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

PRINTED: 04/24/2013
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
	056495	A. BUILDING 01 B. WING	04/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA COLOMA HLTH CARE CENTER	10410 COLOMA RD RANCHO CORDOVA, CA 95670

(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 K6 PLAN APPROVAL: 1963 & 1897 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, TYPE V WOOD FRAME CONSTRUCTION, FULLY SPRINKLERED The following reflects the findings of the California Department of Public Health, during an annual Life Safety Code recertification 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: 27994 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census: 115	K 000	This Plan of Correcton constitutes This facilities allegation of compliance.	
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, the facility failed to	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda M. Patrick — TITLE: Administrator — (X6) DATE: 5/6/2013

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.

accepted 5/20/13 J Gonzalez

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K 012	Continued From page 1 maintain the integrity of the building's construction, as evidenced by unsealed penetrations in the wall and ceilings. This affected four of seven smoke compartments and could result in the increased potential for the spread of fire and smoke to other areas of the facility. Findings: During a tour of the facility with staff on 4/17/13, the walls and ceilings were observed. 1. At 8:43 a.m., there were two penetrations that measured approximately 1/8-inch in the right wall to the Utility room located by Room 21. 2. At 9:04 a.m., there was a penetration that measured approximately 1/4-inch around a blue cord in the ceiling to the Physiotherapy room. 3. At 9:30 a.m., there was a penetration that measured approximately 1/2-inch around two blue cords in the ceiling to the Activity office. 4. At 9:40 a.m., one of two sprinklers was not flush to the ceiling in the Storage room across from Room 71. This created a penetration in the ceiling that measured approximately 1/8-inch.	K 012	K012 It is the policy of this facility to maintain the integrity of the building's construction. 5-17-2013 Temporary and Permanent Correction Penetration located by Room 21 was sealed by Maintenance Supervisor. Penetration around blue cord in Physiotherapy room was sealed by Maintenance Supervisor. Penetration around two cords in Activity Office were sealed by Maintenance Supervisor. Sprinkler in storage room was made to be flush with the ceiling and penetration was sealed by the Maintenance Supervisor. Walls and Ceilings will be inspected monthly by the Asst. Administrator for three months to ensure that sprinklers are flush and no penetrations exist. If good compliance is maintained, monitoring will be reduced to quarterly inspection of physical plant which includes monitoring of ceilings and walls for penetrations. Monitoring will be reviewed by the Quality Assurance Committee to ensure continued compliance.	
K 018 SS=D	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 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is	K 018		

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K 018	Continued From page 2 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, the facility failed to maintain the corridor doors. This was evidenced by a door that was obstructed from closing. This affected one of seven smoke compartments and could result in the inability to contain a fire in the room. Findings: During a tour of the facility with staff on 4/17/13, the corridor doors were observed. At 9:26 a.m., the door to the Office had a rubber wedge that held the door open.	K 018	K 018 Temporary and Permanent Correction It is the policy of this facility that doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 ¾" solid-bonded core wood, or capable of resisting fire for at least 20 minutes. There will be no impediment to the closing of the doors. Rubber wedge was removed. Doors will not be used to hold open doors. Devices that impede pulling door shut will not be used. Assistant Aministrator will monitor doors weekly for one month to ensure that no rubber devices are used to hold open doors. If good compliance is maintained, monitoring will be reduced to monthly inspection of physical plant by Plant Operation Supervisor, that is documented and reported quarterly To the Quality Assurance Committee.	5/17/2013
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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	K 029		

