| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155458 | A. BUILDING 01<br>B. WING | 10/03/2017 |

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| HIGHLAND NURSING AND REHABILITATION CENTER | 9630 FIFTH ST<br>HIGHLAND, IN 46322 |

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| K 0000<br><br>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 483.70(a).<br><br>Survey Date: 10/03/17<br><br>Facility Number: 000367<br>Provider Number: 155458<br>AIM Number: 100289280<br><br>At this Life Safety Code survey, Highland Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 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.<br><br>This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has the capacity for 38 and | K 0000 | Preparation and or execution of this plan of correction does not constitute admission or agreement on the part of the Provider to 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. Facility respectfully requests a desk review. | |

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

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| | had a census of 28 at the time of this survey services are sprinklered<br><br>All areas with resident access are sprinklered. Three detached storage sheds are unsprinklered.<br><br>Quality Review by Lex Brashear, Life Safety Code Specialist on 10/05/17 | | | |
| K 0211<br>SS=F<br>Bldg. 01 | NFPA 101<br>Means of Egress - General<br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>Based on observation and interview, the facility failed to maintain 2 of 4 corridors from obstructions per 19.2.1. LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or | K 0211 | 1.Soiled linen carts were immediately moved to storage area. Bookshelf was immediately removed away from corridor.<br>2.All residents have the potential to be affected by this deficient practice. Administrator and Maintenance Director rounded hallways to ensure there weren't any other items blocking corridors.<br>3.Director of Plant Operations in-serviced Maintenance Director on observing corridors for items obstructing egress. All-staff was also in-serviced on placing soiled linen carts in storage area when not in use.<br>4.To ensure compliance, | 11/02/2017 |

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| | visibility thereof. This deficient practice could affect all occupants in the Main Dining room.<br><br>Findings include:<br><br>Based on observation with the Administrator and the Maintenance Director on 10/03/17 at 9:55 a.m. and again at 10:35 a.m., a soiled linen cart was in the corridor outside of resident room 18. No housekeeper was constantly attending to the soiled linen cart. Furthermore, a bookshelf was in the corridor outside of the Administrator's office. Based on interview at the time of each observation, the Administrator and the Maintenance Director acknowledged that impediments such as the soiled linen cart and the bookshelf were potential impediments to full use of the means of egress access corridors.<br><br>3.1-19(b) | | Administrator or designee will audit corridors daily for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | |
| K 0222<br>SS=F<br>Bldg. 01 | NFPA 101<br>Egress Doors<br>Egress Doors<br>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the | | | |

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| | clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall | | | |

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| | be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>Based on observation, record review, and interview; the facility failed to ensure 3 of 3 exits had a correct code posted. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. LSC 19.2.2.2.5.2 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on observation with the Administrator and the Maintenance Director on 10/03/17 at 9:51 a.m., the | K 0222 | 1.Codes on all three egress doors were changed to the proper code immediately on 10/3/17.<br>2.All residents have the potential to be affected by this deficient practice. Administrator or Designee will audit to ensure correct codes.<br>3.Director of Plant Operations in-serviced Maintenance Director on making sure proper codes are changed in timely manner.<br>4.To ensure compliance, Administrator or designee will audit codes weekly for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | 11/02/2017 |

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| | Front entrance/exit door was held in the locked position with a magnetic hold down device. Furthermore, the exit door was equipped with an electronic keypad entry system that allowed staff to open the locked exit doors with a combination. A code was posted at the entrance/exit door indicating two digit month and year will release the door. Based on an interview at the time of observation, the Administrator and the Maintenance Director confirmed that the code for October had not be updated yet and all three exit doors needed to be updated as well.<br><br>3.1-19(b) | | | |
| K 0300<br>SS=F<br>Bldg. 01 | NFPA 101<br>Protection - Other<br>Protection - Other<br>List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of 18 of 18 battery operated smoke alarms in resident rooms was complete. NFPA 72 14.2.1.1.1 states to ensure operations integrity, the system shall have an inspection, testing, and | K 0300 | 1.There is currently a preventative maintenance monitor in place to test battery operated smoke detectors monthly and to change batteries as needed.<br>2.The Maintenance Director will test the battery operated smoke detectors and replace all batteries to ensure compliance.<br>3.Director of Plant Operations | 11/02/2017 |

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| | maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Administrator and the Maintenance Director on 10/03/17 between 9:35 a.m. and 10:49 a.m., the battery operated smoke alarm documentation indicated the last time the batteries were changed was on 09/23/16. No documentation was available for the manufacturer's recommendation for battery replacement. Based on interview at the time of record review, the Administrator and the Maintenance Director were unable to confirm a battery replacement program was in place and acknowledged the batteries had not been changed in over a year.<br><br>3.1-19(b) | | in-serviced Maintenance Director on ensuring battery operated smoke detectors are tested and batteries are changed as needed.<br>4.To ensure compliance, Administrator or designee will audit smoke detector checklist weekly for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | |
| K 0321<br>SS=F<br>Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br>Hazardous Areas - Enclosure<br>2012 EXISTING<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating | | | |

