STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 01 B. WING	08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 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 483.70(a). Survey Date: 08/31/16 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 At this Life Safety Code survey, Carmel Health & Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial walkout lower level was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms in the	K 0000	Submissionof this plan of correction in no way constitutes an admission by Carmel Health& Living or its management company that theallegations contained in the survey report is a true and accurate portrayal ofthe provision of nursing care or other services provided in this facility. The Plan of Correction is prepared andexecuted solely because it is required by Federal and State Law. The Plan of Correction is submitted in orderto respond to the allegation of noncompliance cited during the Annual Recertificationand State Licensure Survey on August 31, 2016. Please accept this plan of correction as Carmel Health & Living's credibleallegation of compliance by September 26, 2016. The facility respectfully is requesting desk review of the allegationscontained herein.	

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

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	700 and 800 Hall. The facility has battery operated smoke detectors in resident sleeping rooms in the 200, 300, 400 and 500 Hall. The facility has a capacity of 188 and had a census of 130 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/06/16 - DA			
K 0025 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 Based on observation and interview, the facility failed to ensure 1 of 2 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. LSC 19.3.7.3 refers to Section 8.3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of	K 0025	**K025 I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 5 staff could be affected by the deficient practice. 1.The Maintenance staffrepaired the kitchen ceiling furnace room smoke barrier, the areas around thepipes, and the ceiling barriers with fire resistant caulk which provides aminimum of a half an hour fire rating. **II.**	09/26/2016

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	maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. LSC Section 8.3.6.2 states openings in smoke barriers of a building shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or it shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect at least five staff in the kitchen. Findings include: Based on observation with the Environmental Director during a tour of the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, the four inch annular space surrounding a two inch in diameter pipe and the one inch annular space surrounding a one inch in diameter pipe which penetrated the ceiling of the kitchen natural gas fired furnace room were not firestopped. Based on interview at the time of observation, the Environmental Director acknowledged the aforementioned holes in the ceiling smoke barrier did not maintain at least a one half hour fire resistance rating. 3.1-19(b)		**The facility will identify other residents/staffthat may potentially be affected by the deficient practice.** The Facility Maintenance Staff were re-educated onensuring that areas around pipes, barrier walls and ceilings are sealed withcorrect fire resistant foam. The Maintenance Director and/ or Corporate Facilities Staff will physically inspect areas that have beenaddressed by an outside vendor after completion of a job to ensure no holes oropenings are left in smoke compartments. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The facility floor planwas updated to include the kitchen furnace room for facility maintenance staffmonthly preventative maintenance review/audit. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** All vendor repairs to thephysical plant will be reviewed at the facility QAPI meeting monthly to ensurerepairs have been checked by the Maintenance Director or Corporate Facilities. Monthly preventativemaintenance audits will be reviewed at the facility Quality Assurance Committeemeeting to ensure completion. Results of this audit will bereviewed at the monthly Quality Assurance Committee	

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			meeting and frequency andduration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2016.	
K 0027 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 4 of 25 sets of smoke barrier doors would close to form a smoke resistant barrier. LSC 19.3.7.6 requires doors in smoke barriers shall comply with Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 10 residents, staff and visitors in the Therapy Room if smoke was allowed to move from one smoke compartment to another. Findings include: Based on observations with the	K 0027	**K027** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 10 residents, staff and visitors could be affectedby the deficient practice. 1.Facility maintenance staffsanded the doors in the corridor at 800 to ensure the doors properly close. 2.Facility maintenance staffinstalled a self closing device outside the kitchen entrance doors.	09/26/2016

