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	12/04/2018

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: 12/04/18 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Emergency Preparedness survey, Lawrence Manor Healthcare 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 55 certified beds. At the time of the survey, the census was 28. Quality Review completed on 12/06/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0006 SS=C Bldg. --	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2).	E 0006	The facility-based and community-based Risk Assessment utilizing an all-hazards approach, including missing residents and strategies for addressing emergency events identified by the risk assessment, was reviewed and updated with the review date noted.	12/05/2018

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

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	This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation with the Administrator during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, was not available for review. The document stated emergency preparedness policies and procedures for the facility were based on the risk assessment which was to be included with the emergency preparedness documentation but documentation for the risk assessment was left blank. Based on interview at the time of record review, the Administrator agreed a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, specific to Lawrence Manor Healthcare Center was not available for review at the time of the survey.		The deficient practice could affect all occupants and to ensure its implementation all staff will be inserviced on the facility-based and community-based risks and hazard vulnerabilities. The Risk Assessment will be updated annually and as needed. The administrator and department leaders were in serviced on 12/5/2018_regarding the facility Risk Assessment policy. The annual Risk Assessment review will be added to the TELS calendar. To ensure compliance, the administrator will review the Risk Assessment with department leaders monthly for six months and document results. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be developed.	
E 0013 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42	E 0013	Emergency preparedness policies and procedures (the Emergency Operations Plan) were reviewed and updated based upon the current facility-based and	12/05/2018

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	CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation with the Administrator during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, was not available for review. The documents stated emergency preparedness policies and procedures for the facility were based on the risk assessment which was to be included with the emergency preparedness documentation but documentation for the risk assessment was left blank. Based on interview at the time of record review, the Administrator agreed policies and procedures based on a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, specific to Lawrence Manor Healthcare Center were not available for review at the time of the survey.		community-based Risk Assessment utilizing an all hazards approach, with the review date noted. The deficient practice affects all occupants and to ensure its implementation all staff will be inserviced on the facility's Emergency Operations Plan. The Emergency Operations Plan will be updated annually and as needed. The administrator and department leaders were in serviced on 12/5/2018 regarding the Emergency Operations Plan. The annual Emergency Operations Plan review will be added to the TELS calendar. To ensure compliance, the administrator will review the Emergency Operations Plan with department leaders monthly for six months and document results. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be developed.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000		

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	Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/04/18 Facility Number: 000383 Provider Number: 155721 AIM Number: 100289610 At this Life Safety Code survey, Lawrence Manor 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 28 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 12/06/18 - DA			
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier,			

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	or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 self closing doors in the kitchen would self close to form a smoke resistant barrier. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the Administrator and the Maintenance Manager during a tour of the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18, the corridor door to the kitchen was equipped with a self closing device but the device was partially disconnected which served to prop the door in the fully open position. In addition, the hold open chain on the door was not affixed to the energized wall mounted magnetic hold open device for the door. Based on interview at the time of the observations, the Maintenance Manager agreed the self closing device was partially disconnected and the magnetic hold open device was not being utilized which failed to ensure the door would self close to form a smoke resistant barrier. 3.1-19(b)	K 0223	The kitchen door closing device has been reconnected making the door fully operational permitting automatic closure upon activation. The Dietary staff has been in serviced on 12/4/2018 regarding the operation of the kitchen door and the necessity to ensure its functionality when activated. All self-closing doors held open with a release device were inspected to ensure they automatically close upon activation and are fully operational. The kitchen door release device has been added to the weekly kitchen environmental inspection check list. Maintenance will inspect the function of the kitchen door closure upon activation of the fire alarm system during regularly scheduled drills and document results.	12/04/2018

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			To ensure compliance, the maintenance person will monitor the weekly checklist and monthly inspections for six months. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be developed.	
K 0353 SS=F 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 Based on record review, observation and interview; the facility failed to ensure all sprinkler systems were maintained in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in	K 0353	For residents affected by the deficient practice and those potentially affected, Maintenance personnel have added the quarterly waterflow alarm device	12/06/2018

