DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Amended

PRINTED: 08/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055996	A. BUILDING 01 B. WING ______	08/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER - HY-LOND	3408 EAST SHIELDS AVENUE FRESNO, CA 93726

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K 000	INITIAL COMMENTS K3 BUILDING: 01 K6 PLAN APPROVAL: 4/19/68 and 1/16/74 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: TYPE V (111), PARTIALLY 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: 28602. The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 106	K 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. **This Plan of Correction constitutes my written credible allegation of compliance for the deficiencies noted.**	
K 012 SS=D	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 and interview, the facility failed to maintain the integrity of the building construction. This was evidenced by a penetration in the ceiling. This affected one of	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Adm — (X6) DATE: 9-6-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 1 four smoke compartments and could result in the spread of smoke from one area to another in the event of a fire. Findings: During the facility tour and interview with Staff 1 on 8/20/13, the ceilings and walls were observed. At 3:28 p.m., there was an approximately 2 1/2 by 22 1/2 feet cut out penetration in the ceiling in Shower Room 4. The penetration was on the right side of the room. At 3:2 p.m., during an interview, Staff 1 reported the shower room is currently undergoing remodeling. He stated that the remodeling project began approximately fourteen or fifteen months ago and that the project's completion date is in approximately five weeks. Staff 1 reported OSHPD with the local Fire Marshall will be out for the final inspection on 8/31/13. At 4:50 p.m., during an interview, Staff 2 provided documentation from the Office of Statewide Health Planning and Development Facilities Development Division (OSHPD) indicating the permit for "shower renovation," was issued on 5/16/12. The Project # on the documentation was P-2012-00570.	K 012	**K012** **In accordance with §448.331, this deficiency has been submitted under the informal dispute resolution process.** It is the policy of this facility to continuously strive to meet the requirements of maintaining the integrity of the building construction. 1. The penetration in the ceiling of shower room 4 was closed 8-31-13 following the final inspection of the State Fire Marshall for the OSHPD Project #P-2012-00570. 2. The Maintenance Supervisor will inspect penetrations in walls after an outside vendor completes repairs. 3. The Maintenance Supervisor will routinely monitor the ceilings and repair and log any penetrations noted. 4. Any negative trends will be reported to the QAPI Committee for review and development of an action plan. 5. 8/31/13	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20	K 018		

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K 018	Continued From page 2 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were free from impediments, and failed to ensure that corridor doors close and latch. This was evidenced by one corridor door that failed to close and latch, and by one door that was impeded from closing. This failure could result in the spread of smoke or fire, in the event of a fire, and affected two of four smoke compartments. Findings: During a facility tour and interview with Staff 1 and 2, the doors in the facility were observed. 1. At 3:09 p.m., the door to Room 41 was obstructed from closing by a lift positioned in the swing path of the door. There were no staff observed in the vicinity. At 3:10 p.m., during an interview, Staff 2 reported	K 018	K018 It is the policy of this facility to continuously strive to meet the requirements of maintaining the proper mechanics of the corridor doors in the facility. 1. The doorway in room 41 was cleared of the obstruction during the walk through. The self closing door in the Social Services Office was repaired on 8-20-13. 2. The Maintenance Supervisor will instruct staff to report doors not closing properly. An inservice will be conducted with all staff about obstructing doors with equipment. 3. The Maintenance Supervisor will routinely check all corridor doors and log repairs. 4. Any negative trends will be reported to the QAPI Committee for review and development of an action plan. 5. 9/12/13	

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K 018	Continued From page 3 that the lift was there because staff were currently conducting patient care. 2. At 3:25 p.m., the self closing corridor door to the Social Services Office was held open to the fullest extent and allowed to close. The door failed to fully close and latch. The door was tested four times.	K 018		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the integrity of the fire alarm system in accordance with NFPA 101. This was evidenced by the failure of three audible alarms to sound when the fire alarm system was tested. This could result in a delay in notifying residents and staff in the event of a fire, and affected two of four smoke compartments. NFPA 101 Life Safety Code (2000 Edition) 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level	K 052		