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	Environmental Director during a tour of the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, the following was noted: a. the set of smoke barrier doors in the corridor at the entrance to the Therapy Room from the 800 Hall failed to fully close because the top of the west door in the door set hit the frame leaving a two inch gap between the west door and the east door in the door set. b. the self-closing device was removed from the west door in the corridor door set outside the kitchen entrance by the elevator which prevented the door from self closing. c. the self-closing device for the west door in the corridor door set in the tunnel near the lower level riser room was removed which prevented the door from self closing. d. the east door in the corridor door set at the entrance to the lower level tunnel dragged on the floor and became stuck which left a three foot gap in between the two doors in the door set. Based on interview at the time of the observations, the Environmental Director acknowledged the aforementioned sets of smoke barrier doors would not self close to provide a smoke resistant barrier. 3.1-19(b)		3.Facility maintenance staffinstalled a self closing device in the tunnel in the lower level riser roomdoors. 4.Facility maintenance staffsanded the doors in the lower level east side of the tunnel and adjusted thecloser to ensure proper closing. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** Maintenance Director will inservice environmentalstaff to monitor fire doors and resident room doors for proper closing bySeptember 16, 2016. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** Maintenance Director willperform a complete audit of fire doors quarterly to ensure proper closing. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.**	

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			Facility TELs system willprompt maintenance staff to randomly check 25 doors monthly for proper closing. Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2016.	
K 0029 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 5 of 27 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors to hazardous areas are self closing or close automatically upon activation of the fire	K 0029	**K029** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.**	09/26/2016

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	alarm system. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, the following was noted: a. the four inch annular space surrounding a two inch in diameter pipe and the one inch annular space surrounding a one inch in diameter pipe which penetrated the ceiling of the kitchen natural gas fired furnace room were not firestopped. b. the corridor door to the natural gas fired furnace room by Room 707 failed to self-close and latch into the door frame because the handle side of the door hit the door frame preventing it from closing. c. the self-closing device for the corridor door to the business office natural gas fired furnace room failed to function which prevented the door from self closing. d. the self-closing device for the janitor's closet in the Woodland Kitchen which contained a natural gas fired water heater failed to function which prevented the door from self closing. e. the self-closing device for the west		20 residents could be affected by the deficientpractice. The Maintenance staff repaired the attic smokebarrier walls, the areas around the pipes, and the ceiling barriers with fireresistant rated foam which provides a minimum of a half an hour fire rating. 1.The Maintenance staff repaired the kitchen ceiling furnace room smokebarrier, the areas around the pipes, and the ceiling barriers with fireresistant caulk which provides a minimum of a half an hour fire rating 2.Room 707 door will be cut off to ensure proper closing by September 16,2016. 3.The self closing device for the business office was replaced. 4.The self closing device for the Woodland kitchen door was replaced. 5.The self closing device for the west door in the tunnel was installed. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The facility Maintenance staff	

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	door in the corridor door set in the tunnel near the lower level riser room was removed which prevented the door from self closing. The lower level riser room contained a natural gas fired water heater. Based on interview at the time of the observations, the Environmental Director acknowledged the aforementioned fuel fired heater rooms were not separated from other spaces by smoke resistant partitions and doors. 3.1-19(b)		were re-educated onensuring that areas around pipes, barrierwalls and ceilings are sealed with correct fire resistant caulk and selfclosers are in place and in good repair. **III. The facility will put into place thefollowing systematic changes to ensure that the deficient practice does notrecur.** Maintenance Director will perform a complete auditof fire doors quarterly to ensure proper closing. **IV The facility will monitor the correctiveaction by implementing the following measures.** Facility TELs system will prompt maintenance staffto randomly check 25 doors monthly for proper closing. Results of this audit will be reviewed at themonthly Quality Assurance Committee meeting and frequency and duration ofreviews will be adjusted as needed. **V. Plan of Correction**	

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			completion date. Plan of Completion date is September 26, 2016.	
K 0038 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of egress through 5 of 16 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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. Exception No. 1 states 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 25 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of	K 0038	**K038** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 25 residents, staff and visitors could be affectedby the deficient practice number 1. 1resident could be effected by deficient practice number 2. 1.The Maintenance staff postedthe exit codes immediately. 2.The maintenance staffreconfigured the door locking mechanisms. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff andfacility managers were educated on the	09/26/2016

