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

PRINTED: 05/26/2015
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
	056110	A. BUILDING 01 B. WING	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653

(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: 1971 K7 SURVEY UNDER: 2000 EXISTING STRUCTURE TYPE: ONE STORY, CONSTRUCTION TYPE (V) (111), 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: 26387 The facility is not in substantial compliance with 42 CFR 483.70 (a) for Long Term Care Facilities. Census = 140	K 000		
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 maintain the integrity of their building construction. This was evidenced by an unsealed	K 012		

LABORATORY DIRECTOR'S O[redacted] E'S SIGNATURE [redacted]

Any deficiency statement en[redacted]ncy 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 penetration in the facility wall. This could result in the spread of smoke or fire to other locations in the facility. This affected 1 of 6 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 19.1.6.4 Each exterior wall of frame construction and all interior stud partitions shall be firestopped to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement and the first floor. Such firestopping shall consist of wood not less than 2 in. (5 cm) (nominal) thick or shall be of noncombustible material. 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier. Findings: During a tour of the facility with the Director of Environmental Services on 5/20/15, the building construction was observed.	K 012	**K 012 NFPA 101 Life Safety Code Standard** It is the policy of the facility to maintain the integrity of our building, to prevent the spread of smoke or fire to other locations in the facility. **Corrective action for Residents found to have been affected by this deficiency:** It was found that one room had been affected by this deficiency. On 5/20/15, the Director of Environmental Services sealed the penetration in the wall behind the door in room 314. **Identification of other Residents having the potential to be affected by the same deficient practice and corrective action that will be taken:** All Resident rooms have the potential to be affected by this deficiency. On 5/29/15, the Director of Environmental Services completed a sweep of all 107 facility rooms and found no other rooms with same deficiency.	6/11/15

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K 012	Continued From page 2 At 9:02 a.m. there was an approximately 5 inch by 1/4 inch unsealed penetration in the wall behind the door of Room 314.	K 012	**Measures/Corrective action that will be put into place to ensure that this same deficiency does not recur:**	
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 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 corridor their doors. This was evidenced by corridor doors that failed to latch, and by corridor doors that were impeded from closing. This could result in a delay to contain smoke or fire to a room. This affected 3 of 6 smoke compartments.	K 018	On 6/11/15 the Administrator in-serviced The Director of Environmental Services on maintaining the facility building integrity, including; all interior stud partitions shall be fire stopped to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement on the first floor. Such fire stopping shall consist of wood not less than 2". (5cm) thick or shall be noncombustible. Smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. Smoke barriers are required shall be continuous from an outside wall to an outside wall, from the floor to a floor, or from a smoke barrier to a smoke barrier, or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. On 6/11/15 the Director of Environmental Services in-serviced facility Environmental Service staff on maintaining the facility building integrity, including; all interior stud partitions shall be fire stopped to cut off all concealed draft openings, both horizontal and vertical, between any cellar or basement on the first floor. Such fire stopping shall consist of wood not less than 2". (5cm) thick	

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K 018	Continued From page 3 NFPA 101, Life Safety Code, 2000 Edition 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie backs, drop down or plunger type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches. NFPA 80, Standard for Fire Doors and Fire Windows, 1999 Edition 2-4.1.4. All closing mechanisms shall be adjusted	K 018	or shall be noncombustible. Smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. Smoke barriers are required shall be continuous from an outside wall to an outside wall, from the floor to a floor, or from a smoke barrier to a smoke barrier, or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. **Measures that will be implemented to ensure that solutions are sustained:** The Environmental Services Director and/or his/her designee will perform visual inspections of all 107 facility rooms weekly X 12 weeks to ensure compliance of building integrity, and document results of the weekly inspections on the Continuous Quality Improvement audit tool. Results of the documented visual inspections will be forwarded to the QA+A Committee monthly X 3 months for further monitoring and action planning as indicated or until the QA+A Committee determines compliance. **K 018 NFPA 101 Life Safety Code Standard** It is the policy of the facility that doors protecting corridor openings in other than	6/11/15

