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
	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(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 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 (NFPA). The facility was a fully sprinkled two story building of Type V (000) construction built in 1958 and 1987. The building was equipped with a supervised automatic dry sprinkler system with an addressable fire alarm system.	K 000	POC ACCEPTED W/ JILL BLLIOTT, LSD ON 5/20/09.	
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure one of three fire barriers was not maintained. The findings were: Observation on 4/20/09 at 4:32 PM revealed the fire barrier near the laundry had five water pipes that penetrated the barrier. The gap around the pipes was filled with expanding foam. Interview with the maintenance director at the time of observation revealed he did not have flame retardant documentation for the expanding foam. After reviewing the facilities documents he still	K 011	K011 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self- closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This will be accomplished by: 1. The fire barrier near the laundry where gaps by water pipes where filled with expanding foam, the expanding foam will be removed and replaced with fire retardant sheetrock mud. 2. Maintenance staff will be in-serviced to the deficiency. 3. The Maintenance Director or designee will inspect fire barrier walls for penetrations and fill with fire retardant material quarterly. 4. The Maintenance Director or designee will report inspection results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
J M Elliott	Adm/CEO	5-15-09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	535042	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

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K 011	Continued From page 1 was unable to find any documentation on the expanding foam.	K 011		
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 and staff interview the facility failed to ensure corridor doors were smoke resistant in one of nine smoke compartments. The findings were: Observation on 4/21/09 between 1:30 PM and 2:30 PM revealed the corridor door to resident room #207 and #217 did not fully latch into the frame. The latch bolt did not insert into the strike plate after three attempts. Interview with the maintenance director at the time of observation	K 018	K018 Doors protecting corridor openings in other than required enclosures of vertical openings, exits or hazardous areas are substantial doors, such as those constructed of 1 ¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinkled 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 This will be accomplished by: 1. The corridor door to resident room #207 and #217 will be repaired so the latch bolt inserts into strike plate letting door close. 2. Maintenance staff will be in-serviced to the deficiency. 3. The Maintenance Director or designee will inspect corridor doors quarterly to ensure proper closing of doors. 4. The Maintenance Director or designee will report inspection results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009

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K 018	Continued From page 2 revealed corridor doors were not routinely inspected. Corridor doors were only inspected when work orders were submitted.	K 018		
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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure one of nine smoke barrier walls were smoke resistant. The findings were: Observation on 4/20/09 at 4:27 PM revealed the smoke barrier wall near the medical records office had three pipes which penetrated the wall. The gap around the pipes was filled with expanding foam. Interview with the maintenance director at the time of observation revealed he did not have flame retardant documentation for the expanding foam. After reviewing the facilities documents he still was unable to find any documentation on the expanding foam.	K 025	K025 Smoke barriers are constructed to provide at least a ½ 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, 18.3.7.5, 19.1.6.3, 19.1.6.4. This will accomplished by: 1. The smoke barrier wall near medical records where the gaps by pipes where filled with expanding foam, expanding foam will be removed and replaced with fire retardant ~~sheetrock mud~~. CAULK 2. Maintenance staff will be in-serviced to the deficiency. 3. The Maintenance Director or designee will inspect the smoke barrier walls quarterly to ensure there is no unsealed penetration of the smoke barrier wall. 4. The Maintenance Director or designee will report inspection results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009
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	K 029		

