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

PRINTED: 07/28/2016
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
	535056	A. BUILDING 01 - MAIN BUILDING B. WING _____	07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

(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 Nursing Homes Section 42 CFR 483.70 (a) except as otherwise provided in the 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. The facility was a partially sprinklered, one-story building of Type V (111) construction built in 1966. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system. The facility had a capacity of 82 certified Medicare and Medicaid beds with a census of 46.	K 000	**Initial Comment** Preparation and or execution of this plan of correction does not constitute the providers admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to separate the corridor from use areas per NFPA 101. The findings were: Observation on 07/21/2016 at 8:55 AM located at	K 017	K 017 **Corrective Action** All equipment at the west end corridor has been moved back into the therapy gym and the OT room for patient use. **ID Of Others** Maintenance Director/Designee will conduct walking rounds to ensure no other patient care areas are open to corridors. **Systemic Changes** Maintenance Director/Designee will add rounds to ensure no other patient care areas are open to corridors during the monthly facility rounds. Education has been provided to all staff regarding not using areas that are open to the corridors as patient care areas. **Monitor** The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/10/16	

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

Melissa Elliott — Executive Director — 8/6/16

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.

Spoke with Melissa Elliott on 8/16/16 approving the Plan of Correction.

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K 017	Continued From page 1 the west end corridor revealed that the existing activity space adjacent to the exit had been modified for use as a physical therapy location resulting in a patient care area that is open to the corridor. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the corridor was not separated from the patient care area. Ref: 2000 NFPA 101, Section 19.3.6.1	K 017		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain doors in accordance with NFPA 101. The finding were: 1. Observation on 07/21/2016 from 9:05 AM -	K 018		

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K 018	Continued From page 2 11:30 AM located throughout the facility revealed doors that would not positively latch. Additional observation revealed that the failure to latch was contributed to the recent structural lift of the building and recently installed trim, which has led to out-of-square framing and obstructions to the doors within the frame. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the doors were not latching. Ref: 2000 NFPA 101, Section 19.3.6 2. Observation on 07/21/2013 from 9:05 AM - 11:30 AM located at the smoke barrier doors at the north end of the main dining room, and at the south end of the Aspen dining room revealed that the facility failed to provide doors that are resistant to smoke in (2) of (6) smoke compartments. Additional observation revealed that astrigals and sweeps had been damaged or removed during the recent structural lift and reflooring projects resulting in excessive gaps around and below the doors. Interview with the Facility Maintenance Manager at the time of observation acknowledged the gaps in the doors including several smoke barrier doors. Ref: NFPA 101, Section 19.3.6.3.1 3. Observation on 07/21/2013 at 10:56 AM located at the supplies closet door and activities closet door in the Frontier corridor west wing revealed that when the doors were fully opened they protruded more than 7 inches into the corridor due to the recent addition of hand rails on the corridor walls, which impeded the swing of the doors. Interview with the Facility Maintenance Manager at the time of observation was unaware	K 018	K 018 Addressing #1, #2, #3 **Corrective Action** The doors throughout the facility have been adjusted so that they positively latch. Sweeps have been installed on the doors at the north end of the main dining room and at the south end of the aspen dining room. Handrails located at the supplies closet door and activities closet door on the frontier corridor west wing have been removed so that the doors fully open. **ID Of Others** Maintenance Director/Designee will conduct walking round to ensure that all doors positively latch and all fire rated doors have sweeps attached. **Systemic Changes** Maintenance Director/Designee will add rounds monthly to check that all doors positively latch and that all fire doors have sweeps attached. **Monitor.** The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/1016	

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K 018	Continued From page 3 of the requirement. Ref: 2000 NFPA 101, Section 7.2.1.4.4	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 provide rated construction for a hazardous area in accordance with NFPA 101. The findings were: Observation on 07/21/2016 at 10:08 AM located in the Tub room in the 200 corridor revealed that the area was being utilized as a storage room with combustible materials, and that the room did not satisfy the rated construction requirements of NFPA 101 for hazardous areas. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the area was being used as storage and that the area was not provided with rated construction or self-closing doors. Ref: 2000 NFPA 101, Section 19.3.2.1	K 029	K 029 **Corrective Action** The tub room in the 200 corridor is no longer being used as storage the room has had all extra items removed. **ID Of Others** Maintenance director/Designee will conduct walking rounds to ensure no other tub rooms are being used for storage. **Systemic Changes** Maintenance Director/Designee will add rounds monthly to check that tub rooms are not being used as storage. **Monitor** The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/10/16	
K 034	NFPA 101 LIFE SAFETY CODE STANDARD	K 034		