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K 018	Continued From page 4 to overcome the resistance of the latch mechanism so that positive latching is achieved on each door operation. Findings: During a tour of the facility with the Director of Environmental Services on 5/20/15, the doors in the facility were observed. 1. At 8:37 a.m., the Director of Staff Development Office door, was impeded from closing with a rubber wedge under the door. 2. At 8:44 a.m., the Director of Staff Development Office door latching mechanism, was not latching when tested. The latch was stuck inward. 3. At 8:52 a.m., the self-closing Physical Therapy corridor door near Room 301, was not latching when tested. 4. At 10:07 a.m., the self-closing corridor door to the Feeding Supply Room, was not latching when tested. The room was near Room 335. 5. At 10:14 a.m., the self-closing corridor door to Nursing Station 2 Office, was impeded from closing with a rubber wedge under the door.	K 018	required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 13/4" solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors and sprinklers 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. **Corrective action for Residents found to have been affected by this deficiency:** It was found that 5 doors were affected by this deficiency. On 5/20/15 the Environmental Services Director removed the rubber wedge from underneath the DSD office door. On 5/20/15 the Environmental Services Director replaced the latching mechanism for the DSD office door. On 5/20/15 the Environmental Services Director repaired the Physical Therapy corridor door near room 301 latching mechanism. On 5/20/15 the Environmental Services Director repaired the latching mechanism for the Feeding Supply Room near 335.	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by:	K 046		

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K 046	Continued From page 5 Based on observation, document review, and interview, the facility failed to maintain their emergency lighting units. This was evidenced by 3 of 3 emergency lights that failed to illuminate when tested and by the facility failure to perform monthly and annual testing on the emergency lighting units. This could result in a delay in accessing items in the kitchen during a power failure. This affected 1 of 6 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 7.9.3 Periodic Testing of Emergency Lighting Equipment. A Functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1.5 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings: During a tour of the facility with the Director of Environmental Services (DOES) on 5/20/15, the facility emergency lighting units in the kitchen were tested, testing documents were reviewed, and a staff person was interviewed. 1. At 9:38 a.m., the emergency light near the Emergency Food in the kitchen, was not illuminating when tested. 2. At 9:41 a.m., the emergency light near the sink in the kitchen, was not illuminating when tested.	K 046	On 5/20/15 the Environmental Services Director removed the rubber wedge from underneath the Nursing Station 2 Office. **Identification of other Residents having the potential to be affected by the same deficient practice and corrective action that will be taken:** All Resident rooms have the potential to be affected by this deficiency. On 5/22/15, the Director of Environmental Services completed a sweep of all facility doors and found 2 rooms with the same deficiency; a rubber wedge was impeding the door to the dining room near Activities Office; a rubber wedge was impeding the door to the living room entrance. On 5/22/15 the Environmental Services Director removed the rubber wedge from underneath the door to the dining room (near Activities Office) allowing the door to close freely. On 5/22/15 the Environmental Services Director removed the rubber wedge from underneath the door to the living room entrance, allowing the door to close freely. **Measures/Corrective action that will be put into place to ensure that this same deficiency does not recur:**	

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K 046	Continued From page 6 3. At 9:44 a.m., the emergency light near the dish machine in the kitchen, was not illuminating when tested. 4. At 11:04 a.m., the facility provided a testing document for the emergency that indicated that the lights were tested every three months and there was no documented evidence of an annual test. At 11:06 a.m., the DOES said during an interview, that he tested the emergency lights every three months and did not test them annually.	K 046	On 6/8/15 the Administrator in-serviced the Director of Environmental Services on the facility's policy and procedure regarding doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 13/4" solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors and sprinklers 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. On 6/8/15, 6/9/15, 6/10/15, 6/11/15 the DSD in-serviced all facility staff on the facility's policy and procedure regarding doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 13/4" solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors and sprinklers 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. **Measures that will be implemented to ensure that solutions are sustained:**	
K 047 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on document review, and interview, the facility failed to maintain their exit signs. This was evidenced by the failure to perform monthly and an annual tests on the 32 exit signs with a battery back-up. This could result in a delay in evacuation if the exit signs failed to illuminate during a power failure. This affected 6 of 6 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 7.10.9.2 Exit signs connected to or provided with a battery-operated emergency illumination source, where required in 7.10.4, shall be tested and maintained in accordance with 7.9.3.	K 047		

