STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555136	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWAY HEALTHCARE CENTER	15632 POMERADO ROAD POWAY, CA 92064

(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 000	INITIAL COMMENTS K3 BUILDING: 01 K8 PLAN APPROVAL: 8/14/1981 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: One Story, Protected Wood Frame & Stucco Construction, Type V (111), Fully Sprinklered The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code re-certification survey. The findings are in accordance with 42 CFR (Code of Federal Regulations) 483.70 (a) and NFPA (National Fire Protection Association) 101, Life Safety Code 2000 edition, Existing codes. Representing the California Department of Public Health: 29626 Census = 95 The facility was not in substantial compliance with 483.70 (a) for Long Term Care Facilities.	K 000	**This Plan of Correction constitutes my written credible allegation of compliance for the deficiencies noted.**	
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the integrity of the building construction in 2 of 3 smoke compartments. This was evidenced by unsealed penetrations in the	K 012	**K 012** All of the unsealed penetrations noted on the ceilings and walls were sealed. Facility Maintenance Staff will be in-serviced on the importance of maintaining the integrity of the building construction of the smoke compartments related to unsealed penetrations. Monthly facility rounds will be conducted by the Maintenance Staff for unsealed penetrations in the facility. Any unsealed penetrations noted during the rounds will be sealed. The Maintenance Director will monitor for compliance and any trends will be reported and reviewed at the monthly Quality Assurance Committee Meeting.	3.15.13

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
MAR 15 2013
L & C DIVISION SAN JOSE

[redacted] EPRESENTATIVE'S [redacted] TITLE [redacted] DATE

enotes a deficiency [redacted] other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012	Continued From page 2 measured approximately 2-inches. 7. At 3:30 p.m., there were three penetrations on the wall behind Room 307 that measured approximately 1/2-inch each.	K 012		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain doors installed in smoke barrier walls. This was evidenced by doors in the attic space portion of the smoke barrier walls that were not fully closed. This affected 2 of 3 smoke compartments and had the potential to allow the spread of smoke and fire from one smoke compartment to another smoke compartment, increasing the risk of harm to the patients and the staff in the event of a fire. Findings: During a tour of the facility with the Director of Maintenance on 2/14/2013, the smoke barrier walls were observed.	K 027	K 027 The smoke barrier wall doors in the attic space were fully closed and latched. The Maintenance Staff will be in-serviced regarding the importance of maintaining closed and latched doors in the smoke barrier walls in the attic space. Monthly facility rounds will be conducted to ensure the integrity of the smoke barrier wall doors by the Maintenance Staff. Any doors not fully closed or latched will be closed and latched. The Maintenance Director will monitor for compliance and any trends will be reported and reviewed at the monthly Quality Assurance Committee Meeting.	313.B

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K 027	Continued From page 3 1. At 3:40 p.m., the smoke barrier wall by Room 107 had a door that measured approximately 3-feet by 4-feet in the attic space. The door was not fully closed and was not latched. It had multiple cables running between the door and the door frame. 2. At 3:43 p.m., the smoke barrier wall by Room 406 had a door that measured approximately 3-feet by 4-feet in the attic space. The door was not fully closed and had its latching mechanism exposed.	K 027		
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that smoke detectors to the fire alarm system were properly maintained. This was evidenced by 7 of 15 duct detectors that were not tested during inspection and no current record of smoke detector sensitivity testing. This had the potential for detectors to fail and occupants to not be alerted of a fire, resulting in harm to patients, visitors and staff. NFPA 101, Life Safety Code, 2000 Edition 9.6.1.7 To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70, National	K 054	K 054 The facility smoke detector sensitivity testing was completed. The Maintenance Staff will be in-serviced regarding the importance of the smoke detector sensitivity testing. Routine testing will be conducted by the Maintenance Staff per annually and the results recorded. Any issues related to the smoke detector sensitivity testing will be corrected. The Maintenance Director will monitor for compliance and report any trends to the monthly Quality Assurance Committee Meeting.	3/13/13

