STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155298	A. BUILDING -- B. WING	03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
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: 03/08/18 Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690 At this Emergency Preparedness survey, Pyramid Point Post-Acute Rehabilitation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 135 certified beds. At the time of the survey, the census was 38. Quality Review completed on 03/14/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the health and safety code section 1280 and 42 CFR 483.	
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual,	E 0039	E039: 1. See attached Document (see below) which is the facilities EP testing procedures for Emergency Response per Position and Emergency Events. Pyramid Point Post-Acute	04/07/2018

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

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	facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Plan" documentation with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, documentation for testing the facility's emergency preparedness program twice within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility has not conducted community based disaster drills, experienced an actual natural or man-made emergency that requires activation of the emergency plan or conducted a table top exercise on the facility's plan within the most recent twelve month period.		Rehabilitation Center- Section VI –emergency Response (Attachment #1) 2. All residents at Pyramid Point have the potential to be affected by this deficient practice 3. Due top the nature of this newer compliance area, the facilities EP Testing Procedures for emergency Response – Per Position and Emergency Events is attached with this Plan Of Correction and will be retained with the Emergency Operations Plan, and reviewed by the QAA Committee Annual review in December. On-going education will be provided as per regulation for Emergency Operations Plan. Facility has contacted District 6 Hospital Preparedness Planning Committee, Inc. – To Participate in community events. 4. The QAA Committee will review policy and procedures monthly/annually and all appropriate members will document/sign the review.	

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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: 03/08/18 Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690 At this Life Safety Code survey, Pyramid Point Post-Acute Rehabilitation 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 three story facility was determined to be of Type II (222) 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 in all resident sleeping rooms. The facility has a capacity of 135 and had a census of 38 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 03/14/18 - DA	K 0000	The plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the health and safety code section 1280 and 42 CFR 483.	

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K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Emergency Procedure - Fire Watch" documentation with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, the fire watch plan for fire alarm system impairment was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Maintenance Director agreed the fire watch documentation for fire alarm system impairment did not state to contact the Indiana State Department of Health via the ISDH Gateway link or at the e-mail address listed above.	K 0346	K346: 1. It is the policy of Pyramid Point Post-Acute Rehabilitation Center to properly notify the appropriate agencies per policy (see attachment #2) 2. All residents could be affected. 3. Policy has been up-dated to reflect the appropriate notification of State agencies via gateway. Executive Director and QAA Committee will monitor monthly/annually for up-dates. 4. The QAA Committee will review policy and procedures monthly/annually and all appropriate members will document/sign the review.	04/07/2018

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	3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to ensure all private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of SafeCare's "Fire Hydrants and Water Supply Testing" documentation dated	K 0353	K 353 1. It is the policy of Pyramid Point Post-Acute Rehabilitation Center to have fire hydrants tested at a minimum of annually and after operation. Also curtains will not block sprinkler heads for 18 inches from ceiling, from proper operation. 2. All residents could be potentially affected. 3. The fire hydrants were tested 3/22/18, and curtains removed from the shower area of the bath house room.	04/07/2018

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	03/28/16 with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, documentation of fire hydrant inspection within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated documentation of fire hydrant inspection within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director and the Van Driver/Maintenance Assistant from 1:10 p.m. to 3:00 p.m. on 03/08/18, the facility has two fire hydrants. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 1 of over 50 rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met: (1) The curtains are supported by fabric mesh on ceiling track. (2) Openings in the mesh are equal to 70 percent or greater.		4. Hydrants will be tested at a minimum of annually and after usage. All areas will be monitored on a weekly basis for proper curtains and sprinkler effectiveness. Maintenance will report findings to the QAA committee on a monthly basis.	

