PRINTED: 10/31/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF CASPER	4041 SOUTH POPLAR STREET CASPER, WY 82601

(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 Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in this section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care, of the National Fire Protection Association (NFPA). The facility was a fully sprinkled single story building of Type V (111) construction with plan approval in 1992. The building was equipped with a supervised automatic wet sprinkler system with a dry branch and an addressable fire alarm system. The facility had a capacity of 120 certified Medicare and Medicaid beds with a census of 112 residents.	K 000	K 012 This facility will ensure smoke barriers are constructed to ensure smoke resistance. This will be accomplished by: 1) The kitchen janitor's closet ceiling tile was replaced on 10/19/2011; 2) One and one-half (1 ½) inch unsealed cable penetration was sealed using a fire resistant caulk, and coaxial cable cover plate was replaced on 10/25/2011; A. The Maintenance Director will observe smoke barriers to ensure there are no penetrations. Penetrations found will be immediately repaired with fire resistant caulk; B. The Maintenance Director will audit for penetrations and report findings at the monthly Process Improvement (PI) meeting. This will occur for three (3) months or until ongoing compliance.	11/10/11
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure walls and ceilings were smoke resistant in 2 of 7 smoke compartments. The findings were: 1. Observation of the kitchen janitor's closet on 10/17/11 at 3:59 PM showed a 2 foot by 4 foot ceiling tile was missing. At the time of observation the maintenance director reported he was aware walls and ceilings were required to be smoke resistance, he could not explain why this had not been identified and repaired during quarterly	K 012		

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

RN/OON for Tim Haley, ED / Director of Nursing 11/10/2011

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.

RECEIVED
Wyoming Department of Health

Rec'd 11/10/11 w/ Tim Haley, NHA, on 11/16/11

NOV 16 2011

Office of Healthcare Licensing and Surveys

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K 012	Continued From page 1 inspections. 2. Observation of resident room #207 on 10/17/11 at 4:42 PM showed a wall had a 1 ½ inch unsealed cable penetration. Further review showed the coaxial cable cover plate was missing. At the time of observation the maintenance director could not explain why this had not been identified and repaired during quarterly inspections. Reference: NFPA 101, 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.	K 012	K 018 The facility will ensure there are not impediment to the closing of any doors. To ensure safe and proper operation of all doors in accordance with 19.3.6.3. This will be accomplished by: 1) North corridor door in Special Care Unit (SCU) has been repaired on 10/28/2011. A. The Maintenance Director will observe doors to ensure proper operation. Doors noted for repair will be immediately repaired. B. The Maintenance Director will audit for proper door operation and report findings at monthly PI committee meeting. This will occur for three (3) months or until ongoing compliance.	11/10/11
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.	K 018		

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure corridor doors were smoke resistant in 1 of 7 smoke compartments. The findings were: Observation of the special care unit (SCU) dining room on 10/18/11 at 9:36 AM showed the north corridor door was obstructed from closing by a plastic shield attached to the door frame. At the time of observation the maintenance director could not explain why this issue had not been identified and repaired during quarterly inspections.	K 018	K 025 The facility will ensure smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. This will be accomplished by: 1) The penetration of the attic smoke barriers at Northwest and Southwest walls have been repaired on 11/02/2011 using a fire resistant caulk and appropriate width drywall. A. The Maintenance Director will observe smoke barriers to ensure there are no penetrations. Penetrations found will be immediately repaired with a fire resistant caulk. B. The Maintenance Director will audit for penetrations and report findings at the monthly PI committee meeting. This will occur for three (3) months or until ongoing compliance.	11/10/11
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		