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K 034 SS=D	Continued From page 4 Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an exit access stairway in accordance with NFPA 101. The findings were: Observation on 07/21/2013 at 11:23 AM located in the outside stairway adjacent to basement laundry room revealed that the exit access stair way was not provided with handrails. Additional observation revealed what appeared to be markings on the stairway wall where exiting handrails had been removed. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing handrails. Ref: 2000 NFPA 101, Section 7.2	K 034	K 034 **Corrective Action** A handrail has been installed in the stairway adjacent to the basement laundry room. **ID Of Others** Maintenance Director/Designee will conduct walking rounds to ensure that all areas that should have hand rails currently have handrails. **Systemic Changes** Maintenance Director/Designee will add rounds monthly to check all areas that need handrails have them. **Monitor** The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/10/16	
K 038 SS=D	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 provide an exit access that is accessible at all times in accordance with NFPA 101. The findings were: 1. Observation on 07/21/2016 at 8:50 AM located in the secure unit revealed that the cross-corridor doors at the smoke compartment wall in the egress path from the secure unit had been painted with a mural, which rendered the doors as unrecognizable by a non-impaired person,	K 038		

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K 038	Continued From page 5 such as a visitor. Additional observation revealed that the doors were locked with keypad access by staff at all times, which also resulted in minimal door opening hardware on the doors to aide in recognition. Opening hardware was limited to handles on the doors, which had also been painted as part of the mural. Interview with Facility Maintenance at the time of observation was unaware of the requirement maintain a recognizable means of egress to non-impaired persons. Ref: 2000 NFPA 101, Sections 19.2.1 and 7.1 S&C letter 07-07 2. Observation on 07/21/2016 at 8:50 AM located in the west wing revealed an exit door to the outside that required a force above 50 lbs to open. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the door required more than 50 lbs to open. Ref: 2000 NFPA 101, Sections 19.2.2 and 7.2.1.4.5	K 038	K 038 Addressing #1, #2 **Corrective Action** New handrails have been placed on the doors in the secured unit. The Maintenance Director has fixed the door to the west wing exit and no longer requires 50lb of force to open. **ID Of Others** Maintenance Director/Designee will conduct walking rounds to ensure that no other door opening hardware is disguised and that all exit doors do not require more than 50lb of force to open. **Systemic Changes** Maintenance Director/Designee will add rounds monthly to check facility for disguised door opening hardware and doors that require more than 50lb of force to open. **Monitor.** The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/10/16	
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide signs that are displayed in	K 047	K 047 Addressing #1,#2 **Corrective Action** All doors to the exterior that are not maintained as exits have had signs placed that read "No exit". In the main dining room a new "exit" sign was placed on 7/29/16 placed in the corridor between the kitchen hallway and the entrance to the main dining area. **ID Of**	

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K 047	Continued From page 6 accordance with NFPA 101. The finding were: 1. Observation on 07/21/2016 at 8:47 AM - 11:30 AM located throughout the facility revealed that doors to the exterior that are not maintained as exits were provided with signs that read "Not an Exit" in lieu of the language specified by NFPA 101 to read "No Exit." Interview with the Facility Maintenance Manager at the time of observation was unaware of the requirement. 2. Observation on 07/21/2016 at 10:28 AM located in the main dining room heading toward the building entrance revealed a missing exit sign, and therefore the exit was not clearly marked or identifiable from the dining room. Interview with the Facility Maintenance Manager at the time of observation acknowledged there was a missing exit sign. Ref: 2000 NFPA 101, Sections 19.2.10.1 and 7.10	K 047	Others Maintenance Director/Designee will conduct walking rounds to ensure all exit doors have the correct signs and that all exits signs are in line with the exit. Systemic Changes Maintenance director/Designee will add to the monthly rounds to check all exit signs on exit doors and that all exits signs are in the line with the exit. Monitor The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring. Compliance Date: 8/10/16	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by:	K 050		