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K 047	Continued From page 7 7.9.3 Periodic Testing of Emergency Lighting Equipment. A Functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for not less than 1.5 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Findings: During a tour of the facility with the Director of Environmental Services on 5/20/15, the exit sign testing documentation was reviewed, and a staff person was interviewed. 1. At 11:02 a.m., the facility provided a testing document for the exit signs that indicated that the signs were tested every three months and there was no documented evidence of an annual test. 2. At 11:06 a.m., the DOES said during an interview, that he tested the exit signs every three months and did not test them annually.	K 047	The Environmental Services Director and/or his/her designee will perform visual inspections of all facility rooms/doors weekly X 12 weeks to ensure compliance of proper door hold open devices, and document the results of the weekly inspections on the Continuous Quality Improvement audit tool. Results of the documented visual inspections will be forwarded to the QA+A Committee monthly X 3 months for further monitoring and action planning as indicated or until the QA+A Committee determines compliance. **K 046 NFPA 101 Life Safety Code Standard** It is the policy of the facility that emergency lighting of at least 1 ½ hour duration is provided. **Corrective action for Residents found to have been affected by this deficiency:** It was found that 3 emergency lights were affected by this deficiency. On 5/29/15 the DOES replaced the emergency light near the emergency food in the kitchen. On 5/29/15 the DOES replaced the emergency light near the sink in the kitchen.	6/9/15
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	K 064		

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K 064	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain its portable fire extinguishers. This was evidenced by a portable fire extinguisher that was obstructed from access. This could delay extinguishing a fire in the event of a fire. This affected 1 of 6 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition 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 1-6.3 Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. Findings: During a tour of the facility with the Director of Environmental Services (DOES)on 5/20/15, the portable fire extinguishers were observed, and staff was interviewed. 1. At 9:14 a.m. the Kitchen K-class portable fire extinguisher was impeded from access with a metal cart in front of the device. 2. At 9:15 a.m., the DOES said during an interview that nothing should be in front of the fire extinguishers.	K 064	On 5/29/15 the DOES replaced the emergency light near the dish machine in the kitchen. On 5/29/15 the DOES updated the testing log for emergency lights to be carried out monthly, not quarterly starting 6/15/15. **Identification of other Residents having the potential to be affected by the same deficient practice and corrective action that will be taken:** All Resident rooms have the potential to be affected by this deficiency. On 5/29/15 the DOES completed a sweep of all facility emergency lights and found that no other emergency lights have been found to be affected by the same deficiency. **Measures/Corrective action that will be put into place to ensure that this same deficiency does not recur:** On 6/8/18 the Administrator in-serviced the DOES on the facility's policy and procedures regarding emergency lighting of at least 1 ½ hour duration is provided. On 6/8/15 the Administrator in-serviced the DOES on functional emergency lighting testing; a functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30	

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K 147	Continued From page 9	K 147	seconds. An annual test shall be conducted	
K 147 SS=E	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 and interview, the facility failed to maintain their electrical equipment and utilities. This was evidenced by appliances that were plugged into multi-outlet extension cords, by utilizing extension cords as permanent wiring, by multi-outlet extension cords plugged into another multi-outlet extension cords, by an electrical outlet that was missing a cover plate, by an impeded electrical panel, and by medical equipment plugged into a six plug adapter. This could result in an electrical fire. This affected 3 of 6 smoke compartments. NFPA 101, Life Safety Code, 2000 Edition SECTION 9.1 UTILITIES 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction. NFPA 70, National Electrical Code, 1999 Edition 240-4 Flexible cord, including tinsel cord and extension cords, and fixture wires shall be protected against overcurrent by either (a) or (b). (a) Ampacities. Flexible cord shall be protected by an overcurrent device in accordance with its ampacity as specified in Tables 400-5(A) and (B). Fixture wire shall be protected against overcurrent in accordance with its ampacity as	K 147	on every required battery powered emergency lighting system for no less than 1.5 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the DOES. **Measures that will be implemented to ensure that solutions are sustained:** The Environmental Services Director and/or his/her designee shall preform functional emergency lighting testing; a functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for no less than 1.5 hours. Equipment shall be fully operational for the duration of the test; and document the results of the monthly emergency lighting test on the Continuous Quality Improvement audit tool. Results of the documented emergency lighting test will be forwarded to the QA+A Committee monthly X 4 months for further monitoring and action planning as indicated or until the QA+A Committee determines compliance. **K 047 NFPA Life Safety Code Standard**	6/8/15