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K 025	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 5 smoke barrier walls were smoke resistant. The findings were: Observation of the attic smoke barrier walls on 10/18/11 between 10 AM and 11 AM showed the northwest and southwest walls had two and three unsealed pipe penetrations respectively. The largest hole measured 4 inches by 10 inches across. At 10:20 AM the maintenance director could not explain why the holes had not been noticed and repaired during quarterly inspections.	K 025	K 029 The Facility will ensure areas are separated from other spaces by smoke resisting partitions and doors. This will be accomplished by: 1) Pipe and cable penetrations in Laundry washer room, boiler room and Activities office/storeroom have been repaired by using fire resistant foam spray on 10/26/2011; 2) Unit #2 clean utility room corridor door with an automatic closing devise was repaired on 10/28/2011 ensuring door fully latches into door frame; 3) Activities office door is no longer held open with a string. Door operates as intended – Repair completed 10/19/2011. A. The Maintenance Director will observe smoke barriers to ensure there are no penetrations. Penetrations found will be immediately repaired with fire resistant caulk / foam. Continued on next page.	
K 029 SS=E	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 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 and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 4 of 7 smoke compartments. The findings were: 1. Observation of hazardous areas on 10/17/11	K 029		

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K 029	Continued From page 4 between 3 PM and 5 PM showed the laundry washer room, boiler room, and activities office/storeroom had unsealed pipe and cable penetrations. The largest gap measured 1 inch by 4 inches across. At 3:27 PM the maintenance director could not explain why the aforementioned penetrations had not been noticed and repaired during quarterly inspections. 2. Observation of the unit #2 clean utility room on 10/17/11 at 4:56 PM showed the corridor door was equipped with an automatic closing device. Further review showed the closure was not able to fully latch the door into the door frame, with three attempts. At the time of observation the maintenance director could not explain why the door had not been noticed during the weekly door inspections. 3. Observation of the activities office on 10/18/11 at 9:05 AM showed the corridor door was held open with a string attached to the wall behind the door. At the time of observation the activities director reported the door was held open because of convenience.	K 029	K 029 Continued: B. The Maintenance director will observe doors to ensure proper operation. Repairs required will be done immediately. C. The Maintenance Director will audit for proper operations of doors and smoke barrier penetrations, and will be reported to the monthly PI committee meeting for three (3) months or until ongoing compliance.	11/10/11
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure egress pathways were	K 038		

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K 038	Continued From page 5 unobstructed in 3 of 7 smoke compartments. The findings were: 1. Observation of the southwest exit vestibule on 10/17/11 at 4:29 PM showed the exit door was 48 inches wide. Further review showed a damaged copy machine was stored in the vestibule and diminished the total door width to 40 inches. At the time of observation the maintenance director reported he was unaware items were not allowed to be stored in the egress system. 2. Observation of the special care unit (SCU) on 10/18/11 at 9:44 AM showed the courtyard gate was locked with a keyed padlock. Interview with certified nurses assistant (CNA) #1 reported she did not carry a key to the gate padlock at all times. She reported the single key for the padlock was stored at the nurses' station. At the time of observation the maintenance director reported he was unaware every staff member in the SCU was required to carry a key to any lock. 3. Observation of the northwest exit sidewalk on 10/18/11 at 10:48 AM showed two concrete slabs were elevated 1 ½ inch above the adjacent slab creating a trip hazard. At the time of observation the maintenance director was not aware the egress walking path could not have a elevation change greater than ¼ inch. Reference: NFPA 101, 2000 Edition, 19.2.7: 7.7.2 Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge, provided that the criteria of 7.7.2(1)	K 038	K 038 The Facility will ensure exit access is arranged so exits are readily accessible at all times in accordance with 7.1. This will be accomplished by: 1) The copy machine was removed on 10/19/2011; 2) A combination lock was placed on the courtyard gate with all staff in Special Care Unit (SCU) having the combination to said lock, as well as is posted at the entrance to the courtyard. The Lock was changed on 10/21/2011; 3) The process to take out the concrete and repair was started 10/24/2011, contractor has been selected, expected start date is 11/10/2011 – weather dependent. A. The Maintenance Director will observe all exits to ensure they are accessible at all times. Obstructions will be removed immediately. Continued on next page.	

