

PRINTED: 05/10/2011
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: 635048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/26/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401	
(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 II (111) and V (000) construction with plan approval in 1970 and 1990. The building was equipped with a partial automatic wet sprinkler system and with a zoned fire alarm system. The facility had a capacity of 87 certified Medicare and Medicaid beds with a census of 64 residents. The facility meets the Life Safety Code standard based on the acceptance of a plan of correction and an Fire Safety and Evaluation System (FSES). Tag K-012, K-017, and K-058 can be obviated by the FSES. If the facility agrees to the conditions of the FSES they can write and "F" in the providers Plan of Correction column and Complete Date column to accept the FSES. If the facility wants to fix the deficiency they can fill in the Providers Plan of Correction column with the appropriate information and dates. NFPA 101 LIFE SAFETY CODE STANDARD	K 000	Preparation and execution of this plan of correction does not constitute an admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in 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. Completion dates are provided for procedural processing purposed and correlate with the most recently contemplated or accomplished corrective action and do not necessarily correspond chronologically to date the facility is of the opinion it was in compliance with requirements of participation or that corrective action was necessary.	
K 012 SS=F	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	K 012	K012 The facility will ensure ceilings are smoke resistant in all 6 smoke compartments. This will be accomplished by:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 a prerequisite to continued program participation.

PC Modified & Accepted w/ DEB Cozzens, NHA

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: PHF21

Facility ID: WY0008

MAY 20 2011

In continuation sheet Page 1 of 15

ON 5/25/11.

Office of Healthcare
Licensing and Surveys

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 539048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
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K 012	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure ceilings were smoke resistant in 1 of 6 smoke compartments. The findings were: Observation on 4/25/11 at 5:14 PM showed the attic access door was missing from the generator room. The open doorway was 24 inches square. At the time of observation the administrator reported he did not know why the door was missing. He also reported that he was not sure how long the door had been missing. Based on observation and staff interview the facility failed to ensure the minimum construction requirements were met for a non-sprinkled building in 6 of 6 smoke compartments. The findings were: Observation on 4/26/11 between 8 AM and 3 PM showed the facility was primarily constructed of Type II (111) Construction. The following areas were constructed of combustible materials Type V (000) construction and the facility was not protected by a complete supervised automatic sprinkler system: a. The vertical smoke barrier wall above the ceiling tile in hall #2 and hall #3. b. A false wall above the ceiling tile near the janitor's closet in hall #3. c. Two cross corridor draft stop walls above the ceiling tile near the administration area. d. The sky light shaft in halls #1, #2, #3 and #4.	K 012	The attic access door has been installed in the generator room. a. F b. F c. F d. F Monitoring: Director of maintenance will monitor/inspect all areas quarterly. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	05/25/11 F F F F	

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K 012	Continued From page 2 On 4/26/11 at 8 am the administrator confirmed the aforementioned areas were constructed of combustible materials and the building was not equipped with a complete sprinkler system. (The Fire Safety Evaluation System (FSES) will obviate these deficiencies. The facility has the option of correcting these items or placing an "F" in the Providers Plan of Correction column and the Complete Date column to accept the findings of the FSES.)	K 012			
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend 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 the 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, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation the facility failed to ensure corridor walls extended from the floor to the roof deck above in 5 of 6 smoke compartments. The	K 017	K017 F	F	

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K 017	Continued From page 3 findings were: Observation on 4/26/11 between 8 AM and 3 PM showed the corridor walls on halls #1, #2, #3 and #4 stopped above the ceiling tile, except for the new construction on the #1 hall. (The Fire Safety Evaluation System (FSES) will obviate these deficiencies. The facility has the option of correcting these items or placing an "F" in the Providers Plan of Correction column and the Complete Date column to accept the findings of the FSES.)	K 017			
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 2 of 5 smoke barrier walls were smoke resistant. The findings were: Observation on 4/26/11 between 10:30 AM and 11:30 AM showed the 200 hall smoke barrier wall had one cable penetration filled with non-rated	K 025	The facility will ensure that all 5 smoke barrier walls are smoke resistant. This will be accomplished by: The cable penetrations on the 200 hall and 300 hall smoke barrier walls were filled with fire retardant foam. The non- rated expanding foam was removed. 3 Repaired with RETARDANT FOAM. Monitoring: Director of maintenance will monitor quarterly. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	05/25/11 REMOVED	