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| | (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. 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 the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1<br><br>Area Automatic Sprinkler Seperation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K3220) | | | |
| | Based on observation and interview, the facility failed to maintain protection of 1 of 1 Laundry in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect all occupants in the Main Dining room smoke compartment.<br><br>Findings include: | K 0321 | 1.The Maintenance Director immediately adjusted the door to ensure that door closed properly.<br>2.Maintenance Director assessed other doors in the building to ensure they latched properly and no other doors were found to latch improperly.<br>3.Director of Plant Operations in-serviced Maintenance Director on ensuring doors latch properly.<br>4.To ensure compliance, | 11/02/2017 |

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| | Based on observation with the Administrator and the Maintenance Director on 10/03/17 at 10:06 a.m., the Laundry contained fuel-fired equipment. The Laundry room South corridor door was tested. The door failed to fully self-close and positively latch into the frame. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the Laundry door failed to fully close and latch.<br><br>3.1-19(b) | | Administrator or designee will audit doors daily for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | |
| K 0346<br>SS=C<br>Bldg. 01 | NFPA 101<br>Fire Alarm System - Out of Service<br>Fire Alarm - Out of Service<br>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.<br>9.6.1.6<br>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 | K 0346 | 1.Insurance company information and a link to the ISDH gateway has been added to the fire watch plan.<br>2.All residents have the potential to be affected by this deficient practice. Fire watch plan was assessed by Director of Plant Operations to ensure policy is current.<br>3.Director of Plant Operations | 11/02/2017 |

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| | 9.6.1.6. This deficient practice affects all occupants.<br><br>Findings include:<br><br>Based on record review with the Administrator and the Maintenance Director on 10/03/17 at 9:15 a.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the insurance company and contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Administrator and the Maintenance Director acknowledged fire watch policy failed to include contacting the insurance company and include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway.<br><br>3.1-19(b) | | will in-service Maintenance Director on fire watch policy. Administrator will in-service all staff on fire watch policy.<br>4.To ensure compliance, Administrator or designee will do random staff education on fire watch policy for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | |
| K 0353<br>SS=C<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>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. | | | |

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| | a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on record review with the Administrator and the Maintenance Director on 10/03/17 at 10:45 a.m., the sprinkler system was inspected quarterly. No documentation was available for the monthly control valves and monthly wet system gauge inspection. Based on interview at the time of record review, the Administrator and the Maintenance Director acknowledged the lack of | K 0353 | 1.Maintenance Director inspected valves and gauges on 10/3/17.<br>2.All residents have the potential to be affected by this deficient practice. The Director of Plant Operations implemented an audit form for inspection of gauges and valves and in-serviced both Administrator and Maintenance Director.<br>3.Maintenance Director will inspect valves and gauges monthly.<br>4.To ensure compliance, Administrator or designee will audit inspection of sprinkler riser gauges and valves weekly for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | 11/02/2017 |

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| | documentation and were unaware of the requirement.<br><br>3.1-19(b) | | | |
| K 0354<br>SS=C<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Out of Service<br>Sprinkler System - Out of Service<br>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 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.<br>18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)<br>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 occupants.<br><br>Findings include:<br><br>Based on record review with the | K 0354 | 1.Insurance company information and a link to the ISDH gateway has been added to the fire watch plan.<br>2.All residents have the potential to be affected by this deficient practice. Fire watch plan was assessed by Director of Plant Operations to ensure policy is current.<br>3.Director of Plant Operations has in-service Maintenance Director on fire watch policy. Administrator will in-service all staff on fire watch policy.<br>4.To ensure compliance, Administrator or designee will do | 11/02/2017 |

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| | Administrator and the Maintenance Director on 10/03/17 at 9:15 a.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the insurance company and contacting the Indiana State Department of Health via the Web Portal. Based on an interview record review, the Administrator and the Maintenance Director acknowledged fire watch policy failed to include contacting the insurance company and include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway.<br><br>3.1-19(b) | | random staff education on fire watch policy weekly for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | |
| K 0374<br>SS=E<br>Bldg. 01 | NFPA 101<br>Subdivision of Building Spaces - Smoke Barrie<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>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.<br>19.3.7.6, 19.3.7.8, 19.3.7.9 | | | |

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| | Based on observation and interview, the facility failed to ensure 1 of 2 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect staff and up to 30 residents.<br><br>Findings include:<br><br>Based on observation with the Administrator and the Maintenance Director on 10/03/17 at 10:05 a.m., the set of smoke barrier doors near resident room 13 did not latch because the door got caught up on the coordinating device and failed to fully close. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the smoke barrier door catching on the coordinating device.<br><br>3.1-19(b) | K 0374 | 1.The Maintenance Director repaired the fire door coordinator to ensure it closes properly.<br>2.The Maintenance Director inspected all other fire doors in the building to ensure they are working properly.<br>3.Director of Plant Operations will in-service Maintenance Director in regards to checking fire doors monthly.<br>4.To ensure compliance, Administrator or designee will audit fire doors to ensure closure weekly for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | 11/02/2017 |
| K 0511<br>SS=D<br>Bldg. 01 | NFPA 101<br>Utilities - Gas and Electric<br>Utilities - Gas and Electric<br>Equipment using gas or related gas piping | | | |