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K 029	Continued From page 3 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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to protect the hazardous areas. This was evidenced by a door to a hazardous area that was not equipped with a self-closing device. This affected one of seven smoke compartments and could result in the increased potential for the spread of fire and/or smoke to other areas of the facility. Findings: During a tour of the facility with staff on 4/17/13, the hazardous areas were observed. 1. At 8:55 a.m., the Linen closet by the Day room contained approximately a dozen linens. The room measured 65 square feet and the door was not equipped with a self-closing device. 2. At 8:56 a.m., the Main linen closet contained approximately a dozen linens. The room measured 60 square feet and the door was not equipped with a self-closing device. Any combustible storage rooms/spaces over 50 square feet requires the door be self-closing.	K 029	K029 Temporary and Permanent Correction It is the policy of this facility one 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. Linen closet by the Day room and Main Linen closet was equipted with Self closing device by the Plant Operations Supervisor. Staff Developement Coordinator will continue to monitor doors through monthly fire drills, that are documented and reviewed by the Quality Assurance Committee semi-annually. Assistant Administrator will also monitor doors Quarterly through physical plant inspections that are conducted quarterly and reviewed by Quality Assurance Committee.	5/17/2013
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050	Continued From page 4 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure that fire drills be conducted for every shift each quarter. This was evidenced by no fire drill done during the nocturnal (NOC) shift in the third quarter. This affected 115 of 115 residents. This could result in the potential harm to residents when staff members are not trained and unaware of their roles and responsibilities during a fire. Findings: During document review and interview with staff on 4/17/13, the fire drill documents were reviewed. At 1:40 p.m., the fire drill log was missing one of twelve fire drills. There was no fire drill for the NOC shift in the third quarter. Staff stated that the drill was missing.	K 050	K 050 Temporary and Permanent Correction It is the policy of this facility that fire drills will be held at unexpected times under varying conditions. Inservice was provided by the Administrator to the Staff Development Coordinator that reviewed facility policy to hold drills at unexpected times on each shift every quarter. Administrator will monitor drills monthly for one quarter to ensure that compliance is maintained. If good compliance monitoring will be reduced to quarterly review of drills by the Quality Assurance Committee.	5/17/2013
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance	K 052		

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K 052	Continued From page 5 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 document review and interview, the facility failed to maintain their fire alarm system. This was evidenced by no current annual fire alarm testing records and past records showing incomplete testing. This affected 115 of 115 residents and could result in the malfunctioning of fire alarm system during an emergency. NFPA 72, National Fire Alarm Code®, 1999 Edition, 7-5.2.2 A permanent record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 7-5.2.2. (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of	K 052	K 052 Temporary and Permanent Correction It is the policy of this facility to maintain a fire alarm system as required for life safety that is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. Annual Fire Alarm Testing was Completed. Testing included: 1.Date 2.Test Frequency 3.Name of Property 4.Address 5.Name of person performing inspection maintenance, test, or combination thereof, and affiliation, business address, and telephone number. 6.Name address, and representative of approving agency(ies). 7.Designation of the detector(s) tested, For example; "Test performed in accordance with_____". 8.Functional test of detectors. 9.Functional test of required sequence of operations. 10.Check of all smoke detectors. 11. Loop resistance for all fixed-temperature line-type heat detectors	5/17/2013

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K 052	Continued From page 6 approving agency(ies) (7) Designation of the detector(s) tested, for example, " Tests performed in accordance with Section _____." (8) Functional test of detectors (9) *Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Other tests as required by equipment manufacturers (13) Other tests as required by the authority having jurisdiction (14) Signatures of tester and approved authority representative (15)Disposition of problems identified during test (for example, owner notified, problem corrected/successfully retested, device abandoned in place) Findings: During document review and interview with staff on 4/17/13, the fire alarm records were requested. 1. At 11:30 a.m., the facility failed to provide a current annual fire alarm inspection/testing report. The facility provided an annual fire alarm report that was dated 4/1/12. 2. At 11:31 a.m., the facility failed to provide a complete fire alarm inspection/testing report. The documentation provided, titled "Service Ticket 408126," was dated 4/1/12 and it was incomplete. The report failed to indicated how many smoke detectors and pull stations were tested, their	K 052	12.Other tests as required by equipment manufacturers. 13.Other tests as required by the authority having jurisdiction. 14.Signatures of tester and approved authority representative. 15.Disposition of problems identified during test (for example, owner notified, problem corected/successfully retested, device abandoned in place. Annual calendar of due date for Annual Fire Inspection was provided By the Administrator to the Plant Operations Supervisor. Next inspection will be performed before May 17, 2014. All documentation of inspection will be reviewed by the Administrator to ensure that all requirments of inspection are completed and documented.	5/17/2013