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K 038	Continued From page 6 through (3) are met: (a) Such discharge shall lead to a free and unobstructed way to the exterior of the building, and such way is readily visible and identifiable from the point of discharge from the exit. (b) The level of discharge shall be protected throughout by an approved, automatic sprinkler system in accordance with Section 9.7, or the portion of the level of discharge used for this purpose shall be protected by an approved, automatic sprinkler system in accordance with Section 9.7 and shall be separated from the nonsprinklered portion of the floor by a fire resistance rating meeting the requirements for the enclosure of exits (see 7.1.3.2.1). 7.1.6.2 Changes in Elevation. Abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (0.6 cm). Changes in elevation exceeding 1/4 in. (0.6 cm), but not exceeding 1/2 in. (1.3 cm), shall be beveled 1 to 2. Changes in elevation exceeding 1/2 in. (1.3 cm) shall be considered a change in level and shall be subject to the requirements of 7.1.7. 19.2.2.2.5 Doors located in the means of egress that are permitted to be locked under other provisions of this chapter shall have adequate provisions made for the rapid removal of occupants by means such as remote control of locks, keying of all locks to keys carried by staff at all times, or other such reliable means available to the staff at all times. Only one such locking device shall be permitted on each door.	K 038	K 038 Continued: B. The Maintenance Director will audit for obstructions to exits and report findings at monthly PI committee meetings. This will occur for three (3) months or until ongoing compliance.	11/30/11
K 046 SS=F	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.	K 046		

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K 046	Continued From page 7 This STANDARD is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to ensure 2 of 2 emergency battery lights were tested annually for 90 minutes and failed to ensure 1 of 2 lights were capable of illumination. The findings were: 1. Review of the emergency battery light testing records showed the facility did not have record of the last time the two lights were tested for 90 minutes on an annual basis. On 10/18/11 at 11:50 AM the maintenance director reported he was unaware of the annual testing requirement and he did not have any other records to review. 2. Testing of the electrical room emergency battery light on 10/18/11 at 11:55 AM showed the light did not illuminate when the test button was depressed. At the time of observation the maintenance director reported he had not tested the light since he was hired three weeks ago. Reference: NFPA 101, 2000 Edition,19.2.9.1; 7.9.2.1* Emergency illumination shall be provided for not less than 11/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 11/2 hours. A maximum-to-minimum illumination	K 046 ✓	K 046 The Facility will ensure emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9. This will be accomplished by: 1) Electrical room emergency battery light was replaced by a licensed electrician on 10/27/2011; 2) Testing of emergency battery lighting completed on 11/07/2011 – test on all emergency for 90 minute successful. A. The Maintenance Director will observe emergency lighting to ensure correct operation. Testing will be done in accordance with 7.9. Improper lighting found will be repaired immediately. B. The Maintenance Director will audit emergency lighting to include required testing. Results will be reported at the monthly PI committee meeting for three (3) months or until ongoing compliance.	11/10/11

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K 046	Continued From page 8 uniformity ratio of 40 to 1 shall not be exceeded.	K 046		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 record review and staff interview, the facility failed to ensure fire drills were held on each shift during 3 of the past 4 quarters. The findings were: Review of the fire drill records showed a drill had not been held on the third shift during the fourth quarter of 2010, first quarter of 2011 and the third quarter of 2011. On 10/18/11 at 11:50 AM the maintenance director reported he was aware of the quarterly testing requirement. Furthermore he confirmed there were no other records to review.	K 050	K 050 The Facility will ensure fire drills are held at unexpected times at least quarterly on each shift in accordance with 19.7.1.2. A) The Maintenance Director will conduct fire drills as required on each shift starting 11/07/2011 and on-going. He will record the same. B) The Executive Director will audit / observe fire drills on all shifts and report status at monthly PI committee meeting for three (3) months or until ongoing compliance.	11/10/11
K 052 SS=F	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	K 052		