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K 050	Continued From page 7 Based on document review and staff interview, the facility failed to provide fire drills in accordance with NFPA 101. The findings were: 1. Document review on 07/21/2016 at 1:02 PM revealed that the facility did not run a fire drill test for the months of April and May 2016, which did not satisfy the quarterly test on each shift requirement. Interview with Facility Maintenance Manager acknowledged that the facility did not run a test in April and May. 2. Document review on 07/21/2016 at 1:02 PM revealed that the facility did not activate the fire alarm on a monthly basis. Interview with Facility Maintenance Manager was unaware of the requirement. Ref: 2000 NFPA 101, Section 19.7.1.2	K 050	K 050 Addressing #1, #2 Corrective Action Facility conducted a fire drill on 7/28/16. The fire alarm was activated on 7/28/16. ID Of Others NA Systemic Changes Maintenance Director/Designee will conduct quarterly fire drills and activate the fire alarm for each shift. Monitor All fire alarm activation testing will come to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/10/16	
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual	K 051		

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K 051	Continued From page 8 signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on document review and staff interview the facility failed to maintain the fire alarm system in accordance with NFPA 72. The findings were: Document review on 07/21/2016 at 1:27 PM revealed that the facility did not have documentation of the quarterly supervisory signal tests. Interview with the Maintenance Manager at the time of observation acknowledged the missing documentation. Ref: 2000 NFPA 101, Section 19.3.4 & 9.6 1999 NFPA 72, Table 7-3.2, 15	K 051	K 051 Corrective Action A quarterly supervisory signal test has been conducted. ID Of Others NA Systemic Changes Maintenance Director/Designee will conduct a quarterly supervisory signal test Monitor All quarterly supervisory signal test will be brought to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/10/16	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NFPA 13 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 056	K 056 Facility is requesting an extension of 180 days.	

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K 056	Continued From page 9 facility failed to protect the building throughout by and approved, supervised automatic sprinkler system. Observation on 07/21/16 at 11:00 AM revealed built-in closets that were located in resident rooms along the 400 corridor. Additional observation revealed that the closets included a bar for hanging clothing, and that the top of the closet enclosure was continuous to the ceiling of the room. Further observation revealed that the closets were not provided with sprinkler protection within each closet. Interview with the Facility Maintenance Manager during the observation revealed that this condition was typical for approximately 38 closets within the facility. Ref: 2000 NFPA 101, Sections 19.3.5.1 and 9.7.1.1, 1999 NFPA 13, Section 1-6.1	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that automatic sprinkler systems are installed and continuously maintained per the requirements of NFPA 13 and NFPA 25. The finding were: 1. Observation on 07/21/2016 at 9:30 AM located in the medical records closet revealed an escutcheon ring with a gap in excess of	K 062	K 062 Addressing #1, #2, #3 Corrective Action Gap around the escutcheon ring has been filled in the medical records closet. An additional sprinkler head has been installed on to provide appropriate sprinkler coverage in the dining room. Quarterly test of the water flow alarm has been conducted on ID Of Others Maintenance Director/Designee will conduct walking rounds to check for gaps in walls and appropriate sprinkler head coverage throughout the facility. Systemic Changes Maintenance Director/Designee will add to the monthly rounds to check for gaps in the walls, appropriate sprinkler head coverage and timely water flow testing. Monitor The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/10/16	

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	536056	A. BUILDING 01 - MAIN BUILDING B. WING _____	07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAGE VIEW CARE CENTER	1325 SAGE STREET ROCK SPRINGS, WY 82901

(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 062	Continued From page 10 one-quarter inch around escutcheon. Interview the Facility Maintenance Manager at the time of observation acknowledged the gap of the escutcheon ring. 2. Observation on 07/21/2016 at 10:23 AM located in the main dining room adjacent to the rolling kitchen door revealed a concealed storage nook that was shadowed from sprinkler coverage due to adjacent construction. Interview with the Facility Maintenance Manager at the time of observation acknowledged the observation. 3. Document review on 07/21/2016 at 1:25 PM revealed that the facility was missing documentation for the quarterly test of the water flow alarm. Interview with the Maintenance Manager at the time of observation acknowledged the missing documentation. Ref: 2000 NFPA 101, Sections 18.3.5.1, 19.3.5.1, 9.7.1.1 1999 NFPA 13, Section 3-2.7.2, and 1998 NFPA 25, 9-2.7	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide portable fire extinguishers in accordance with NFPA 10. The finding were: 1. Observation on 07/21/2016 at 8:35 AM in the	K 064	K 064 Addressing #1,#2 **Corrective Action** The fire extinguisher has been moved in the SCU to meet the 60 inches requirement The fire extinguisher box has been moved down to meet the 60 inch requirement in the kitchen. **ID Of Others** Maintenance Director/Designee will conduct walking rounds to ensure all fire extinguishers within the facility meet the 60 inch height requirement. **Systemic Changes** Maintenance Director/Designee will add to the monthly rounds to check all fire	