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K 052	Continued From page 7 location, their functional test and visual check. The report failed to indicated if each device passed or failed. Staff stated the facility will contact the vendor to get a complete fire alarm report.	K 052	K 062 Temporary and Permanent Correction	
K 062 SS=E	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 the integrity of the automatic sprinkler. This was evidenced by sprinkler heads that were corroded, had paint, had lint build up, and had less than 18 inches of clearance. This affected five of seven smoke compartments and could result in the ineffective operation of the automatic sprinkler system during a fire. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1998 Edition. 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition. 2-1. The minimum requirements for annual routine inspection, testing, and maintenance of sprinkler systems shall conform to Table 2-1 that shall be used to determine the system components to be tested and the minimum required frequencies for inspection, testing, and maintenance.	K 062	It is the policy of this facility to maintain automatic sprinkler systems that are in reliable operating condition, that are inspected and tested periodically. Sprinklers were replaced by Plant Operations Supervisor. Sprinklers to be replaced include: 1.Sprinkler in room 25. 2.Sprinkler in room 22. 3.Three sprinklers in Laundry's clean side. 4.Three sprinklers in Laundry's dirty side. 5.Sprinkler in Storage room by room 79. 6.Sprinkler in Dietary Supervisor's Office. 7.Four sprinklers in the Dining room. 8.Five sprinklers in Kitchen dishwasher area. 9.Two sprinklers in the Day room. 10.Decoration in room 31 that obstructed spray pattern was removed by maintenance.	5/17/2013

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K 062	Continued From page 8 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 Sprinkler Systems, 1999 Edition 3-2.6.3 Unless applied by the manufacture, sprinklers shall not be painted, and any sprinklers that have been painted shall be replaced with new listed sprinklers of the same characteristics, including orifice size, thermal response, and water distribution. 5-5.6 The clearance between the deflector and the top of storage shall be 18 in. (457 mm) or greater. Findings: During a tour of the facility with staff on 4/17/13, the sprinkler heads were observed. 1. At 8:45 a.m., one of three sprinklers had paint on the spoke, in Room 25. 2. At 8:50 a.m., one of three sprinklers had paint on the spoke, in Room 22. 3. At 9:00 a.m., three sprinklers had paint on the frame and the head, in the Laundry's clean side. 4. At 9:01 a.m., three of four sprinklers had lint build up, in the Laundry's dirty side.	K 062	Inservice will be provided to maintenance Staff on cleaning of sprinkler heads to remove lint that may occummulate and painting, that will not allow any paint to occummulate on sprinkler head. Administrator will monitor sprinkler heads through inspection of all sprinkler heads weekly for one month. If good complaince is maintained. Monitoring will be reduced to monthly inspection of facility plant by Plant Operation Supervisor including inspecting sprinkler heads to ensure that sprinklers are free from corrosion, foreign materials, paint and physical damage. Record of inspection will be maintained and reviewed by the Administrator quarterly.	5/17/2013

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K 062	Continued From page 9 5. At 9:32 a.m., a sprinkler had green corrosion on the spoke, in the Storage room by Room 79. 6. At 9:43 a.m., a sprinkler was corroded and had paint on the head, in the Dietary supervisor office. 7. At 9:45 a.m., four of six sprinklers had paint on the spoke and on the head, in the Dining room. 8. At 9:47 a.m., five sprinklers were corroded with green corrosions, in the Kitchen dishwasher area. 9. At 9:50 a.m., two of eight sprinklers had paint and lint build up, in the Day room. 10. At 9:53 a.m., a decoration was stationed at 7-inches from the sprinkler head, in Room 31. This obstructed the sprinkler's spray pattern and did not maintain a clearance of at least 18-inches.	K 062	K 064 Temporary and Permanent Correction It is the policy of this facility to provide Portable fire extinguishers in accordance With NFPA. Fire Extinguisher is Kitchen was lowered by the Plant Operations Supervisor. Fire Extinguishers will be inspected quarterly by Plant Operations Supervisor and reviewed annually by the Administrator to ensure contined compliance.	5/17/2013
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 their portable fire extinguishers. This was evidenced by a fire extinguisher that was mounted above the minimum height requirement. This affected one of seven smoke compartments. This could result in a delayed response to a fire and increase the risk of injury when reaching for the portable fire extinguisher.	K 064		