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	accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of SafeCare's "Report of Inspection" documentation dated 11/28/17 and Integrated Electronics of Indiana's (I.E.I.) "Form for Inspection, Testing & Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 04/11/18 with the Administrator and the Maintenance Manager during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, quarterly waterflow alarm device testing and inspection documentation for the first quarter (January, February, March) 2018 was not available for review. The aforementioned documentation did not state the facility's wet sprinkler system had a vane-type or pressure switch-type waterflow alarm device. Based on interview at the time of record review, the Maintenance Manager stated the facility switched sprinkler system contractors sometime after 11/28/17 and agreed quarterly waterflow alarm device testing and inspection documentation for the first quarter 2018 was not		inspection to the sprinkler system preventative maintenance program on the TELS calendar. Maintenance person was given inservice education regarding quarterly waterflow alarm device inspections and record keeping using the sprinkler system preventative maintenance log on 12/6/2018. The administrator will review the sprinkler system preventative maintenance logs and vendor inspection reports, including quarterly inspection of the waterflow alarm device, weekly for six months. The results of these audits will be taken to the monthly QAPI committee meeting, overseen by the administrator and reviewed by corporate risk management. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	available for review. Based on observations with the Administrator and the Maintenance Manager during a tour of the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18, SafeCare and I.E.I. had affixed hanging tags to the facility's sprinkler system riser which did not document a quarterly waterflow alarm device test and inspection for the first quarter 2018. 3.1-19(b)			
K 0355 SS=E 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 ensure 1 of 13 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Laundry.	K 0355	The fire extinguisher in the laundry was inspected by an approved vendor to meet the annual maintenance requirement. All fire extinguishers were checked to ensure annual maintenance was performed and documented. The maintenance person was inserviced on 12/6/2018 regarding the requirement for annual inspection and maintenance of portable fire extinguishers by the approved vendor. The maintenance person will visually inspect the portable fire extinguishers monthly and document results in the preventative maintenance log.	12/06/2018

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	Findings include: Based on observations with the Administrator and the Maintenance Manager during a tour of the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18, the portable ABC fire extinguisher located in the Laundry had an affixed maintenance tag documenting the date the most recent annual maintenance was performed by Allied Safety Services in July 2017. Based on interview at the time of the observations, the Maintenance Manager agreed the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve month period. 3-1.19(b)		The administrator will review the fire extinguisher preventative maintenance log and vendor inspection and maintenance reports weekly for six months. The results of these audits will be taken to the monthly QAPI committee meeting, overseen by the administrator and reviewed by corporate risk management. If a threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall	K 0711	The Emergency Operations Plan was revised to include a policy for the relocation of wheeled equipment during a fire or similar emergency; and the location of the	12/06/2018

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	provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Operations Plan: Fire Procedure" documentation with the Administrator during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, the written fire safety plan for the facility did not address the relocation of wheeled equipment during a fire or similar emergency. In addition, the written fire safety plan for the facility did not address the location of fire doors for evacuation purposes. The written fire safety plan stated to "remove persons from the room, continue past fire doors with evacuated		fire doors for evacuation purposes. The deficient practice affects all occupants and to ensure its implementation all staff will be inserviced on the relocation of wheeled equipment during a fire or similar emergency; and the location of the fire doors for evacuation purposes. The administrator and department leaders were in serviced on 12/6/2018_regarding the Emergency Operations Plan including the relocation of wheeled equipment and the location of fire doors for purposes of evacuation. The annual Emergency Operations Plan review will be added to the TELS calendar. To ensure compliance, the administrator will review the Emergency Operations Plan with department leaders monthly for six months and document results. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be developed	