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K 052	Continued From page 4 of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. 9.6.1.4 A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code, unless an existing installation, which shall be permitted to be continued in use, subject to the approval of the authority having jurisdiction. 9.6.3.6 Notification signals for occupants to evacuate shall be by audible and visible signals in accordance with NFPA 72, National Fire Alarm Code, and CABO/ANSI A117.1, American National Standard for Accessible and Usable Buildings and Facilities, or other means of notification acceptable to the authority having jurisdiction shall be provided. 9.6.3.8 Audible alarm notification appliances shall be of such character and so distributed as to be effectively heard above the average ambient sound level occurring under normal conditions of occupancy. Finding: During fire alarm testing with Staff 1 on 8/20/13, the manual pull alarms and smoke detectors were tested. 1. At 10:13 a.m., the combination audible/visual alarm by the classroom was observed. The chime failed to alarm after activation of a manual pull station.	K 052	K052 It is the policy of this facility to continuously strive to meet the requirements of maintaining the integrity of the fire alarm system. 1. The audible/visual alarm by the classroom, in the hallway near room 20, and near the medical records office were repaired by the outside vendor on 8-20-13. The alarm panel had been tested on 7-11-13 during the annual fire alarm testing by the vendor and all audible/visual alarms were found to be in working condition at that time. 2. The Maintenance Supervisor will oversee the quarterly testing of the fire alarm system by the outside vendor. 3. The Maintenance Supervisor will routinely monitor the fire alarm panel and its components to maintain its function. 4. Any negative trends will be reported to the QAPI Committee for review and development of an action plan. 5. 8/20/13	

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K 052	Continued From page 5 2. At 10:14 a.m., the combination audible/visual alarm in the hallway near Room 20 was observed. The chime failed to activate an audible alarm after activation of the manual pull station. 3. At 10:25 a.m., the combination audible/visual alarm near the medical records office was observed. The chime failed to alarm after activation of a manual pull station.	K 052		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the automatic sprinkler system was installed in accordance with NFPA 101, NFPA 13, and NFPA 25. This was evidenced no automatic sprinkler system located under the wood frame overhangs. This could result in the spread of fire in the event of a fire, and affected the exterior of the facility.	K 056		

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K 056	Continued From page 6 NFPA 101, 2000 Edition 4.6.12 Maintenance and Testing 4.6.12.1 Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 13 Installation of Sprinkler Systems, 1999 Edition 5-13.8 Exterior Roofs or Canopies. 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 M) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. Finding: During the facility tour and interview with Staff 1 on 8/20/13, the exterior of the facility was observed. 1. At 8:38 a.m., during an entrance conference, Staff 1 and Staff 2 were asked about the project to install automatic sprinkler coverage for the overhangs in the facility over four feet in width, that were required by CMS to have complete automatic sprinkler coverage and to be fully sprinklered by 8/13/13. 2. At 8:39 a.m., during an interview, both Staff 1	K 056	K056 It is the policy of this facility to continuously strive to meet the requirements of maintaining a automatic sprinkler system. 1. Outside vendor is currently installing the additional sprinklers required by NFPA 101, 13, and 25. It is anticipated that the work will be completed by 9-18-13. 2. The Maintenance Supervisor and Executive Director are overseeing the installation of the required additional sprinklers. 3. The automatic sprinkler system is maintained and tested quarterly per requirements. 4. Any negative trends will be reported to the QAPI Committee for review and development of an action plan. 5. 9-18-13	

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K 056	Continued From page 7 and Staff 2 reported they were under the impression that they had until the end of August, 2013, to complete the automatic sprinkler project. Staff 1 reported the vendor was on site currently working on the installation of the sprinklers in the overhangs. 3. At 10:10 a.m., during an interview, the vendor reported that it would take approximately three weeks to complete the automatic sprinkler project. 4. At 1:15 p.m., during an interview, Staff 1 reported the Southwest side of the facility had been completed. Staff stated that the Southeast side was currently being worked on, and that the East and the West side of the facility did not exceed the four foot wide overhang requirement, therefore there was no need to add automatic sprinklers. The front, North side of the facility, will be worked on once the Southeast side was completed. 5. At 1:28 p.m., there was no automatic sprinkler distribution piping or sprinkler heads located under an approximately six foot, nine inch wide overhang on the North side of the facility. 6. At 1:30 p.m., there was no sprinkler distribution piping or sprinkler heads located under the overhangs on the Northwest side of the facility, which measured approximately six foot wide, to eight and a half foot wide. The overhang varied in width from approximately six feet in width, to seven and a half feet in width, to eight and a half feet in width. 7. At 4:52 p.m., during an interview, Staff 2 provided an e-mail dated 8/15/2013, from the	K 056		