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	056110	A. BUILDING 01 B. WING	05/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGUNA HILLS HEALTH AND REHABILITATION CENTER	24452 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653

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K 147	Continued From page 10 specified in Table 402-5. Supplementary overcurrent protection, as in Section 240-10, shall be permitted to be an acceptable means for providing this protection. 400-8 Unless specifically permitted in Section 400-7, flexible cord 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 (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 NFPA 70, National Electrical Code, 1999 Edition 370-25. Covers and Canopies. In completed installations, each box shall have a cover, faceplate, or fixture canopy. Article 110-26(a)(2) Width of Working Space. The width of the working space in front of the electric equipment shall be the width of the equipment or 30 in. (762 mm), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. Article 110-26(3)(b) Clear Spaces. Working space required by this section shall not be used for storage. Findings:	K 147	It is the policy of the facility that all exit and directional signs are displayed in accordance with section 7.10 with continuous also served by the emergency lighting system. **Corrective action for Residents found to have been affected by this deficiency:** It was found that 32 emergency exit signs were affected by this deficiency. On 5/20/15 the DOES performed a monthly test on the 32 exit signs. **Identification of other Residents having the potential to be affected by the same deficient practice and corrective action that will be taken:** No Residents and exit signs have the potential to be affected by this deficiency. **Measures/Corrective action that will be put into place to ensure that this same deficiency does not recur:** On 6/8/18 the Administrator in-serviced the DOES on the facility's policy and procedures regarding periodic testing of emergency lighting equipment, including; a functional test should be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual shall be conducted on every required battery powered emergency lighting system for not	

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K 147	Continued From page 11 During a tour of the facility with the Director of Environmental Services on 5/20/15, the electrical equipment and wiring were observed. 1. At 8:39 a.m., there was an orange extension cord in use in the Staff Development office. 2. At 8:48 a.m., there was a multi-outlet extension cord that was plugged into another multi-outlet extension cord in the Admission Office. 3. At 8:49 a.m., the refrigerator in the Admission Office was plugged into a multi-outlet extension cord. 4. At 8:55 a.m., there was a multi-outlet extension cord that was plugged into another multi-outlet extension cord in the Payroll office in the Business office. 5. At 8:57 a.m., Bed A and the oxygen machine near Bed A in Room 312 were plugged into a six plug adapter. At 8:59 a.m., the DOES said during an interview, that the facility did not have any electrical waivers and he thought that the six plug adapter was okay. 6. At 9:00 a.m., the electrical outlet behind Bed A in Room 312, was missing a cover plate. 7. At 9:05 a.m., the Activities Office microwave was plugged into an orange extension cord that was plugged into a multi-outlet extension cord. 8. At 9:56 a.m., there was an orange extension	K 147	less than 1.5 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the DOES. **Measures that will be implemented to ensure that solutions are sustained:** The Environmental Services Director and/or his/her designee shall preform periodic testing of emergency lighting equipment including; a functional test should be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual shall be conducted on every required battery powered emergency lighting system for not less than 1.5 hours. Equipment shall be fully operational for the duration of the test and document the results of the monthly emergency lighting system test on the Continuous Quality Improvement audit tool. Results of the documented emergency lighting test will be forwarded to the QA+A Committee monthly X 4 months for further monitoring and action planning as indicated or until the QA+A Committee determines compliance. **K 064 NFPA 101 Life Safety Code Standard**	6/8/15