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| | 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.<br>18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>Based on observation and interview, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition in accordance with 19.5.1.1. LSC 19.5.1.1 requires utilities 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, 2011 Edition, Article 314.28(C) requires all pull boxes, junction boxes, and conduit bodies shall be provided with covers compatible with the box or conduit body construction and suitable for the conditions of use. This deficient practice could affect staff only.<br><br>Findings include:<br><br>Based on observation with the Administrator and the Maintenance Director on 10/03/17 at 10:30 a.m., there was exposed wiring in an electrical box without a cover in the Riser room. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the exposed wiring in the Riser room. | K 0511 | 1.Maintenance Director immediately placed cover on bare wires on 10/3/17.<br>2.Maintenance Director will inspect all areas of facility to ensure bare wires are covered appropriately.<br>3.Director of Plant Operations will in-service Maintenance Director on the covering of bare wires.<br>4.To ensure compliance, Administrator or designee will audit facility for any bare wires weekly for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | 11/02/2017 |

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| | 3.1-19(b) | | | |
| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7<br>Based on record review and interview, the facility failed to conduct quarterly fire drills for 3 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents.<br><br>Findings include:<br><br>Based on record review of the "Fire Drill Record" form with the Administrator and the Maintenance Director on 10/03/17 at 9:30 a.m., there was no documentation for a second shift fire drill in the first and third quarters of 2017 and the fourth quarter of 2016. Additionally, there was no documentation for a third shift fire | K 0712 | 1.Fire Drills are scheduled monthly on various shifts to ensure that the facility is in compliance with conducting a fire drill at least quarterly on each shift.<br>2.All residents have the potential to be affected by this deficient practice. A fire drill is scheduled to be completed in the month of October.<br>3.Director of Plant Operations will in-service Maintenance Director on fire drill procedures and monthly schedule.<br>4.To ensure compliance, Administrator or designee will audit fire drills monthly for 6 months. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action | 11/02/2017 |

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| | drill in the third quarter of 2017. Based on interview at the time of record review, the Administrator and the Maintenance Director were unable to provide further documentation.<br><br>3.1-19(b)<br>3.1-51(c) | | plans are submitted to regional and corporate teams for review. | |
| K 0918<br>SS=F<br>Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>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.<br>Written records of maintenance and testing are maintained and readily available. EES | | | |

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| | electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 2012 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. In addition, NFPA 101 at Section 4.6.12.1 requires that any device, equipment or system required for compliance with this Code shall be continuously maintained. This deficient practice could affect all occupants in the facility including staff, visitors and residents.<br><br>Findings include:<br><br>Based on an observation with the Administrator and the Maintenance Director on 10/03/17 at 10:20 a.m., the generator annunciator panel contained an illuminated light which indicated the generator was not in auto. Based on an interview at the time of observation, the Administrator and the Maintenance Director confirmed they were unaware of | K 0918 | 1.Safecare was called immediately to assess panel when identified by surveyor. Safecare arrived same day on 10/3/17 and repairs were complete.<br>2.All residents have the potential to be affected by this deficient practice. After Safecare repaired the panel the Maintenance Director tested the generator to ensure generator is properly working.<br>3.Director of Plant Operations will in-service Maintenance Director on annunciator panel functions.<br>4.To ensure compliance, Administrator or designee will audit annunciator panel for any trouble lights daily for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | 11/02/2017 |

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| | the illuminated light on the generator annunciator panel.<br><br>3-1.19(b) | | | |
| K 0920<br>SS=F<br>Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>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 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<br>Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with | K 0920 | 1.The Maintenance Director immediately removed refrigerator plug from surge protector and plugged directly into wall outlet.<br>2.All residents have the potential to be affected by this deficient practice. The | 11/02/2017 |

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| | NFPA 70, National Electrical Code.<br>NFPA 70, 2011 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 all occupants open to the Main Dining room.<br><br>Findings include:<br><br>Based on observation with the Administrator and the Maintenance Director on 10/03/17 at 10:25 a.m., a surge protector was powering a refrigerator in the MDS office. Based on interview at the time of observation, the Administrator and the Maintenance Director acknowledged the surge protector powering a high amperage device.<br><br>3.1-19(b) | | Maintenance Director inspected facility to ensure there were no high amperage devices plugged into surge protector and plugged directly into wall outlets.<br>3.All staff members have been in-serviced on use of surge protectors and plugging high amperage items into wall outlet.<br>4.To ensure compliance, Administrator or designee will audit facility to monitor high amperage items weekly for four weeks and monthly for 6 months thereafter. If compliance isn't achieved, than an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. | |