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	(3) The mesh extends a minimum of 22 inches down from the ceiling. NFPA 25, Section 5-5.5.1 says a continuous or noncontinuous obstruction less than or equal to 18 inches below the sprinkler deflector prevents the spray pattern from fully developing. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Bath House on the third floor. Finding includes: Based on observations with the Maintenance Director and the Van Driver/Maintenance Assistant from 1:10 p.m. to 3:00 p.m. on 03/08/18, the privacy curtain in the shower area of the Bath House on the third floor was hung on a horizontal rod with the top of the curtain installed less than 18 inches from the ceiling. The shower area was not provided with a sprinkler and was blocked from sprinkler coverage by the sprinkler in the Bath House outside the shower area. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned privacy curtain caused sprinkler spray pattern obstruction less than 18 inches from the ceiling. 3.1-19(b)			
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities			

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	having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of 38 of 38 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Procedure - Fire Watch" documentation with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, the fire watch plan for sprinkler system impairment was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. In addition, the fire watch plan for sprinkler impairment also did not include notification of the insurance carrier and the	K 0354	K354 1. It is the policy of Pyramid Point Post-Acute Rehabilitation Center to have in the Fire Watch policy the appropriate State Notification for a Fire Watch. 2. All residents affected. 3. The policy has been up-dated to reflect the ISDH gateway website and email to notify the State of Indiana of a fire watch situation. (see attachment #3) 4. The QAA Committee will review Policy and Procedures of Emergency Plan monthly/annually and all appropriate members will document/sign the review.	04/07/2018

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	building owner. Based on interview at the time of record review, agreed the fire watch documentation for sprinkler system impairment did not state to contact the Indiana State Department of Health via the ISDH Gateway link or at the e-mail address listed above and did not state to contact the insurance carrier and the building owner. 3.1-19(b)			
K 0363 SS=E 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 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			

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	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 over 50 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 over five residents staff and visitors in the vicinity of the Occupational Therapy Room on the first floor. Findings include: Based on observations with the Maintenance Director and the Van Driver/Maintenance Assistant from 1:10 p.m. to 3:00 p.m. on 03/08/18, the corridor door to the Occupational Therapy Room on the first floor was propped in the fully open position with a wedge placed on the floor under the door. Based on interview at the time of the observations, the Maintenance Director agreed the door had an impediment to closing, latching and would not resist the passage of smoke. 3.1-19(b)	K 0363	K 363: 1. It is the policy of Pyramid Point Post-Acute Rehabilitation Center to have Corridor Doors that close correctly and are not impediment prevent door form closing correctly 2. Only residents who would be in Occupational Therapy room would be affected. 3. Impediment was immediately removed during survey by Maintenance. Maintenance Director or Designee will check doors for impediments 3 times a week for 2 months or 100% compliance achieved after 2 months. Staff will be in-serviced on use if impediments to keep doors opened. 4. Findings will be brought to the QAA Committee for review and further evaluation if needed	04/07/2018

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K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation and interview; the facility failed to document testing of 2 of 2 elevator firefighter's service recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect over five residents, staff and visitors. Findings include:	K 0531	K531: 1. It is the policy of Pyramid Point Post-Acute Rehabilitation Center to have documented firefighter's service recall tested per regulation 2. All residents could be affected. 3. Firefighter's service call System is to be inspected by Elevator company on a monthly basis and findings reported to Maintenance Director or Designee. 4. Findings will be reported to	04/07/2018

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	Based on record review with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, documentation of monthly firefighter's service recall testing for the most recent twelve month period was not available for review. Based on observations with the Maintenance Director and the Van Driver/Maintenance Assistant from 1:10 p.m. to 3:00 p.m. on 03/08/18, the facility has two elevators equipped with firefighter's service recall. Thyssen Krupp had "Hydraulic Maintenance Task" documentation for each elevator in the elevator machine room which documented monthly inspections for each elevator but the documentation did not include monthly firefighter's service recall testing. Based on interview at the time of record review and of the observations, the Maintenance Director stated the facility does not perform elevator recall testing outside of the contractor checks and agreed monthly firefighter's service recall testing could not be assured for both elevators during the most recent twelve month period. 3.1-19(b)		QAA Committee on a monthly basis for further input as needed.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.			