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	the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, the exit door by Room 202, Room 210, Room 221 and by Room 227 were each marked as a facility exit, were magnetically locked and could be opened by entering a four digit code but the code was not posted. In addition, the exit door by Room 501 was marked as a facility exit and was equipped with a magnetic holding device which will only release with activation of the fire alarm system. Based on interview at the time of the observations, the Environmental Director stated not all residents who have a clinical diagnosis to be in a secure building have access to the aforementioned exit doors and acknowledged the exit doors were not readily accessible for residents without a clinical diagnosis requiring specialized security measures. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 Salon bathrooms were readily accessible for residents without a clinical diagnosis requiring specialized security measures. 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		requirement of posting the exit codes ateach exit on September 14, 2016. The maintenance staff wereeducated on the importance of ensuring staff can readily unlock doors at all times. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The Maintenance staff and facility managers makedaily rounds and will monitor the exit code postings to ensure they are posted. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** An audit form will be usedto ensure the exit codes remained posted 24/7 at each facility exit. Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction**	

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	egress side. Exception No. 1 states 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 1 resident or staff. Findings include: Based on observation with the Environmental Director during a tour of the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, the bathroom in the Salon has two exits doors, one into the Salon and one into the Medical Director's Office and each door required a key to unlock the door from inside the bathroom. Based on interview at the time of observation, the Environmental Director acknowledged the exit doors from the Salon bathroom required a key to unlock the door from inside the bathroom. 3.1-19(b)		**completion date.** Plan of Completion date is September 26, 2016.	
K 0052 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety			

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	shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on observation and interview, the facility failed to maintain 4 of over 200 smoke detectors in accordance with NFPA 72. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, smoke detectors shall not be located where airflow prevents operation of the detectors. NFPA 72, A-2-3.5.1 explains smoke detectors should not be located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. This deficient practice could affect 23 residents, staff and visitors in the 700 Hall and the 800 Hall. Findings include: Based on observations with the Environmental Director during a tour of the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, the smoke detector in Room 727, Room 735, Room 824 and Room 829 was mounted on the wall one foot from a ceiling mounted air return vent. Based on interview at the time of the observations, the Environmental Director acknowledged the aforementioned smoke	K 0052	**K052** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 23 residents, staff and visitors in the 700 and 800hall could be affected by the deficient practice. Thesmoke detectors will be moved by 9-26-16 by facility maintenance staff. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff werere-educated on importance placement of smoke detectors not being located in adirect airflow nor closer than 3 feet from an air supply diffuser or return airopener.	09/26/2016

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	detectors were each located one foot of an air return vent. 3.1-19(b)		**III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The maintenance director will perform a facilitywide audit to ensure all smoke detectors have appropriate placement. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** The Maintenance Director and / or CorporateFacilities Staff will physically inspect areas that have been addressed by an outsidevendor after completion of a job to ensure smoke detectors have been installedin appropriate places. Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2016.	

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K 0074 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 o Newly introduced upholstered furniture and mattresses means purchased since March, 2003. Based on observation and interview, the facility failed to ensure window curtains in 2 of 22 smoke compartments were flame resistant. This deficient practice could affect 23 residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of	K 0074	**K074** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 23 residents could be affected by the deficientpractice. Thefacility has ordered fire resistant spray to treat all	09/26/2016

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	155181	A. BUILDING 01 B. WING	08/31/2016

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	the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, the window valence in resident sleeping Room 507 and the curtains in the family meeting room near the main entrance to the 700 Hall and the 800 Hall each had no affixed documentation stating each curtain and window valence was inherently flame retardant. A manufacturer's tag was affixed to each curtain and window valence stating the material was 100% polyester. Based on interview at the time of the observations, the Environmental Director stated the resident family for Room 507 most likely brought the valence in the facility and hung it, valences and curtains in the facility are not treated with flame retardant material and acknowledged the resident room window valence and family room window curtain flame resistant documentation was not available for review. 3.1-19(b)		draperies and valances. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff/housekeepingstaff were re-educated on importance ensuring all window coverings must becovered in a flame resistant material. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The facility maintenance director will perform afacility audit of all window coverings to ensure all are sprayed with flameresistant spray. Housekeeping staff move in and out room audits wereupdated to include window coverings and to alert the director to new coveringsbrought in from new admits. **IV Thefacility will monitor the corrective action by implementing the**	