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K 025	Continued From page 4 expanding foam. Further review showed the 300 hall smoke barrier wall had two unsealed conduit penetrations and one pipe penetration filled with non-rated expanding foam. At 10:53 AM the administrator reported the facility did not have flame retardant documentation for the expanding foam. Furthermore he was not aware of a smoke barrier inspection interval.	K 025			
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 1 of 6 smoke compartments. The findings were: Observation of the central supply storeroom on 4/26/11 at 10:09 AM showed the corridor door was held in the open position by a kick down door stop. At the time of observation the maintenance director reported he was not aware hazardous areas corridor doors were prohibited from being held open unless they release with the activation	K 029	The facility will ensure hazardous areas were separated from use areas in all 6 smoke compartments. This will be accomplished by: The Kick down door stop was removed from the central supply storeroom corridor door. Monitoring: Director of maintenance will monitor quarterly. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	05/25/11	

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K 029	Continued From page 5	K 029			
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038			
SS=K	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 emergency exit egress through the fenced courtyard for 14 of 14 secure unit residents. In the event of a fire the residents from the secure unit would likely have been trapped without means of escape. This resulted in Immediate Jeopardy. The findings were: 1. Observation of the secure unit courtyard on 4/26/11 at 5:19 PM showed the latch was attached to the outside of the north gate. The latch was secured by a keyed padlock. At the time of observation the administrator stated he did not have a key for the padlock. He reported that he thought the newly appointed maintenance director had the key. Observation of the west gate showed it was secured from the outside by a combination lock. Observation revealed the latch had previously been installed on the inside of the gate. The administrator reported he knew egress doors were not to be locked in a manner that would prevent them from being opened from the path of travel. The administrator was not sure when the locks had been moved to the outside of the gates. Furthermore, he stated that he would move the latches and locks to the interior side of		K038 The facility will ensure emergency exit egress through the fenced courtyard for 14 of 14 secure unit residents. This will be accomplished by: On the morning of April 26, 2011 the two locks were removed from the outside of the gates and two new locks were installed on the inside of the gates to secure the Unit Courtyard and labels were made with two new combinations and placed on the vinyl fence. → THE COMBINATIONS All staff that were in the building on April 26, 2011 were in-serviced on the knowledge of the evacuation plan through the Courtyard and the importance of the locks being accessible from the inside to include location of locks, posting of the combination, and evacuation through Unit Courtyard. In-servicing has continued to ensure that all staff is in-serviced. Monitoring: Director of maintenance will monitor weekly for the first quarter and then quarterly. Any issues noted will be addressed immediately.		04/26/11

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K 038	Continued From page 6 the gates the next morning, which would make them accessible from the courtyard. 2. On 4/26/11 at 7:53 AM it was determined that Immediate Jeopardy existed. The administrator was notified at 8:05 AM. 3. Interview on 4/26/11 at 8:10 AM, with the assistant director of nursing (ADON), who was the head nurse in the secure unit revealed the unit had a capacity of 20 residents, with a current census of 14. She also reported she did not have a key or combination to the courtyard gates, but she thought the maintenance staff might have the keys. 4. Interview on 4/26/11 at 8:18 AM confirmed the maintenance director did not have a key to the padlock or know the combination for the west gate. The only key to the padlock was held by the assistant maintenance director/van driver. The ADON reported she was aware of the combination to the lock at the west entrance to the unit. She was the only member of staff interviewed who knew the combination. She reported the locks had been moved more than six months earlier because a resident was continually playing with the locks. The administrator confirmed the combination was not posted on or near the gate. 5. On 4/26/11 at 8:25 AM the administrator reported that the facility did not have an evacuation policy for secure unit residents through the courtyard. 6. Observation on 4/26/11 at 8:30 AM revealed the latches attached to the secure unit's two	K 038	Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.		