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K 147	Continued From page 12 cord in use in the Central Supply Office. The extension cord was plugged into the refrigerator. 9. At 10:01 a.m., Electrical Panel MI in the MDS office, was impeded from access with a storage cabinet and two boxes in front of the panel. 10. At 12:32 p.m., there was an orange extension cord plugged into the outside light near the laundry.	K 147	It is the policy of the facility that all portable fire extinguishers are provided in all health care occupancies. **Corrective action for Residents found to have been affected by this deficiency:** It was found that 1 fire extinguisher was affected by this deficiency. On 5/20/15 the DOES removed the meal cart that was impeding access to the fire extinguisher in the kitchen. **Identification of other Residents having the potential to be affected by the same deficient practice and corrective action that will be taken:** All residents have the potential to be affected by this deficiency. On 5/20/15 the DOES did a facility sweep of all fire extinguishers and found that no other extinguishers were affected by the same deficiency. **Measures/Corrective action that will be put into place to ensure that this same deficiency does not recur:** On 6/8/18 the Administrator in-serviced the DOES on the facility's policy and procedures regarding fire extinguishers, including;	

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			maintaining its portable fire extinguishers, fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. On 6/8/18 the DSD in-serviced all facility staff on the facility's policy and procedures regarding fire extinguishers, including; maintaining its portable fire extinguishers, fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. **Measures that will be implemented to ensure that solutions are sustained:** The DOES and/or his/her designee shall preform weekly facility sweeps on maintaining its portable fire extinguishers; fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. The documented results of the weekly fire extinguisher sweep will be reported on the Quality Improvement audit tool. Results of the documented fire extinguisher sweep will be forwarded to the QA+A Committee monthly X 4 months for further monitoring and action planning as indicated or until the QA+A Committee determines compliance.	

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			K 147 101 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code 9.1.2 It is the policy of the facility that all electrical equipment and utilities be maintained in accordance with NFPA 70. **Corrective action for Residents found to have been affected by this deficiency:** It was found that 10 electrical outlets were affected by this deficiency. 1. On 5/20/15 the DOES initiated corrective action, a replacement extension cord (Levlton medical grade plug strips), compliant with NFPA 70, will be ordered and will be delivered by 6/30/15. 2. On 5/20/15 the DOES removed the extension cord in the Admission Office. 3. On 5/20/15 the DOES removed the multi-outlet extension cord that the refrigerator in the Admissions Office was plugged into. 4. On 5/20/15 the DOES initiated corrective action for the multi-outlet extension cord that was plugged into another multi-outlet extension cord in the payroll office in the business office. A replacement extension cord (Leviton medical grade plug strips), compliant with NFPA 70, will be ordered and will be delivered by 6/30/15.	6/30/15

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			5. On 5/20/15 the DOES removed the six plug adapter from 312A. 6. On 5/20/15 the DOES provided an electrical outlet cover plate for 312A. 7. On 5/20/15 the DOES removed the orange extension cord in the activities office. 8. On 5/20/15 the DOES removed the orange extension cord in the Central Supply Office. 9. 5/20/15 the DOES removed the storage cabinet and two boxes that were impeding access to the electrical panel MI in the MDS office. 10. On 5/20/15 the DOES removed the orange extension cord from outside the laundry room. **Identification of other Residents having the potential to be affected by the same deficient practice and corrective action that will be taken:** All residents have the potential to be affected by this deficiency. On 6/3/15 the DOES did a facility sweep of all facility resident rooms and offices, and found that 116 resident rooms and/or offices were affected by the same deficiency. On 6/3/15 the DOES initiated corrective action for all 116 resident rooms/offices to	

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			remove multi-outlet extension cords and replace them with Leviton medical grade plug strips that are compliant with NFPA 70, this will be completed by 6/30/15. **Measures that will be implemented to ensure that solutions are sustained:** The DOES and/or his/her designee shall preform weekly facility sweeps on maintaining electrical equipment and utilities in accordance with NFPA 70. The documented results of the weekly electrical equipment and utilities sweep will be reported on the Quality Improvement Audit Tool. Results of the documented electrical equipment and utilities sweep will be forwarded to the QA+A Committee monthly X 4 months for further monitoring and action planning as indicated or until the QA+A Committee determines compliance.	