STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G005	A. BUILDING _____ B. WING _____	C 03/11/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONESBORO HUMAN DEVELOPMENT CENTER	4701 COLONY DRIVE JONESBORO, AR 72404

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W 000	INITIAL COMMENTS Complaint #14294 was unsubstantaited.	W 000		

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 requisite to continued program participation.

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	04G005	A. BUILDING _____ B. WING _____	C 01/21/2010

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W 000	INITIAL COMMENTS Complaint #: 15139 Unsubstantiated With No Deficiency Cited	W 000		

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	04G005	A. BUILDING _____ B. WING _____	10/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. A full survey was conducted 10/19/09 through 10/28/09.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure shower bath rooms were in good repair, closets and armoires had handles and latches, dishes in the kitchen were inverted when stored, cabinet drawers did not fall when opened, food was not stored in the microwave, the microwave was not missing a handle, and all food items in the kitchen were dated as received. These failed practices had the potential to affect 112 clients. The findings are: 1. On 10/27/09 at 8:50 a.m., the following observations were made in Living unit 1400.	W 104		

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	04G005	A. BUILDING _____ B. WING _____	10/28/2009

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W 104	Continued From page 1 a. In the bath and shower room the grout and caulking around the jet tub had spaces and cracks 1/4 to 3/8 inches wide. Two shower stalls had no covering over the area where the shower head came through the tile leaving a space large enough to stick in a finger. b. None of the closets or armoires in the client bedrooms had handles or latches on the doors. c. The kitchen had shelf liner in the bottom shelf in the upper cabinets. The liner was stuck to the shelf. The bread box had some of the shelf liner rolled up inside. d. In the kitchen, the first cabinet by the hall door had 2 skillets and 1 bowl that were not inverted. The drawer in that bottom cabinet had shelf liner. The bottom 3 drawers to the right of the sink fell down when opened 4-6 inches. The pans in the cabinet next to the refrigerator were not inverted. e. A bag of honey buns (5) and 2 loose buns were in the microwave. The refrigerator door was missing a handle for opening the door. 2. On 10/27/09 at 9:45 a.m., the following observation were made of the main kitchen: a. In the dry goods storage area there were boxes of grits and pop tarts, 4 clear bags of vanilla wafers, 6 boxes of chocolate cake mix, 1 box of sugar free cake mix and 3 packages of gravy mix not dated. b. In the storeroom the nutritional supplements (Jevity and Ensure) were not dated as to the date	W 104		

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	04G005	A. BUILDING _____ B. WING _____	10/28/2009

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W 104	Continued From page 2 received. c. In the refrigerator was a container with donut holes and 4 pies that was not dated. d. There were 4 racks that held #10 cans and none of the cans were dated. e. The freezer across from the hand sink had numerous packages of waffles, bread and tamales with no dates. There were 2 large clear zip-lock bags of chicken breast in the other freezer with no date. 3. On 10/28/09 at 10:10 a.m., cooks in the kitchen were asked about dates on the items in the refrigerator and freezers. They stated that they didn't date anything until it was opened. They were showed the waffles in the door of the freezer with no dates and they just said "oh". They stated they did not know they were supposed to date the cans in the racks. 4. On 10/28/09 at 10:00 am, the Acting Kitchen Supervisor was questioned about dating food items and he stated, "I have no idea about that."	W 104		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.	W 249		

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	04G005	A. BUILDING _____ B. WING _____	10/28/2009