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K 038	Continued From page 7 courtyard gates were removed and reattached to the interior side of the gates. Combination locks were installed and the combinations were posted on each gate. Nursing staff in all three units were notified of the new locks and the location of the posted combinations.	K 038			
K 046 SS=F	7. The facility developed an action plan which addressed the locking mechanism, the egress system protocol and a staff training procedure and timeline. The Immediate Jeopardy was abated on 4/26/11 at 2:23 PM. 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: Based on record review and staff interview the facility failed to ensure emergency battery lights were tested during 4 of the past 12 months. The findings were: Review of the emergency battery light testing records showed the monthly 30 second test had not been performed during the months of October 2010, January, February and March of 2011. On 4/26/11 at 1:30 PM the maintenance director confirmed the aforementioned tests had not been completed. He also reported the testing record had not been added to the 2011 preventative maintenance log and assumed that was why the tests had not been completed.	K 046	K046 The facility will ensure that the 30 second test of the emergency battery lighting is conducting monthly. This will be accomplished by: 1. The 30 second emergency battery lights were tested on May 2, 2011 Monitoring: Director of maintenance will monitor monthly. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	06/25/11	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050	K050 The facility will ensure that fire drills are		

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K 050	Continued From page 8 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 conducted at varying times on 3 of 3 shifts. The findings were: Review of the fire drill records showed the first shift hours were 6 AM to 2 PM. The second shift hours were 2 PM to 10 PM. The third shift hours were 10 PM to 6 AM. The record documented all fire drills conducted on the first shift during the past four quarters occurred between 9 AM and 10:40 AM. The fire drills conducted on the second shift during the past four quarters were documented as having occurred between 2:16 PM and 3:20 PM. The fire drills conducted on the third shift during the past four quarters all occurred between 10:25 PM and 10:30 PM. On 4/26/11 at 1:30 PM the maintenance director reported he was unaware fire drills were required to be scheduled at varying times throughout each shift.	K 050	conducted during all three shifts. This will be accomplished by: 1. A fire drill will be conducted quarterly on the 10pm to 6am shift. 2. A fire drill will be conducted quarterly on the 6am to 2pm shift. 3. A fire drill will be conducted quarterly on the 2pm to 10pm shift. 4. Fire drills for all three shifts will be conducted at a variety of times. Monitoring: Administrator will monitor quarterly. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	05/25/11 05/25/11 05/25/11 05/25/11	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056	K056 F		F

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K 056	Continued From page 9 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 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 the facility failed to ensure 6 of 6 smoke compartments were fully sprinkled. The findings were: Observation on 4/26/11 between 8 AM and 3 PM showed the building was primarily constructed of Type II (111) construction, but several areas were observed to have wood construction making the building a Type V (000) structure. The following areas were constructed of combustible materials: a. The vertical smoke barrier wall above the ceiling tile in hall #2 and hall #3, b. A false wall above the ceiling tile near the janitor's closet in hall #3. c. Two cross corridor draft stop walls above the ceiling tile near the administration area. d. The skylight shaft in halls #1, #2, #3 and #4. The building did not have a complete supervised automatic sprinkler system as required by the Code for type V buildings. The facility did have a domestic wet sprinkler system in the file store	K 056			

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K 056	Continued From page 10 room, the laundry, and the oxygen transferring room. (The Fire Safety Evaluation System (FSES) will obviate these deficiencies. The facility has the option of correcting these items, or placing an "F" in the Providers Plan of Correction column and the Complete Date column to accept the findings of the FSES.)	K 056			
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K 066 The facility will ensure staff members are following the smoking policy in the staff smoking area. This will be accomplished by: Staff was in-serviced on 05/17/2011 and 05/18/2011 in the importance of using the ashtrays and not to have cigarette butts strewn about and mingled with dried grass and leaves. In-servicing will continue until all staff is in-serviced. ALL BUTTS WERE CLOSED UP. Monitoring: Director of Housekeeping will monitor monthly. Any issues noted will be addressed immediately. Quality Assurance: Director of Housekeeping will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.		05/25/11