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K 029	Continued From page 3 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 two of nine smoke compartments. The findings were: 1. Observation on 4/21/09 at 11:15 AM revealed the west electrical room had five unsealed wall penetrations. The gap around the pipes were from one-half to a full inch larger than the pipes. Interview with the maintenance director at the time of observation revealed hazardous areas were not routinely inspected. 2. Observation on 4/21/09 at 11:27 AM revealed the pass through hallway north of the ice cream parlor was storing five cardboard boxes filled with paper products. The two corridor doors to this areas were not equipped with latching devices. The area in the door where a latch would be located was hollow and missing any type of equipment. Interview with the maintenance director at the time of observation revealed the areas was not supposed to be used for storage, but staff continually used the areas for storage.	K 029	K029 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 plated that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This will be accomplished by: 1. • The wall penetrations and gaps in west electrical room will be filled with fire retardant ~~sheetrock mud~~. • Hallway north of ice cream room boxes were removed. 2. Housekeeping staff will be in-serviced to deficiency. 3. Maintenance staff will be in-serviced to the deficiency. 4. The Maintenance Director or designee will inspect for wall penetration quarterly. 5. The Maintenance Director or designee will report inspection results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009 6/4/2009
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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K 050 SS=F	Continued From page 4 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure fire drills were held at unexpected times on one of three shifts. The findings were: 1. Review of the fire drill records revealed the morning shift occurred between 7 AM and 3 PM. The four drill conducted in 2008 all occurred between 2:15 PM and 2:30 PM. 2. Interview with the maintenance director on 4/21/09 at 9:30 AM revealed he was not aware that fire drills needed to be conducted at varying times throughout the shift.	K 050	K050 The facility will hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. When drills are conducted between 9pm and 6am coded announcement may be used instead of audible alarms. This will be accomplished by: 1. Fire drills will be conducted once a month per a ~~rotating~~ shift schedule. 2. Maintenance staff will be in-serviced to the deficiency. 3. The Maintenance Director or designee will conduct the fire drill per rotating shift schedule. 4. The Maintenance Director or designee will report fire drill results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully	K 056	K056 The facility will have a automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage of all portions of the building. This will be accomplished by: 1. The sprinkler heads in the medical records office and the west lounge will be relocated to within seven and one-half feet from the walls ~~with new sprinkler heads installed~~ as required to meet the NFPA 13 code.	6/4/2009

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K 056	Continued From page 5 supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide adequate sprinkler coverage in two of nine smoke compartments. The findings were: Observation on 4/21/09 between 11:30 AM and 12:30 AM revealed the sprinkler heads in the medical records office and the west lounge were located more than the allowed seven and one-half feet from walls. The sprinkler heads in both locations were located eleven feet from walls. Interview with the maintenance director at the time of observation revealed the areas had been modified within the last year. Review of the 9/30/08 sprinkler testing report revealed the aforementioned areas did not have adequate coverage. The maintenance director reported that he was unaware of the contractors comments about the areas.	K 056	2. Maintenance staff will be in-serviced to the deficiency. 3. The Maintenance Director or designee will inspect the location of sprinkler heads annually to ensure proper placement within seven and one-half feet from walls. 4. The Maintenance Director or designee will report inspection results to the QA team annually. K062 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 will be accomplished by: 1. The two sprinkler head in the ice cream parlor that have painted on them will be ~~cleaned or~~ replaced.	6/4/2009 6/4/2009 6/4/2009 6/4/2009
K 062 SS=F	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	K 062	2. Maintenance staff will be in-serviced to the deficiency. 3. The Maintenance Director or designee will inspect the sprinkler heads annually. 4. The Maintenance Director or designee will report inspection results to the QA team annually.	6/4/2009 6/4/2009 6/4/2009

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K 062	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the sprinkler system free of obstruction in one of nine smoke compartments. The findings were: Observation on 4/21/09 at 11:34 AM revealed two of four sprinklers in the ice cream parlor sky lights had been partially covered with paint. Interview with the maintenance director at the time of observation revealed the sprinkler system was inspected annually by an outside contractor. Review of the annual sprinkler reported revealed the areas was not noted in the comment section. The maintenance director reported that he was not aware of the last time the area was painted.	K 062		
K 141 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure NO SMOKING signs were posted on resident rooms were oxygen was being used in one of nine smoke compartments. The findings were: Observation on 4/21/09 between 12:30 PM and 1 PM revealed resident rooms #31 and #32 had oxygen in use and the corridor doors were not posted with NO SMOKING signs. Interview with the maintenance director at the time of observation revealed the NO SMOKING signs were monitored my the nursing staff.	K 141	K141 Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2 This will be accomplished by: 1. Oxygen signs will be placed on resident rooms #31 and #32 where oxygen is in use. 2. Maintenance staff and nursing staff will be in-serviced to the deficiency. 3. The Nursing management staff and Maintenance will inspect and place oxygen in use signs on resident rooms for oxygen equipment and/or oxygen in use weekly. 4. The DON or designee will report inspection results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009

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Wyoming Dept of Health
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Office of Healthcare Licensing and Surveys

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	535042	A. BUILDING 02 - EAST BUILDING 02 B. WING	04/22/2009