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PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

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	19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide documentation of a fire drill conducted on the third shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report Form" documentation with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, documentation of a fire drill conducted on the third shift for the third quarter of 2017 was not available for review. Based interview at the time of record review, the Maintenance Director stated a fire drill for that shift and quarter was conducted but agreed documentation of a fire drill conducted on the aforementioned shift and quarter was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report Form" documentation with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, second shift fire drills conducted on 02/28/17, 05/31/17, 08/31/17 and 11/30/17 were conducted at, respectively, 2:25 p.m., 2:00 p.m., 3:00 p.m. and 2:30 p.m. Based on interview at the time of record review, the Maintenance Director	K 0712	K 712: 1. It is the policy of Pyramid Point Post-Acute Rehabilitation Center to have fire drills conducted monthly at different times on different shifts throughout the year. 2. All residents could be affected. 3. Executive Director and QAA Committee will do audits to insure that drills are conducted monthly and at different times through out the year. 4. QAA committee will monitor monthly for compliance and make recommendations as needed.	04/07/2018

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	agreed the aforementioned second shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the			

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	emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to document the facility exercised the generator for 1 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Weekly Generator Test" documentation with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, monthly load testing documentation for December 2017 was not available for review. Based on interview at the time of record review,	K 0918	K918: 1. It is the policy of Pyramid Point Post-Acute rehabilitation Center to test monthly the Generator, recording findings and a 30% load test at least once yearly 2. All residents could be affected. 3. Test will be conducted monthly as specified in regulation and findings recorded by Maintenance and a load test will be performed annually by contractor to insure proper load test is performed. Batteries for the generator have been ordered by Maintenance. Reports from vendor will be reviewed with Executive Director for items needing replaced. 4. Findings will be presented to the QAA Committee for review monthly and as needed for further recommendations.	04/07/2018

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	the Maintenance Director stated the facility conducted a monthly load test in December 2017 but load testing documentation for the load test was not available for review. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Section 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Weekly Generator Test" documentation with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on			

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	03/08/18, monthly load testing documentation for the twelve month period of March 2017 through February 2018 did not state load testing was conducted under loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or under operating temperature conditions achieving not less than 30 percent of the EPS nameplate kW rating. Monthly load testing documentation for December 2017 was also not available for review. In addition, annual supplemental load testing documentation within the most recent twelve month period was also not available for review. Based on interview at the time of record review, the Maintenance Director stated the generator is tested under load on a monthly basis, documentation does not indicate load testing achieves 30% of the name plate rating and annual supplemental load testing documentation was also not available for review. Based on observations with the Maintenance Director and the Van Driver/Maintenance Assistant from 1:10 p.m. to 3:00 p.m. on 03/08/18, the nameplate affixed to the diesel fired generator indicated it was rated at 175 kW. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to ensure the starting batteries for the emergency generator were maintained in accordance with Section 5.6.4.5.5 of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems. Section 5.6.4.5.5 states all batteries used in this service shall have been designed for this duty and shall have demonstrable characteristics of performance and reliability acceptable to the authority having jurisdiction. NFPA 110, Section 8.3.4 states a permanent record of the Emergency			

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	Power Supply System (EPSS) inspections, tests, exercising, operation and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of MacAllister Machinery "Level 1 Inspection" documentation dated 03/05/18 with the Maintenance Director during record review from 9:25 a.m. to 1:10 p.m. on 03/08/18, the "batts need replace due to age." Based on interview at the time of record review, the Maintenance Director stated the starting batteries for the emergency generator have not been replaced on or after 03/05/18, the batteries are going to be replaced but documentation of a purchase order or proposal for replacement on or after 03/05/18 was not available for review. Based on observations with the Maintenance Director and the Van Driver/Maintenance Assistant from 1:10 p.m. to 3:00 p.m. on 03/08/18, documentation affixed to the starting batteries indicated they were manufactured February 2015. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for			

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	non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity	K 0920	K920; 1. It is the policy of Pyramid Point Post-Acute rehabilitation Center to not use power strips for those items in resident room that are for non patient care-related electrical equipment. 2. All residents could be affected. 3. Maintenance has removed the power strip in question from room. Rooms will be randomly checked 3 times a week by Maintenance Director or Designee for compliance 4. Findings will be brought to QAA Committee Monthly for review and for other recommendations as needed.	04/07/2018

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	extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 332. Findings include: Based on observations with the Maintenance Director and the Van Driver/Maintenance Assistant from 1:10 p.m. to 3:00 p.m. on 03/08/18, a refrigerator was plugged into a power strip placed on the floor five feet from the resident bed in Room 332. The UL listing of the power strip could not be determined. Based on interview at the time of the observations, the Maintenance Director agreed a power strip was being used as a substitute for fixed wiring in the patient care vicinity at the aforementioned location. 3.1-19(b)			