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W 249	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure continuous active treatment program for the evening time period was developed and implemented for 5 (Client #1, 3, 8, 10 and 11) of 12 (Client #1 -12) sampled clients. The findings are: 1. Client #1 had diagnoses of Profound Mental Retardation, Encephalopathy, Cerebral Palsy, Functional vision (Blind in left eye), Chronic Constipation, Sialorrhea, Generalized Tonic-Clonic Seizure Disorder, Gastroesophageal Reflux, Suppression of Menses and Osteopenia. a. The Individual Program Plan (IPP) meeting conducted on 3/11/09, page 12, Service Objective #10 documented, "To assist me to achieve goals #1 and #2, I will be assisted to choose daily from the activity menu recreational activities of my choice in which to participate in my home." b. On 10/20/09 at 5:15 p.m., in house 1100, the client was on the love seat in the day room with her feet on the floor, the rest of her body was laid over and she was covered with a quilt. Direct Care Staff stated that she will uncover her head when she hears something to get her attention. She uncovered her head to see the surveyor, but laid back down and covered her head. At 5:40 p.m., supper was finished and the client was back on the love seat, covered with a quilt. At 6:05 p.m., the client was still on the love seat, covered completely with a quilt.	W 249		

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W 249	Continued From page 4 At 6:05 p.m., Direct Care Staff was asked what they would be doing tonight and she said they would probably watch a movie or sing or something. At 6:18 p.m., the client was still on the love seat under her quilt. She raised the quilt and looked around when the surveyor talked to staff. As of 6:18 p.m., the Direct Care Staff did not interact with the client. When staff was asked about the client, they stated that she wasn't asleep, she just liked to stay under her quilt. Staff did not reference a menu or list of things to do when asked about activities. 2. Client #8 had diagnoses of Profound Mental Retardation secondary to Microcephaly, Myoclonic Seizures, Generalized Tonic-Clonic Seizure Disorder, Chronic Constipation, Sialorrhea, Osteopetrosis, Angelman's Syndrome and Gastroesophageal Reflux. a. The Monthly Plan Review and Progress Note with a staffing date of 7/19/09 documented on page 10, service objective 1: "To assist in achieving goal #1 and to increase exposure to appropriate leisure activities, I will be offered media sessions one time weekly." and on page 19, service objective 24 "To assist in achieving goal #1 and to promote leisure skills, staff persons will encourage me to attend leisure activities." b. On 10/20/09 at 4:55 p.m., in House 1400, the client was in her bedroom and staff was assisting her out of the room. The client went down the hall and stood in the window by the outside door. Direct Care Staff said that was what she liked to	W 249		

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W 249	Continued From page 5 do. At 5:50 p.m., the client was standing at the window again. At 6:00 p.m., the client moved to her bedroom where she sit on the side of the bed and laid her body down with her feet still on the floor. c. On 10/22/09 at 5:45 p.m., the client was sitting in the dayroom on the couch with a toy in her hand. Staff #3 stated that they were entertaining tonight. That they were having over other clients for a movie and popcorn. When asked how often they did that, Staff #3 stated they tried to do it once a month. d. On 10/22/09 at 6:15 p.m., the television was on, but no one was watching except staff. Some clients were just sitting, doing nothing. One client was putting chips in a connect 4 game that had no bottom and chips were falling onto the table. There was no staff interaction with clients. 3. Client #3 had diagnoses of Mild Mental Retardation, Seizure Disorder, History of Cerebrovascular Accident, Benign Prostatic Hypertrophy, Chronic Urinary Tract Infection, Neurogenic Bladder, Intermittent Explosive Disorder, Hypertension, and Macrocytic Anemia. a. Service Objectives (SO) dated 7/23/09 documented: "#7. Client will assist with setting up the kitchen for supper, with verbal prompting #9. Client will assist with my meal preparation (putting my food on my plate) at breakfast. # SO 4- Staff will remind client to use his napkin to enhance mealtime skills.	W 249		

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W 249	Continued From page 6	W 249		

b. On 10/26/09 from 4:45 p.m. until 5:45 p.m., the client was sitting in a recliner with his feet up, there was no staff present and the Living Room TV was on. The client was asked what he does during the time when he comes home from work until supper and he stated nothing. The client was asked if he helped with meal preparation and he stated no, but he puts dishes in the dishwasher after supper. The client stated he did not fix his plate at breakfast because no one told him he was supposed to. There were no structured activities going on in building 1600.