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K 000	INITIAL COMMENTS Requirements for Long Term Care Facilities 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 (NFPA). The facility was a partially sprinkled single story building of Type II (111) construction built in 1979. The building was equipped with a supervised automatic wet sprinkler system with an addressable fire alarm system.	K 000	POC ACCEPTED W/ THE PLAN OF CORRECTION, DON 5/20/09.	
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 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure two of three smoke barrier walls were smoke resistant. The findings were: 1. Observation on 4/20/09 at 4:49 PM revealed the smoke barrier wall near resident room #6 had three pipe penetrations that were filled with expanding foam. Interview with the maintenance	K 025	K025 Smoke barriers are constructed to provide at least a ½ 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, 18.3.7.5, 19.1.6.3, 19.1.6.4. This will accomplished by: 1. The smoke barrier wall near RESIDENT ROOM #6 ~~medical records~~ where the gaps by pipes where filled with expanding foam, expanding foam will be removed and replaced with fire retardant ~~sheetrock mud~~. CAULK. 2. Maintenance staff will be in-serviced to the deficiency. 3. The Maintenance Director or designee will inspect the smoke barrier walls quarterly to ensure there is no unsealed penetration of the smoke barrier wall. 4. The Maintenance Director or designee will report inspection results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009

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

[signature] ADM/CEO — 5-15-09

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K 025	Continued From page 1 director at the time of observation revealed he did not have flame retardant documentation for the expanding foam. He reviewed facility documents, but was unable to find any documentation for the expanding foam. 2. Observation on 4/20/09 at 5:10 PM revealed the smoke barrier wall near the east nurse's station had one unsealed conduit penetration. The gap around the conduit was one inch larger than the conduit. Interview with the maintenance director at the time of observation revealed the smoke barrier walls were not inspected on a routine basis.	K 025	K029 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 plated that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This will be accomplished by:	
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 one of two smoke compartments. The findings were: Observation on 4/21/09 at 10:39 AM revealed the east boiler room had one unsealed pipe	K 029	1. • The wall penetrations and gaps in ~~west electrical~~ room will be filled with fire retardant ~~sheetrock mud.~~ ~~• Hallway north of ice cream room boxes were removed.~~ 2. Housekeeping staff will be in-serviced to deficiency. 3. Maintenance staff will be in-serviced to the deficiency. 4. The Maintenance Director or designee will inspect for wall penetration quarterly. 5. The Maintenance Director or designee will report inspection results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009

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SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

5/20/09

(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 029	Continued From page 2 penetration. The gap around the pipe was one-half inch larger than the pipe. Interview with the maintenance director at the time of observation revealed the pipe was installed during a project that concluded in June 2008. He further reported hazardous areas were not routinely inspected.	K 029		
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 at unexpected times on one of three shifts. The findings were: 1. Review of the fire drill records revealed the morning shift occurred between 7 AM and 3 PM. The four drills conducted in 2008 all occurred between 2:15 PM and 2:30 PM. 2. Interview with the maintenance director on 4/21/09 at 9:30 AM revealed he was not aware that fire drills were to be conducted at varying times.	K 050	K050 The facility will hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. When drills are conducted between 9pm and 6am coded announcement may be used instead of audible alarms. This will be accomplished by: 1. Fire drills will be conducted once a month per a ~~rotating~~ RANDOM shift schedule.	6/4/2009
			2. Maintenance staff will be in-serviced to the deficiency.	6/4/2009
			3. The Maintenance Director or designee will conduct the fire drill per rotating shift schedule.	6/4/2009
			4. The Maintenance Director or designee will report fire drill results to the QA team no less than quarterly.	6/4/2009
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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
	535042	A. BUILDING 02 - EAST BUILDING 02 B. WING _____	04/22/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEPHERD OF THE VALLEY	60 MAGNOLIA CASPER, WY 82604

(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 147	Continued From page 3 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 electrical equipment was replaced once damaged in one of two smoke compartments. The findings were: Observation on 4/21/09 at 10:23 AM revealed the electrical cord to the oxygen concentrator in resident room #116 was damaged at the plug. The outer sheath of the cord was split, which exposed the insulated electrical wires. Interview with the maintenance director at the time of observation revealed the electrical appliances were only inspected annually. The last annual inspection occurred in January 2009.	K 147	K147 Electrical wiring and equipment is in accordance with NFPA 10, National Electrical Code. 9.1.2 This will be accomplished by: 1. Electrical cord on oxygen concentrator was repaired, IN RESIDENT Room #116. 2. Maintenance staff will be in-serviced to the deficiency. 3. The Maintenance Director or designee will inspect the electrical system to include electrical cords quarterly. 4. The Maintenance Director or designee will report inspection results to the QA team no less than quarterly.	6/4/2009 6/4/2009 6/4/2009 6/4/2009