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K 064	Continued From page 10 NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition 1-6.10 Fire extinguishers having a gross weight not exceeding 40 lbs shall be installed so that the top of the fire extinguishers is not more than 5 ft above the floor. Fire extinguishers having a gross weight greater than 40 lbs shall be so installed that the top of the fire extinguishers is not more than 3 1/2 feet above the floor. In no case shall the clearance between the bottom of the fire extinguisher and the floor be less than 4 inch. Findings: During a tour of the facility with staff on 4/17/13, the portable fire extinguishers were observed. At 9:15 a.m., a portable ABC class fire extinguisher in the Kitchen was mounted with the handle at approximately 65 inches from the floor.	K 064	K 067 Temporary and Permanent Correction It is the policy of this facility to maintain heating and ventialating, and air conditioning that comply with the provisions of section 9.2, and are installed in accordance with the manufacturer's specifications. Vendor was contacted by Administrator and provided a full damper report as required. Inservice was provided to Plant Operations Supervisor by Administrator reviewing proper report documentation that must be provided by vendors that do inspections. Reports will be reviewed by the Administrator upon completion to ensure that complete inspections and reporting is maintained and documentation is complete and available for review.	5/17/2013
K 067 SS=C	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 This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to maintain their smoke/fire dampers. This was evidenced by the facility's failure to provide a complete documentation that confirmed that all their smoke/fire dampers had	K 067		

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	056495	A. BUILDING 01 B. WING _____	04/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASA COLOMA HLTH CARE CENTER	10410 COLOMA RD RANCHO CORDOVA, CA 95670

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K 067	Continued From page 11 been inspected within the past 4 years. This affected two of seven smoke compartments. This had the potential for the dampers to not function and fail to contain smoke in the event of a 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. 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 fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Findings: During document review and interview with staff on 4/17/13, the inspection records for the smoke/fire dampers were requested. At 11:29 a.m., the facility was observed to have dampers with fusible links in the 60s and 70s hallway. The facility failed to provide a complete documentation that confirmed that their mechanical type dampers with fusible links had been inspected within the past 4 years. The documentation titled "Service Information," dated 7/13/12, indicated the facility had 100 fusible links. The report failed to provide the locations of all the dampers and the report did not indicate if they passed or failed. Staff stated the facility will contact the vendor for a complete damper report.	K 067		
K 073 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable	K 073		

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K 073	Continued From page 12 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, the facility failed to ensure that furnishings or decorations of highly flammable character are not used in the facility or are treated with flame retardant product. This was evidenced by upholstered furniture in a room that had no smoke detector installed or had not been treated with a flame retardant product and evidenced by the walls to the corridor and a room that were filled with combustible decorations belonging to residents. This affected one of seven smoke compartments and could result in the rapid spread of smoke and fire to other locations in the facility. NFPA 101, Life Safety Code, 2000 Edition 19.7.5.2 Newly introduced upholstered furniture within health care occupancies shall meet the criteria specified when tested in accordance with the methods cited in 10.3.2(2) and 10.3.3. Exception: Upholstered furniture belonging to the patient in sleeping rooms of nursing homes, provided that a smoke detector is installed in such rooms. Battery-powered single-station smoke detectors shall be permitted. Findings: During a tour of the facility with staff on 4/17/13, furnishings and decorations were observed. 1. At 9:33 a.m., an orange upholstered chair in Room 76 was not labeled as inherently flame resistant or treated with a flame retardant	K 073	K 073 Temporary and Permanent Correction It is the policy that furnishings and Decorations of highly flammable character are not used. Orange upholstered chair in room 76 was treated with flame retardant product by maintenance. All cumbustible puzzle decorations in room 74 wall and outside in corridor were removed by housekeeping supervisor. It was discussed with resident that cumbustible puzzle decorations can not be used. Rooms will be inspected monthly by Plant Operations Supervisor or his designee that ensure that furnishings brought in by residents will be inherently flame resistant or flame retardant will be applied by maintenance. Decorations that are highly cumbustible will not be allowed and will be removed.	5/17/2013