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K 056	Continued From page 8 architect which stated "Design drawings for the work are currently being processed through the Rapid Review permitting process as this project falls within the constraints of the review program." 8. On 8/26/2013, at 8:45 a.m., in an interview, Staff 2 stated that no documentation for submitting the project to OSHPD, no project approvals or a building permit, had been received from OSHPD for the automatic sprinkler system project. Staff 2 stated that Corporate was handling the installation of the automatic sprinkler system. 9. On 8/26/13, at approximately 10:30 a.m., during an interview, Staff 2 stated they had been in contact with the Architect, who reported there was no documentation from OSHPD on this project. Staff stated that the Architect was currently working with OSHPD to determine if this project would be an over the counter review, or an expedited review. CMS issued S&C-09-04, dated October 3, 2008, titled "Adoption of New Fire Safety Requirements for Long Term Care Facilities, Mandatory Sprinkler Installation Requirement". This letter required all long term care facilities to be equipped with a supervised sprinkler system by August 13, 2013, installed in accordance with the 1999 Edition of the National Fire Protection Association's (NFPA) Standard for for Installation of Sprinkler Systems (NFPA 13), and maintained in accordance with the 1998 Edition of the National Fire Protection Association's (NFPA) Standard for for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, (NFPA 25).	K 056		

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K 073 K 073 SS=E	Continued From page 9 NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the rooms free from highly flammable decorations. This was evidenced by four rooms that had flammable decorations on the corridor doors. This could result in a fire to build and spread to other locations of the facility, and affected two of four smoke compartments. Findings: During a facility tour and interview with Staff 1 and 2 on 8/20/13, the decorations in the facility were observed. 1. At 3:10 p.m., there was a silk flower wreath approximately 21 inches in diameter hanging on the corridor door to Room 44. There were no tags on the wreath that indicated that it was flame resistant or had been treated with fire retardant substance. 2. At 3:11 p.m., there was a silk flower wreath approximately 18 inches in diameter hanging on the corridor door to Room 45. There were no tags on the wreath that indicated that it was flame resistant, or had been treated with fire retardant substance. 3. At 3:18 p.m., there was a silk flower wreath approximately 16 inches in diameter hanging on the corridor door to Room 46. There were no	K 073 K 073	K073 It is the policy of this facility to continuously strive to maintain the resident rooms free from highly flammable decorations. 1. The wreaths on the doors of Rms. 44, 45, and 46 and 36 have been treated with a fire retardant substance per the manufacturer's instructions. 2. The Maintenance Supervisor and all Management team will monitor decorations brought in by families and notify maintenance to treat the items. 3. The Maintenance Supervisor will keep a log of the items treated with fire retardant substance and re-treat as specified by the manufacturer. 4. Any negative trends will be reported to the QAPI Committee for review and development of an action plan. 5. 9-3-13	

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K 073	Continued From page 10 tags on the wreath that indicated that it was flame resistant, or had been treated with fire retardant substance. 4. At 3:35 p.m., there was a silk flower wreath approximately 20 inches in diameter hanging on the corridor door to Room 36. The wreath was made on with dry twigs. There were no tags on the wreath that indicated that it was flame resistant, or had been treated with fire retardant substance. During an interview, Staff 1 stated the resident's family members bring in items for the residents, and staff was not informed. Staff 1 stated they did not know if the wreaths were flame resistant or not. Staff stated they had not treated the wreaths.	K 073		
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that smoke barrier walls maintain a 1/2 hour fire resistance rating. This was evidenced by one of four smoke barrier walls that had penetrations. This affected two of four smoke compartments, and could result in the spread of smoke from one compartment to another in the event of a fire. NFPA 101, Life Safety Code, 2000 edition.	K 104		

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K 104	Continued From page 11 8.3.2 Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous throughout all concealed spaces, such as those found above a ceiling, including interstitial spaces. 8.3.6.1. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tube and ducts, and similar building services equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed of the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 104	K104 It is the policy of this facility to continuously strive to maintain the smoke barrier walls have a 1/2 hour fire resistance rating. 1. The 1/2 inch penetration in the smoke barrier wall between Room 11 and 14 was repaired on 8-20-13, the day of the survey. 2. The Maintenance Supervisor will inspect smoke barrier walls after an outside vendor completes repairs. 3. The Maintenance Supervisor will routinely monitor the smoke barrier walls and repair and log any penetrations noted. 4. Any negative trends will be reported to the QAPI Committee for review and development of an action plan. 5. 8/20/13	

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(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 104	Continued From page 12 Findings: During the facility tour and interview with Staff 1 on 8/20/13, the smoke barrier walls in the facility were observed. 1. At 9:15 a.m., there was an approximately 1/2 inch penetration in the smoke barrier wall between Room 11 and Room 14. The penetration was below a flexible conduit on the upper left side of the wall, directly at the attic access. 2. At 9:16 a.m., during an interview, Staff 1 reported that a piece of material used to cover the penetration around the conduit had broken off.	K 104		
K 147 SS=F	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 observations and interview, the facility failed to maintain their electrical equipment and utilities. This was evidenced by broken cover plates, receptacles and ground ports, and by the use of surge protectors as a substitute for fixed wiring. This affected four of four smoke compartments, and could result in an increased risk of an electrical fire. NFPA 101, Life Safety Code, 2000 Edition 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations,	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055996	A. BUILDING 01 B. WING _____	08/20/2013

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K 147	Continued From page 13 which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70 National Electrical Code 1999 Edition 110-12(C) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasive, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. 400.8 Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. (5) Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (6) Where installed in raceways, except as otherwise permitted in this Code. Findings:	K 147		

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K 147 Continued From page 14

During the facility tour and interview with Staff 1 and 2 on 8/20/13, the electrical equipment and wiring were observed.

