/19 at 12:42 p.m., the oxygen trans-filling room door had a small hole in the corridor door. Based on an interview at the time of observation, the Maintenance Director agreed there was a small hole in the oxygen trans-filling room door. 3.1-19(b)	K 0927	K927 The small hole in the oxygen room door was repaired with fire-resistive caulk. This is the only oxygen trans-filling room in the facility. The maintenance person was inserviced 5-23-19 on the necessity for the oxygen trans-filling room to be protected with a one-hour fire-resistive construction. A visual inspection of the oxygen trans-filling room to ensure there are no penetrations or construction compromise was added to the oxygen trans-filling room inspection checklist log. The oxygen trans-filling room is inspected weekly. The maintenance person will inspect the oxygen trans-filling room weekly for six months and ongoing and findings documented on the inspection log. The audit logs will be reviewed monthly by the QAPI committee and reviewed by corporate risk management. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	06/20/2019

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