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K 054	Continued From page 4 Electrical Code, and NFPA 72, National Fire Alarm Code. NFPA 72, National Fire Alarm Code, 1999 Edition 7-2.2 Fire alarm systems and other systems and equipment that are associated with fire alarm systems and accessory equipment shall be tested according to Table 7-2.2. Table 7-3.2 Testing Frequencies 16. Initiating Devices. h. All Smoke Detectors - Functional Annually 7-3.2.1 Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods: (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its	K 054		

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K 054	Continued From page 5 listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Findings: During a tour of the facility with the Director of Maintenance on 2/14/2013, the fire alarm system inspection documents were reviewed. 1. At 11:23 a.m., the facility's fire alarm system inspection report, dated 6/8/12, identified the following 7 of 15 duct detectors as not tested annually (see K67 for finding on air duct access): 1. The duct detector device #0301 located above Nurse Station. 2. The duct detector device #0302 located above Conference Room. 3. The duct detector device #0303 located above Conference Room. 4. The duct detector device #0304 located in AH-3 Supply Main. 5. The duct detector device #0305 located in AH-3 Return Main. 6. The duct smoke detector device #0170 located in the 300-400 Wing West #3. 7. The duct smoke detector device #0171 located in the 300-400 Wing East #1. 2. At 4:30 p.m., the fire alarm system annual report, dated 6/8/12, was reviewed. The report did not contain record of smoke detector sensitivity testing. The Director of Maintenance	K 054		

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K 054	Continued From page 6 provided a report for smoke detector sensitivity, dated 1/4/2011, but they were unable to find reports for current or prior years that showed the smoke detector sensitivity test.	K 064		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain their automatic sprinkler system. This was evidenced by a sprinkler head that did not maintain an 18-inch clearance and a sprinkler head with foreign material. This affected 1 of 3 smoke compartments. This could result in the ineffective disbursement of water and the sprinkler head not activating during a fire, resulting in injury to residents, visitors, and staff. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition 2-2.1.1 Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. NFPA 13, Standard for the Installation of	K 062	K 062 1) The 18-inch clearance was maintained in the walk-in refrigerator in the kitchen. 2) The sprinkler head in Room 410 was cleared of the white colored foreign material. The Maintenance and Kitchen Staff will be in-serviced regarding maintaining an 18-inch clearance in the walk-in refrigerator in the kitchen and keep the sprinkler heads clean and free of debris. Monthly facility rounds will be conducted by the Maintenance Staff. Any issues noted related to the sprinkler system will be corrected. The Maintenance Director will monitor for compliance and any trends will be reported to the monthly Quality Assurance Committee Meeting.	3.13.13

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K 062	Continued From page 7 Sprinkler Systems, 1999 Edition 5-5.6. The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. During a tour of the facility with the Director of Maintenance on 2/14/2013, the sprinkler system was observed. 1. At 2:18 p.m., the sprinkler head installed in the walk-in refrigerator located in the kitchen had a box placed approximately 10-inches from the sprinkler's deflector. 2. At 3:28 p.m., the sprinkler head installed in the bathroom in Room 410 had a white colored foreign material on its fusible link and deflector.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain portable fire extinguishers. This was evidenced by a fire extinguisher with its pressure gauge indicating it was not fully charged, effected 1 of 3 smoke compartments. This could result in a delayed response to a fire and increase the risk of injury to residents, visitors, and staff. NFPA 101, Life Safety Code, 2000 Edition 9.7.4 Manual Extinguishing Equipment	K 064		