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SAGE VIEW CARE CENTER	1326 SAGE STREET ROCK SPRINGS, WY 82901

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K 084	Continued From page 11 secure unit revealed a fire extinguisher adjacent to entry door that was in a cabinet with the top of the extinguisher located at 63 inches from the ground in lieu of the required 60 inches. Interview with the Facility Maintenance Manager at the time of observation was unaware of the height requirement. 2. Observation on 07/21/2016 at 10:17 AM located in the kitchen revealed a fire extinguisher located at 62.5 inches from the top of the extinguisher to the floor in lieu of the required 60 inches. Interview with the Facility Maintenance Manager at the time of observation was unaware of the height requirement. Ref: 2000 NFPA 101, Sections 19.3.5.6 and 9.7.4.1 1996 NFPA 10, Section 1-6.10	K 084	extinguishers and make sure they meet the 60 inch height requirement. Monitor The Results will be brought to QAPI monthly for determination of need/frequency of on-going monitoring Compliance Date: 8/10/16	
K 106 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an EES system in accordance with NFPA 99. The findings were: Observation on 07/21/2013 at 9:24 AM located at the remote alarm annunciator panel for the generator revealed that the annunciator was missing an indication lamp for when the battery	K 106	K 106 Corrective Action The indication lamp was found. The lamp has been found at the rehab nurses station. The lamp properly functions to identify a malfunctioning battery. ID Of Others NA. Systemic Changes Maintenance Director/Designee will add to the monthly rounds to check that the panel for when the charger is malfunctioning is working. Monitor audits will be brought to QAPI and monitored until deemed appropriate. Compliance Date: 8/10/16	

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K 106	Continued From page 12 charger is malfunctioning. Interview with the Facility Maintenance Manager at the time of observation was unaware of the requirement. Ref: 1999 NFPA 99, Sections 3-5.1 and 3-4.1.1.15	K 106		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide documentation in accordance with NFPA 110. The Findings were: Document review on 07/21/2016 at 1:20 PM revealed that the facility could not provide documentation for annual load bank test. Interview with Facility Maintenance Manager at the time of observation acknowledged the missing documentation. Ref: 2000 NFPA 101, Sections 19.2.9.1 and 7.9.3	K 144	K 144 **Corrective Action** Annual load bank test will be conducted on or about 8/9/16. **ID Of Others NA Systemic Changes.** Maintenance Director/Designee will confirm that the annual load bank test is conducted on an annual basis. **Monitor** Maintenance director will provide supporting documentation that the annual load bank test was conducted and brought to QAPI Compliance Date: 8/10/16	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on Observation and Staff Interview, the facility failed to meet electrical wiring in accordance with NFPA 70. The findings were: 1. Observation on 07/21/2016 at 9:08 AM located	K 147		

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K 147	Continued From page 13 In the main entrance bathroom revealed that a receptacle directly under the sink was not equipped with a ground-fault circuit-interrupter. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing ground-fault circuit-interrupter. Ref: 1999 NFPA 70, Article 210.8 2. Observation on 07/21/2016 at 10:00 AM located in bath room 307 revealed a receptacle missing a face plate. Interview with the Facility Maintenance Manager at the time of observation acknowledge the missing face plates. Ref: 1999 NFPA 70, Article 110-27	K 147	K 147 Addressing #1, #2 **Corrective Action** A GFC has been installed in the main entrance bathroom under the sink. A face plate has been placed on the receptacle in the bathroom in room 307. **ID Of Others** Maintenance Director/Designee will conduct a facility wide audit to confirm that GFCs are installed in all bathrooms and that no face plates are missing. **Systemic Changes** Maintenance Director/Designee will add to the monthly rounds to check that no GFCs or face plates are missing. **Monitor** audits will be brought to QAPI and monitored until deemed appropriate. Compliance Date: 8/10/16	