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	persons" but did not identify the location of fire doors in the facility. Based on interview at the time of record review, the Administrator stated the evacuation routes were listed on the wall mounted floor plans in the corridor but stated she was unsure if the written fire safety plan addressed the relocation of wheeled equipment from the corridor during a fire or similar emergency and the location of fire doors for evacuation purposes. Based on observations with the Administrator and the Maintenance Manager during a tour of the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18, Hoyer lifts were stored in the corridor outside Rooms 27, 28 and 29. Crash carts were stored in the corridor near nurse's station 1 and nurse's station 2. 3.1-19(b)			
K 0712 SS=C 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. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the second and third shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors.	K 0712	For residents affected by the deficient practice and those potentially affected, fire drills in the month of December were held on second and third shifts at times which varied from the most recent quarterly drills.	12/06/2018

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	Findings include: Based on review of "Fire Drill Record" documentation with the Administrator and the Maintenance Manager during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, the following was noted: a. second shift fire drills conducted on 01/19/18, 02/12/18, 03/13/18, 04/05/18, 05/10/18, 06/13/18, 07/26/18, 08/25/18, 09/25/18, 10/21/18 and 11/08/18 were conducted at, respectively, 9:40 p.m., 9:30 p.m., 9:00 p.m., 7:30 p.m., 9:00 p.m. 9:00 p.m., 9:00 p.m., 9:30 p.m., 9:30 p.m., 9:00 p.m. and 9:30 p.m. b. third shift fire drills conducted on 01/18/18, 02/12/18, 03/27/18, 05/22/18, 06/13/18, 07/25/18, 08/25/18, 09/25/18, 10/22/18 and 11/08/18 were conducted at, respectively, 10:20 p.m., 10:05 p.m., 11:00 p.m., 10:55 p.m., 10:00 p.m. 10:00 p.m., 11:45 p.m., 11:00 p.m., 10:00 p.m. and 10:05 p.m. Based on interview at the time of record review, the Maintenance Manager agreed the aforementioned second and third shift fire drills were not conducted at unexpected times under varying conditions. 3.1-19(b)		The maintenance person was in serviced on 12/6/2018 regarding fire drills to be held at expected and unexpected times under varying conditions at least quarterly on each shift. The results of fire drills including the times conducted will be documented. Maintenance person will maintain a rolling calendar indicating the time variances drill to drill on each shift. To ensure compliance, the administrator will review the rolling calendar and fire drill reports monthly for six months and ongoing. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be developed	
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			

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	155721	A. BUILDING 01 B. WING	12/04/2018

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	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 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, observation and interview; the facility failed to ensure 1 of 1 automatic transfer switches was maintained in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, Section 8.3 states the EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. Section 8.3.4 states a written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and	K 0918	The automatic transfer switch was replaced on 12/10/2018. The generator was inspected and exercised under load on 12/17/2018 and the test/inspection documented on the Weekly Generator Inspection Monthly Load Test Log. The facility will ensure the emergency generator is fully functional, is tested weekly, and load testing occurs monthly with record of the available load, and a	12/10/2018

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	visitors. Findings include: Based on review of Edwards Mechanical "Work Order" documentation dated 07/31/18 with the Administrator and the Maintenance Manager during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, the automatic transfer switch controller does not transfer building power from the normal source to the generator. Based on interview at the time of record review, the Maintenance Manager stated company policy required bids for the repair and it is scheduled to be replaced by MacAllister Machinery on 12/10/18 as evidenced by MacAllister's confirmation e-mail dated 12/04/18. Based on observations with the Administrator and the Maintenance Manager during a tour of the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18, the "Not in Auto" light was illuminated and an audible alarm signal was noted at the generator location and at the remote annunciator located at nurse's station 1 inside the facility. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 8 of 52 weeks. NFPA 99, Healthcare Facilities Code, 2012 Edition, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available		written record is available for review. The maintenance person was in serviced on 12/6/2018 regarding generator function, weekly inspection, and exercising the generator under load monthly; and availability of documentation for review by the Authority having Jurisdiction. A plan of correction audit calendar has been implemented. The administrator or designee will monitor emergency generator operation weekly for two months and monthly thereafter with results and documentation forwarded to the regional director of operations to ensure continued compliance. If any component of the emergency generator system fails the minimum test and inspection requirements it shall be repaired or replaced immediately. All test and inspection shall be documented accordingly as well as any necessary repair or replacement activities. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be developed.	