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			followingmeasures. Results of these audits willbe reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2016.	
K 0144 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on observation and interview, the facility failed to ensure the remote manual stop for 1 of 3 emergency generators was provided with an alarm indicator and annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily	K 0144	**K144** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** All residents could be affected by the deficientpractice. Thefacility contracted with an outside vendor who found the facility generator tohave the	09/26/2016

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	observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. [NFPA 110: 3-5.5.2] NFPA 110, Standard for		annunciator panel with a remote stop indicator shutdown. **II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff werere-educated on importance of ensuring generators have remote stop indicatorshutdowns on the annunciator panel. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** The maintenance director will add checking for theremote stop indicator shutdown switch to the monthly audit form. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** An audit form will be usedby maintenance to ensure the facility has appropriate remote stop indicatorshutdown switches for all generators monthly. Results of these audits willbe	

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	Emergency and Standby Power Systems, 1999 Edition, Section 1-3 states NFPA 110 applies to new installations of Emergency Power Supply System (EPSS). Section 3-5.5.2(d) requires battery-powered individual alarm indication to annunciate visually at the control panel the occurrence of any of the conditions in Table 3-5.5.2(d); additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs. A lamp test switch (es) shall be provided to test the operation of all alarm lamps listed in Table 3-5.5.2(d). Table 3-5.5.2(d) states a remote emergency stop indicator for the shutdown of the emergency generator shall be provided. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Environmental Director during a tour of the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, the facility has three emergency generators one of which, Generator II, has a remote manual stop located outside the facility near the Station 5 exit by Room 501. The annunciator panel for Generator II located at the Station 5 nurse's station was not provided with a remote stop		reviewed at the monthly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as needed. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2016.	

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	indicator for shutdown of the emergency generator. Manufacturer's information affixed to Generator II indicated it was manufactured in 2004 and was rated at 15 kW. Based on interview at the time of the observations, the Environmental Director stated he was unaware if the remote stop would remain depressed if pushed not allowing the emergency generator to start and acknowledged the emergency generator annunciator panel located at the Station 5 nurse's station did not provide a visual and audible signal of system trouble for remote stop switch activation. 3.1-19(b)			
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure all electrical wiring in the lower level tunnel was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box.	K 0147	**K147** **I. The corrective actions to be accomplished forthose residents found to have been affected by the deficient practice.** 5 staff and visitors could be affected by thedeficient practice. Thefacility is installing an electrical box to incase wiring and wire nuts.	09/26/2016

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	This deficient practice could affect five staff and visitors on the lower level. Findings include: Based on observation with the Environmental Director during a tour of the facility from 10:45 a.m. to 3:40 p.m. on 08/31/16, spliced electrical wiring above the wall mounted magnetic door holding device for the west door in the corridor door set at the entrance to the lower level tunnel was exposed and was not confined within a junction box and a cover compatible with the box. Based on interview at the time of observation, the Environmental Director acknowledged the spliced electrical wiring for aforementioned magnetic holding device was not confined within a junction box and a cover compatible with the box. 3.1-19(b)		**II. The facility will identify other residentsthat may potentially be affected by the deficient practice.** The Maintenance staff werere-educated on ensuring wiring is incased and up to code. **III. Thefacility will put into place the following systematic changes to ensure thatthe deficient practice does not recur.** Maintenance director will perform monthlyenvironmental audit of the facility specific to electrical /wiring concerns andaddress as needed. **IV Thefacility will monitor the corrective action by implementing the followingmeasures.** An audit form CorporateFacilities will be used to ensure electrical issues are within code on a quarterlybasis. Results of these audits willbe reviewed at the quarterly Quality Assurance Committee meeting and frequencyand duration of reviews will be adjusted as	

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			needed. **V. Plan of Correction completion date.** Plan of Completion date is September 26, 2016.	