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K 073	Continued From page 13 product. There was no smoke detector installed in the room. 2. At 9:59 a.m. there were combustible decorations observed throughout the walls in Room 74 by Bed A. There were a dozen large puzzle pieces that were hung on the wall to the room and in the corridor. The puzzles varied in sizes, measuring from 19-inches by 26-inches, 19-inches by 13-inches, 24-inches by 24 inches, and 38-inches by 27-inches. There was no evidence provided that showed that a flame retardant product was used with documented fire spread flame rating.	K 073	Activity Director will provide inservice at next Resident Council meeting that reviews facility policy not to hang highly cumbustible items on walls. Documentation of inspections will be completed monthly and will be reviewed quarterly by the Administrator to ensure continued compliance.	5/17/2013
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to properly maintain the generator. This was evidenced by failing to run and document the monthly load test at greater than 30% of the generator's nameplate rating or perform an annual load bank test. This affected all staff and residence and could potentially result in a generator failure during an emergency.	K 144		

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K 144	Continued From page 14 NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition. 6-4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. 6-4.2.1 Equivalent loads used for testing shall be automatically replaced with the emergency loads in case of failure of the primary source. 6-4.2.2 Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. The census was 123 and the licensed capacity was 138 at the time of the survey. Findings: During document review and interview with staff on 4/17/13, the generator annual load bank test was requested. At 11:02 a.m., the generator records indicated that the generator was started and operated under load for 30 minutes each month. Records	K 144	K 144 Temporary and Permanent Correction It is the policy of this facility that Generator will be inspected weekly And exercised under load for 30 minutes every month in accordance with NFPA 99. Annual load bank testing was completed. Documentation of testing will be maintained and reviewed by the Administator. Inservice was provided by the Administrator to the Plant Operations Supervisor that reviewed documentation needed for monthly load tests to ensure that monthly testing shows the amperage, voltage, or what the output was during the monthly load tests. Testing will be maintained by Plant Operations Supervisor and reviewed by Administrator Quarterly to ensure continued compliance.	5/17/2013

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K 144	Continued From page 15 did not show the amperage, voltage, or what the output was during the monthly load tests. Actual load documentation is required in order to determine if 30 percent of the name plate rating is being met for diesel generators. No documentation of a current annual load bank test was provided. The last annual load bank test was done on 8/2011. Staff stated there was no current annual load bank test.	K 144	K 147 Temporary and Permanent Correction It is the policy of this facility to maintain electrical wiring and equipment in accordance with National Electric Code. 1.Breathing Machine in room 64 was plugged into the wall and surge protector cord was removed. 2.Grey extension cord in room 75 was removed. 3.Adaptor cord was removed from Day Room. Inservice will be provided by Administrator to housekeeping and Maintenance staff the reviews facility policy on extension cords. This will cover appropriate use of adapters and that medical devices must be plugged directly into the wall and no adapters shall be used. Plant operations supervisor will inspect rooms monthly to ensure that adapters are used appropriately and that medical devices are plugged directly ito the wall. Documentation will be kept by the Plant Operations Supervisor and reviewed Quarterly by the Administator to ensure continued compliance.	5/17/2013
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 observation, the facility failed to maintain their electrical equipments and utilities. This was evidenced by the use of multi-outlet adapters on medical equipment and adapters used inappropriately. This affected two of seven smoke compartments and could result in an electrical fire hazard. NFPA 70, National Electrical Code, 1999 Edition 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 Findings: During a tour of the facility with staff on 4/17/13, the electrical equipment and utilities were observed. 1. At 9:21 a.m., a breathing matching was	K 147		

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K 147	Continued From page 16 plugged into a surge protector, in Room 64. 2. At 9:33 a.m., a gray extension cord was plugged into a three plug adapter, in Room 75. 3. At 9:51 a.m., a CD player was plugged into an adapter plug that was suspended off the floor, in the Day room.	K 147		