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2011
NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
(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 066	Continued From page 11 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure staff members were following the smoking policy in 1 of 1 staff smoking areas. The findings were: Observation of the staff smoking area on 4/26/11 at 5:08 PM showed 40 cigarette butts strewn about and mingled with dried grass and leaves. Further review showed the area was supplied with two ashtrays. At the time of observation the facility manager did not know why the ashtrays had not been used.	K 066			
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by:	K 143	K143 The facility will ensure protective equipment is provided in the liquid oxygen storeroom. This will be accomplished by: A facemask and gloves have been purchased and mounted with easy access in the liquid oxygen storeroom. Monitoring: Director of Maintenance will monitor weekly to ensure still intact and easily accessible. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.	04/25/11	

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K 143	Continued From page 12 Based on observation and staff interview the facility failed to ensure protective equipment was provided in 1 of 1 liquid oxygen storeroom. The findings were: Observation of the liquid oxygen storeroom on 4/26/11 at 9:52 AM showed a protective face shield and leather gloves were not provided for the transfer process. At the time of observation the administrator reported he was aware staff members were required to wear safety equipment during the transfer of liquid oxygen into portable containers. He also reported the shield and gloves had been provided at one time, but did not know how long they had been missing.	K 143			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review and staff interview the facility failed to ensure the emergency generator transferred from normal power to emergency power in 10 seconds or less, for 2 of the past 12 months. The findings were: Review of the emergency generator testing records showed the transfer times were not 10	K 144	K144 The facility will ensure the emergency generator transfers from normal power to emergency power in 10 seconds or less every month. This will be accomplished by: The test performed May 4, 2011 – the generator transferred to emergency power in 6 seconds. If a transfer time is greater than 10 seconds – will run a check for 7 (seven) days and if it continues to be greater than 10 seconds will contact Generator Company to come and inspect. Monitoring: Director of maintenance will monitor	05/25/11	

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NAME OF PROVIDER OR SUPPLIER WORLAND HEALTHCARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 HOWELL AVENUE WORLAND, WY 82401		
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K 144	Continued From page 13 seconds or less for February or March of 2011. The records showed a transfer time of 18 seconds on 2/25/11 and 22 seconds on 3/08/11. On 4/26/11 at 1:30 PM the maintenance director reported he had only held this position for one day and had no knowledge of the testing results or records.	K 144	monthly. Any issues noted will be addressed immediately.		
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 and failed to ensure damaged electrical equipment was replaced in 3 of 7 smoke compartments. The findings were: 1. Observation on 4/26/11 between 9:30 AM and 10 AM showed the television set in the secure unit was plugged into a surge protector, which was plugged into a 6-way adapter. Further review showed the residential type clothing drier in the laundry was plugged into a 3-way adapter. At 9:38 AM the administrator reported he was aware electrical adapters were prohibited. He stated he did not know why the adapter was being used. 2. Observation of the electrical system in resident room #308 on 4/26/11 at 10:26 AM showed the outlet near bed "B" was cracked and missing the top half of the face. At the time of observation the administrator reported the electrical system was inspected on a quarterly basis. He also reported	K 147	Quality Assurance: Director of Maintenance will report results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions. K147 The facility will ensure that electrical systems are properly maintained. This will be accomplished by: 1. The power strip plugged into the 6-way adapter in the Secure Unit has been plugged directly into the wall. 2. The 3-way adapter that had the drier in the laundry plugged into it has been removed and 2 new separate outlets have been installed. 3. The outlet cover near bed "B" in room #308 has been replaced. Monitoring: Director of maintenance will monitor weekly. Any issues noted will be addressed immediately. Quality Assurance: Director of Maintenance will report		05/25/11 05/25/11 05/25/11

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K 147	Continued From page 14 damaged electrical equipment should be observed by the nursing or housekeeping staff and reported to the maintenance staff. He stated he did not know why this had not happened.	K 147	results of monitoring quarterly or more frequently as needed at the Quality Assurance meeting for review and suggestions.		