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	for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Weekly Generator Inspection Checks Monthly Load Test" documentation with the Administrator and the Maintenance Manager during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, weekly emergency generator inspection documentation for October and November 2018 was not available for review. Based on an interview at the time of record review, the Maintenance Manager stated Edwards Mechanical performed an automatic transfer switch inspection on 07/31/18 which found the transfer switch controller does not work so he stopped doing weekly inspections on the generator after 09/28/18 and agreed weekly emergency generator inspection documentation for October and November 2018 was not available for review. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to maintain a complete written record of monthly generator load testing for 2 months of the most recent 12 month period. In addition, the facility failed to annually exercise the generator with supplemental loads for diesel powered EPS installations that do not meet the requirements of NFPA 110, Section 8.4.2. NFPA 99, Health Care Facilities Code, 2012 Edition, Chapter 6.4.4.1.1.4(A) requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 2010 Edition,			

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	Section 8.4.2 requires diesel generator sets in service to 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% of the 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 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. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Weekly Generator Inspection Checks Monthly Load Test" documentation with the Administrator and the Maintenance Manager during record review from 8:50 a.m. to 1:15 p.m. on 12/04/18, monthly emergency generator load testing documentation for October and November 2018 was not available for review. In addition, review of monthly load testing documentation for June 2018 through September 2018 indicated the monthly load test never exceeded 11%. Based on interview at the time of record review, the Maintenance Manager stated Edwards Mechanical performed an automatic transfer			

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	switch inspection on 07/31/18 which found the transfer switch controller does not work so he stopped doing monthly load testing on the generator after 09/28/18 and agreed monthly load testing documentation for October and November 2018 was not available for review. In addition, the Maintenance Manager stated monthly load testing for the diesel fired generator does not achieve 30% load or more and the facility did not perform an annual load bank test within the most recent twelve month period. Based on observations with the Administrator and the Maintenance Manager during a tour of the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18, the facility has one diesel fired emergency generator. Manufacturer's nameplate information affixed to the unit indicated it was rated at 150 kW. The "Not in Auto" light was illuminated and an audible alarm signal was noted at the generator location and at the remote annunciator located at nurse's station 1 inside the facility. 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 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			

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	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. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Administrator's Office near the main entrance lobby. Findings include: Based on observations with the Administrator and the Maintenance Manager during a tour of the facility from 1:15 p.m. to 2:25 p.m. on 12/04/18, a refrigerator, a microwave oven and a coffee pot were plugged into a power strip. Based on interview at the time of the observations, the Maintenance Manager agreed a power strip was	K 0920	The extension cord and power strip cited at the time of survey was removed. All resident rooms, offices, storage areas and common use spaces were inspected for the use of extension cords and or power strips not specifically permitted and used as a substitute for fixed wiring. Any cited were removed. Administrator, maintenance and department leaders were in serviced on 12/6/2018 regarding the prohibition of extension cords and or power strips unless specifically permitted. The maintenance person will include the prohibition of extension cords and or power strips on the regularly scheduled preventative maintenance rounds of resident rooms, offices, storage areas and common use spaces and results documented. To ensure compliance, the administrator will review	12/06/2018

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	being used as a substitute for fixed wiring at the aforementioned location. 3.1-19(b)		preventative maintenance logs for the presence of extension cords and power strips and ensure the removal weekly for eight weeks and monthly thereafter. Results of the monitoring will be reviewed during the facility's QAPI Committee meeting overseen by the administrator and reviewed by corporate risk management. If a compliance threshold of 95% is not achieved an action plan will be developed.	