1. At 1:33 p.m., there was a broken receptacle and ground port in the Fire Place Room. The receptacle was on the left wall.

2. At 1:50 p.m., there was a six plug surge protector used to connect a bed, and a fan to the wall outlet, in the resident Room 12.
At 1:51 p.m., during an interview, Staff 1 reported the surge protector was equipped with a 15 amp breaker.

3. At 1:52 p.m., there was a six plug surge protector connecting 2 beds, to the wall outlet in Room 18.

4. At 1:53 p.m., there was a six plug surge protector connecting 2 beds, a radio and a Nebulizer to the wall outlet in Room 24.
At 1:53 p.m., during an interview, Staff 1 reported the facility was having new electrical work installed in the facility, as it had been approved by Corporate.

5. At 1:57 p.m., there was an eight plug surge protector connecting a refrigerator and computer equipment to the wall outlet, in the classroom.

6. At 2:00 p.m., there was a six plug surge protector connecting a bed, a concentrator, a recliner chair, and a phone to the wall outlet in Room 25, by bed A.

7. At 2:01 p.m., there was a six plug surge protector connecting two beds, to the wall outlet in Room 23.

K 147 **K147 AMENDED**

In accordance with §448.331, this deficiency has been submitted under the informal dispute resolution process.

It is the policy of this facility to continuously strive to maintain the electrical wiring in accordance with NFPA 70.

1. The broken receptacle in the Fire Place Room was replaced 9-4-13.

The cracked cover plate in the wall outlet in the Break Room was replaced 9-4-13.

The wall outlet in the Back Dining Room was replaced 9-4-13.

The adapter has been removed from the microwave in the Occupational Therapy Room and the cover plate replaced 9-4-13.

The cracked wall outlet has been replaced in the Women's Restroom 9-4-13.

The wall outlet has been replaced in the Admissions Office 9-4-13.

The surge protectors identified have been removed. OSHPD project #P-2013-0059 is pending starting state. . This will eliminate the need for the surge protectors. A 45 day time line is anticipated for the project once it begins. Currently waiting for OSHPD review.

2. The Maintenance Supervisor will inspect the facility for broken receptacles and surge protectors during his routine preventative maintenance rounds and replace as needed.

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K 147	Continued From page 15 8. At 2:07 p.m., there was a cracked cover plate to wall outlet in the Staff Lounge/Break Room. 9. At 2:08 p.m., there was a two plug wall outlet with broken ground ports in the Back Dining Room. The wall outlet was located on the left wall. 10. At 2:30 p.m., there was an adapter used to connect a microwave to the wall outlet in the Occupational Therapy charting room. 11. At 2:34 p.m., the cover plate to a two plug wall outlet was broken in the Occupational Therapy. The cover plate was in the room located in the right corner, adjacent to a bed. There was an approximately 1/2 inch broken off the top of the cover plate. 12. At 3:17 p.m., there was a six plug surge protector used to connect the bed, a TV and a fan to the wall outlet in Room 50. 13. At 3:21 p.m., there was a cracked wall outlet in the Women's Restroom across from the Social Services Office. 14. At 3:22 p.m., there was a broken ground port on the wall outlet in the Admissions Office. 15. At 3:34 p.m., there was a six plug surge protector connecting a bed to the wall outlet in Room 38. 16. At 3:47 p.m., there was a six plug surge protector connecting two beds and a concentrator in Room 5.	K 147	3. Staff will be inserviced to notify maintenance of any broken receptacles. 4. Any negative trends will be reported to the QAPI Committee for review and development of an action plan. 5. 9-19-13	

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K 147	Continued From page 16 During an interview, Staff 1 reported that the surge protectors were used because there were not enough electrical wall outlets in the rooms. At 4:40 p.m., during an interview, Staff 2 reported the facility was currently in the process of upgrading the electrical system in the rooms. Staff provided documentation from OSHPD that indicated the plan approval date of 4/29/13, with Project #P-2013-00559.	K 147		