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K 064	Continued From page 8 9.7.4.1 Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition 4-3 Inspection. 4-3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. 4-3.2 Procedures. Periodic inspection of fire extinguishers shall include a check of at least the following items: (g) Pressure gauge reading or indicator in the operable range or position Findings: During a tour of the facility with the Director of Maintenance on 2/14/2013, the fire extinguishers were observed. At 11:04 a.m., the fire extinguisher, located in the corridor by the conference room and shower room 4, had its pressure gauge needle pointed in the red zone. The green zone is marked as its operable range.	K 064	K 064 All fire extinguishers were checked for the appropriate pressure gauge reading and indicator in the operable range or position. Maintenance Staff will be in-serviced on how to inspect the fire extinguishers. Fire extinguishers will be inspected monthly by the Maintenance Staff and recorded. Any issues related to the fire extinguishers will be corrected. The Maintenance Director will monitor for compliance and any trends will be reported to the monthly Quality Assurance Committee Meeting.	313.B
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

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K 067	Continued From page 9 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their Air-Conditioning and Ventilating Systems in accordance with NFPA 90A. This was evidenced by failing to provide air duct openings to service and test smoke detectors, failing to ensure that all fire/smoke dampers were tested, and failing to provide drawings with locations of all dampers. This affected 3 of 3 smoke compartments. This had the potential for the dampers to not function and fail to contain smoke and fire, resulting in injury to residents, staff, and visitors from smoke inhalation. NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems, 1999 Edition 2-3.4.1 A service opening shall be provided in air ducts adjacent to each fire damper, smoke damper, and smoke detector. The opening shall be large enough to permit maintenance and resetting of the device. 2-3.4.2 Service openings shall be identified with letters having a minimum of 1/2 in. (1.27 cm) to indicate the location of the fire protection device(s) within. 2-3.4.5 Openings in walls or ceilings shall be provided so that service openings in air ducts are accessible for maintenance and inspection needs.	K 067	K 067 The smoke detectors and fire/smoke dampers were tested. Mechanical plan drawings were created for the locations of the fire/smoke dampers. The Maintenance Staff will be in-serviced regarding testing the smoke detectors and fire/smoke dampers. The smoke detectors and fire/smoke dampers will be tested per manufacturer's specifications and the results recorded. Any issues identified with the smoke detectors and fire/smoke dampers will be corrected. The Maintenance Director will monitor for compliance and any trends will be reported to the monthly Quality Assurance Committee Meeting.	3.13.13

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K 067	Continued From page 10 3-3.5.1 Smoke dampers shall be installed at or adjacent to the point where air ducts pass through required smoke barriers, but in no case shall a smoke damper be installed more than 2 ft (0.6 m) from the barrier or after the first air duct inlet or outlet, whichever is closer to the smoke barrier. 3-4.5.1 All fire dampers and ceiling dampers shall close automatically, and they shall remain closed upon the operation of a listed fusible link or other approved heat-actuated device located where readily affected by an abnormal rise of temperature in the air duct. 3-4.6.1 The locations and mounting arrangement of all fire dampers, smoke dampers, ceiling dampers, and fire protection means of a similar nature required by this standard shall be shown on the drawings of the air duct system. 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they close fully; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. 5-1.2 Records shall be maintained on acceptance test results and shall be available for inspection. Findings: During a tour of the facility with the Director of Maintenance on 2/14/2013, maintenance records for fire/smoke dampers were requested.	K 067		

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K 067	Continued From page 11 At 11:25 p.m., the fire alarm company's annual inspection report, dated 6/8/2012, stated that 7 of 15 smoke detectors in the air duct system were not tested since they were not accessible (see K54 for location of smoke detectors). At 1:29 p.m., the Director of Maintenance stated that he did not know and did not have any evidence that showed that the fire/smoke dampers had been inspected within the past four years. The only record available for review was an inspection performed on 2/28/2007 that identified 31 fusible links replaced on dampers. At 1:32 p.m., the Director of Maintenance did not know the locations of the fire/smoke dampers and he did not have mechanical plan drawings that showed the damper locations.	K 067		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain means of egress continuously free of obstructions. This was evidenced by items obstructing the exit discharge and restricting it to less than 4-feet. This affected 3 of 8 exits. This had the potential to delay egress in the event of an emergency evacuation, resulting in injury to residents, visitors and staff.	K 072		