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K 052	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure pull stations were not obstructed in 1 of 7 smoke compartments and failed to ensure the fire alarm system was activated on a monthly basis. The findings were: 1. Observation of the entrance lobby on 10/17/11 at 3:46 PM showed a large artificial tree was placed in front of the manual pull station. At the time of observation the maintenance director reported he was unaware pull stations were required to be unobstructed at all times. Furthermore he reported the tree was in this location because of a remodel in the area, which had been going on for more than three days. 2. Review of the fire alarm system testing records showed the system was not activated during May and September 2011. On 10/18/11 at 11:50 AM the maintenance director reported he was unaware the fire alarm system receiver was required to be tested on a monthly basis. Reference: NFPA 101, 2000 Edition,19.3.4.1; 9.6.2.6* Each manual fire alarm box on a system shall be accessible, unobstructed, and visible. NFPA 72, 1999 Edition;	K 052	K 052 The Facility will ensure fire alarm system is installed, tested and maintained in accordance with NFPA 70, and NFPA 72. 1) Artificial tree in lobby was moved on 10/19/2011 in order to not be in front of manual pull station; 2) A complete review of fire alarm system and it's testing by Phoenix Fire Protection, Inc. was conducted on 11/07/2011. The fire alarm system shall be tested / activated on a monthly basis. A) The Maintenance Director will activate the fire alarm system on a monthly basis. B) The Maintenance Director will observe manual pull stations to ensure they are not obstructed. If obstructions are noted the obstructions will be moved immediately. Continued on next page.	

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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 052 K 062 SS=F	Continued From page 10 Table 7-3.2 Testing Frequencies. 23. Receivers,.....monthly 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, record review, and staff interview, the facility failed to ensure sprinkler heads were not corroded in 4 of 7 smoke compartments, failed to ensure the spare sprinkler cabinet had the adequate amount of heads, and failed to ensure the supervisory equipment was tested for 1 of the past 4 quarters. The findings were: 1. Periodic observations of the sprinkler system on 10/17-18/11 showed sprinkler heads in the laundry washer room, therapy department, and above the special care unit (SCU) exit door were corroded. On 10/17/11 at 3:26 PM the maintenance director reported all sprinkler heads were inspected by an outside contractor and the last annual inspection report (3/14/11) did not indicate any heads were corroded. 2. Observation of the spare sprinkler cabinet on 10/17/11 at 3:40 PM showed there were only 10 spare sprinkler heads, not the required 12 heads. Further observation showed there was only one spare 212 degree upright head to replace the one installed in the boiler room. At the time of	K 052 K 062	K 052 Continued: C) The Maintenance director will educate Facility staff on the requirement to keep pull stations clear of obstructions at the November all-staff inservice. D) The Maintenance Director will audit pull stations for obstructions and report to the monthly PI committee meeting.	11/11/11

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	535049	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/18/2011

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K 062	Continued From page 11 observation the maintenance director reported the spare sprinkler heads were reviewed by an outside contractor and the last quarterly inspection report (6/22/11) did not indicate any heads were missing from the cabinet. 3. Review of the sprinkler system testing records showed the 6/14/10 quarterly testing record reported the pressure gauges had not been tested in the last five years. Review of the gauges showed a date was not present to indicate when they were last calibrated or replaced. On 10/18/11 at 2 PM during the exit conference, the administrator could not show that the gauges had been replaced in the past five years. Reference: NFPA 101, 2000 Edition, 19.3.5.1, 9.7.5; NFPA 25, 1998 Edition; 2-2.1.1* Sprinklers shall be visually 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 or loaded, or in the improper orientation. 2-4.1.4 A supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. The cabinet shall be so located that it will not be exposed to moisture, dust, corrosion, or a temperature exceeding 100 degrees Fahrenheit.	K 062	K 062 The Facility will ensure the automatic sprinkler systems are continuously maintained in reliable operating condition and tested periodically. 1) A complete review of the sprinkler system and sprinkler heads was conducted by Phoenix Fire Protection, Inc. on 11/07/2011, and all corroded heads were replaced; 2) 12 spare sprinkler heads along with an extra 212 degree upright head is in sprinkler cabinet on 11/08/2011; 3) Replacement, testing and certification of sprinkler pressure gauges was completed on 11/07/2011 by Phoenix Fire Protection, Inc. A) The Maintenance Director will observe sprinkler heads quarterly to ensure reliable operating condition. If corroded heads are noted, sprinkler heads will be replaced immediately. Continued on next page.	