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K 072	Continued From page 12 NFPA 101, Life Safety Code, 2000 Edition 19.2.3.3 Any required aisle, corridor, or ramp shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Findings: During a tour of the facility with the Director of Maintenance on 2/14/2013, the exits, exit access, and exit discharges were observed. At 9:40 a.m., the exit discharge on the south portion of the building had multiple items obstructing the pathway to the public way. The exit discharge included exits from the smoking area patio, South Dining Room, and the Kitchen. The pathway was decreased to approximately 2-feet with tables, locker cabinet, milk carts, wheelchairs, janitor carts, and other wheeled carts.	K 072	<u>K 072</u> The exit discharge on the south portion of the building was cleared of any items obstructing the exit pathway. Facility staff will be in-serviced on the importance of maintaining means of egress and continuously free of obstructions. Maintenance Staff will conduct monthly facility rounds of the exits, exit access and exit discharges. Any issues related to the exits, exit access and exit discharges will be corrected. The Maintenance Director will monitor for compliance and any trends will be reported to the monthly Quality Assurance Committee Meeting.	3.13.13
K 074 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the	K 074		

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K 074	Continued From page 13 methods cited in 10.3.2 (2) and 10.3.3. 19.7.6.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that their curtains were flame resistant. This was evidenced by curtains installed in corridor with no record of fire-retardant coating treatment or flame resistant rating, affected 1 of 3 smoke compartments. This could result in the rapid spread of fire and cause injury to residents. NFPA 101, Life Safety Code, 2000 Edition 10.3.1 Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. 10.3.6 Fire-retardant coatings shall be maintained to retain the effectiveness of the treatment under service conditions encountered in actual use. Findings: During a tour of the facility with the Director of	K 074	K 074 The curtains in the corridor by Nursing Station 2 are treated to be flame resistant and recorded as such. Facility Staff will be in-serviced regarding ensuring facility curtains are flame resistant and recorded. Maintenance Staff will conduct monthly facility rounds for any facility draperies, curtains and decorations to ensure that they are flame resistant. Any issues related to this will be corrected. The Maintenance Director will monitor for compliance and any trends will be reported to the monthly Quality Assurance Committee Meeting.	3.13.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555135	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/14/2013

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K 074	Continued From page 14 Maintenance on 2/14/2013, the facility's curtains were observed. At 11:53 a.m., curtains were observed in the corridor by Nursing Station-2. The curtains did not contain a tag indicating the flame resistant rating. The Director of Environmental Services stated that the curtains were treated with a fire-retardant coating, but they did not maintain records on how often they are treated and when they were last treated.	K 074	**K 076** The oxygen gas cylinder in the storage room was immediately secured. The Facility Staff will be in-serviced on the proper storage of the oxygen gas cylinders. The Maintenance Staff will conduct monthly facility rounds related to the proper storage of oxygen gas cylinders. Any issues related to the storage of oxygen gas cylinders will be corrected. The Maintenance Director will monitor for compliance and any trends will be reported to the monthly Quality Assurance Committee Meeting.	3.13.13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2; 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to properly store their medical gas cylinders. This was evidenced by an oxygen cylinder that was not individually secured. This affected 1 of 3 smoke compartments. This could cause harm to patients, visitors, and staff in the event the cylinder fell on something or someone and/or the high pressure valve was damaged and caused	K 076		

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K 076	Continued From page 15 the cylinder to move about in an uncontrolled manner. NFPA 101, Life Safety Code, 2000 Edition 19.3.2.4 Medical Gas. Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. NFPA 99, Health Care Facilities, 1999 Edition 4-3.1.1.1. Cylinder and Container Management. Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over. Findings: During a tour of the facility with the Director of Maintenance on 2/14/2013, the medical gas cylinders storage area was observed. At 2:41 p.m., the medical gas cylinder storage room, located by the South Dining Room, had an oxygen gas cylinder that was standing upright and not individually secured. The cylinder measured approximately 24 cubic feet.	K 076		
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide postings of precautionary signs where oxygen was in use or stored. This was evidenced	K 141		

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K 141	Continued From page 16 by no posting of a non smoking sign or symbol in the medical gas cylinders storage room. This had the potential for causing fire in the event that a flame is sparked in the area, resulting in injuries to residents, visitors, and staff. Findings: During a tour of the facility with the Director of Maintenance on 2/14/2013, the oxygen storage areas and areas where oxygen was in use were observed. At 2:44 p.m., there was no posting of a non-smoking sign or symbol by the door to the medical gas storage room containing oxygen cylinders.	K 141	K 141 Oxygen signs are posted where oxygen is in use and/or stored. Facility staff will be in-serviced on providing oxygen signs where oxygen is in use and/or stored. Maintenance and Nursing staff will conduct weekly rounds for the presence of oxygen signs where oxygen is in use and/or stored. If an oxygen sign is found not posted, it will be immediately corrected. The Maintenance Director will monitor for compliance and any trends will be reported to the monthly Quality Assurance Committee Meeting.	3.13.13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on document review and observation, the facility failed to maintain electrical safety. This was evidenced by no record of tension and polarity testing done on all receptacle wall outlets and damaged cover plates to receptacle wall outlets, affected the entire facility and had the potential for increasing risk of electrical fire and electrical shock, injuring residents, visitors, and staff. NFPA 70, National Electrical Code, 1999 Edition 110-12. Mechanical Execution of Work. Electrical equipment shall be installed in a neat and	K 147		

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K 147	Continued From page 17 workmanlike manner. NFPA 99, Standard for Health Care Facilities, 1999 Edition 3-3.3.2.5 Test Equipment. Electrical safety test instruments shall be tested periodically, but not less than annually, for acceptable performance. 3-3.3.3 Receptacle Testing in Patient Care Areas. (a) The physical integrity of each receptacle shall be confirmed by visual inspection. (b) The continuity of the grounding circuit in each electrical receptacle shall be verified. (c) Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. (d) The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 15g (4oz). 3-3.4.3 Recordkeeping. 3-3.4.3.1 General. A record shall be maintained of the tests required by this chapter and associated repairs or modification. At a minimum, this record shall contain the date, the rooms or area tested, and an indication of which items have met or have failed to meet the performance requirements of this chapter. Findings: During a tour of the facility with the Director of Maintenance on 2/14/2013, the documentation for the inspection of receptacle wall outlets were requested and electrical equipments were observed. 1. At 1:30 p.m., the Director of Maintenance	K 147	K 147 Tension and polarity testing was completed. The broken cover plates were replaced in Rooms 201 and 314. The Maintenance Staff will be in-serviced regarding tension and polarity testing, receptacle wall outlets and electrical equipment. The Maintenance Staff will conduct tension and polarity testing per manufacturer's specifications and record the results. The Maintenance Staff will conduct monthly facility rounds related to inspecting wall outlets and electrical equipment. Any issues related to the tension and polarity testing, receptacle wall outlets and electrical equipment will be corrected. The Maintenance Director will monitor for compliance and any trends will be reported to the monthly Quality Assurance Committee Meeting.	3.13.13

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K 147	Continued From page 18 stated that they had no records available that showed the listing of all the receptacle wall outlets inspected for integrity, tension, and polarity within the past 12 months. 2. At 2:58 p.m., the receptacle wall outlet installed behind Bed B in Room 201 had a broken cover plate. 3. At 3:24 p.m., the receptacle wall outlet installed behind Bed B in Room 314 had a broken cover plate.	K 147		