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K 062	Continued From page 12 2-4.1.5 The stock of Spare Sprinklers shall be as follows: (a) ...Under 300 sprinklers - no fewer than 6 sprinklers (b) ...300-1000 sprinklers - no fewer than 12 sprinklers.... 6-3.6 Pressure gauges shall be tested every 5 years with a calibrated gauge in accordance with the manufacturer's instructions. Gauges not accurate to within 3 percent of the scale of the gauge be tested shall be recalibrated or replaced.	K 062	K 062 Continued: B) The Maintenance Director will audit sprinkler heads for proper condition and report to the monthly PI committee meeting for three (3) months or until ongoing compliance.	11/30/11
K 145 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99, 3.4.2.2.2. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure electrical panel directors were complete in 1 of 3 electrical rooms. Observation of electrical panel "A" on 10/18/11 at 11:56 AM showed a conduit ran from the electrical room emergency battery light into panel "A." Review of the circuit directory attached to the panel door showed there was not a circuit indicated that provided power to the emergency battery light. At the time of observation the maintenance director could not explain why the circuit director had not been updated by the installing contractor. Reference; NFPA 101, 2000 Edition, 19.5.1, 9.1.2; NFPA 70, 1999 Edition;	K 145	K 145 The Facility will ensure electrical wiring and equipment is in accordance with NFPA 99. 1) The emergency battery light in panel "A" has a circuit indicated that provides power to the emergency battery light on 10/21/2011. A) The Maintenance Director will observe power panels ensuring circuits are properly labeled. If a circuit is not labeled it will be corrected immediately. B) The Maintenance Director will audit electrical panels for proper labeling and report to the monthly PI committee meeting monthly.	11/10/11

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K 145	Continued From page 13 384-13 ...All panel board circuits and circuit modifications shall be legibly identified as to purpose or use on a circuit directory located on the face or inside of the panel doors.	K 145	K 147 The Facility will ensure electrical wiring and equipment is in accordance with NFPA 70.	
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 staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 4 of 7 smoke compartments. The findings were: Periodic observations of the electrical system on 10/17-18/11 showed the computer in the dietary office, computer in the marketing office, amplifier in the telephone room, and television set (TV) in the Unit #1 TV room were plugged into electrical adapter that were plugged into second adapters inline. On 10/17/11 at 3:57 PM the maintenance director reported he was aware electrical adapters were not allowed to be connected inline, he could not explain why these adapter had not been noticed and replaced during quarterly electrical inspections. Reference: NFPA 101, 2000 Edition,19.5.1, 9.1.2; NFPA 70, 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	K 147	1) The electrical adapters that were plugged into second adapters have been removed on 10/31/2011. A) The Maintenance director will observe wiring and equipment to ensure accordance with NFPA 70. If issues are observed, repair or removal will occur immediately. B) The Maintenance Director will educate the staff on the NO-use of electrical adapters plugged into second adapters at the November, 2011 all-staff inservice. C) The Maintenance Director will audit for the use of double electrical adapters monthly and report his findings to the monthly PI committee meeting for three (3) months or until ongoing compliance.	11/10/11

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K 147	Continued From page 14 (2) Where run through holes in walls ..., (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces	K 147		