c. On 10/26/09 at 5:00 p.m., the client went to Dining Room for supper and sat down at the table. The staff did not ask the client to prepare his plate. The staff prepared the client's plate and carried it over and sat it down in front of the client. During dinner there was no staff interaction with the client.

d. On 10/26/09 at 5:30 p.m., Staff #1 stated they usually have 3-4 staff in the building, but they were short staffed and only had 2 people working tonight. Staff #1 was asked what was the structured activity the clients participated in from the time they arrived home until supper and he stated they have leisure time. Staff #1 was asked if all the clients were able to do leisure time activities on their own. He stated, "No, they need supervision." Staff #1 was asked if staff knew what the clients program plan stated for the assistance each client needed and he stated he knew there was but he had no time to look for them.

e. On 10/26/09 at 4:35 p.m., Staff #2 stated that sometimes one of the clients helped with supper. Staff #2 also stated that Client #3 loaded the

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	04G005	A. BUILDING _____ B. WING _____	10/28/2009

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W 249	Continued From page 7	W 249		

dishwasher and one other client helped if he wanted to. Staff #2 stated that the staff prepared the clients' plates and handed them to the clients.

4. Client #10 had diagnoses of Profound Mental Retardation, Chronic Mouth Ulcers, Reflux, Osteoporosis, Constipation, and a History of Seizures.

a. The Service Objectives dated 1/14/09 documented, #4 "Client will go to the food cart, get his plate, and take it back to his seat, with verbal prompting, #6 "Client will pour opened carton of milk into a glass, with hand over hand assistance" and #9 "Client will be encouraged to use functional signs to include, eat, drink, please, thank you, and book to promote social communication." There was no interaction between the client and staff before or during supper.

b. On 10/26/09 from 4:35 p.m. - 5:45 p.m., the client was sitting on a couch thumbing through a magazine over and over. The TV was on, but the client never looked up at the TV. There was no staff interaction with the client.

c. At 5:10 p.m., the client sat down at the table and the staff brought his plate to him already prepared with the meal.

d. On 10/28/09 at 10:00 a.m., Staff #3, Qualified Mental Retardation Professional (QMRP), stated "The clients have leisure time from the time they get off work until supper." She also stated, "[Client #10] looks at magazines. He doesn't have the ability to do activities on his own. A little down time is fine, but not a lot of structured activities going on. There is supposed to be a

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	04G005	A. BUILDING _____ B. WING _____	10/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 249	Continued From page 8	W 249		

data book in each facility for the staff to use, if they don't know there is a data book..." Staff #3 stated she didn't know when the last inservice was, but they have monthly house meetings to update staff. "We need to go back with all the staff to Phase I, basic information is there, they just don't do it."

5. Client #11 had diagnoses of Profound Mental Retardation, General Tonic Clonic Disorder, Dandruff, Chronic Sinusitis, Hyperglycemia, Anxiety Disorder, Seborrhea, and Osteoarthritis.

a. The IPP dated 2/23/09 documented, "Goal #1 Needed Services/Supports: Staff will continue to provide training and support to increase Clients level of participation and independence in self-help, and daily-living and leisure activities. Staff will continue to assist Timmy to follow his dietary guidelines and encourage/assist him to choose appropriate foods... Provide reminders to eat more slowly and not to overeat."

b. Service Objectives dated 2/23/09 documented, "#3... Client will participate in a leisure activity for a minimum of ten minutes with verbal/physical prompts... #7 client will put a puzzle together with physical prompts..."

c. On 10/26/09 from 4:35 p.m. - 5:45 p.m., the client was standing outside the building. He came in and out of the Living Room and did not interact with other clients or staff.

6. On 10/27/09 at 8:30 a.m., Staff #1 was asked about evening active treatment. She stated that time was open and it was up to staff to provide treatment. She also stated that she did not make a list of things that could be done.

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	04G005	A. BUILDING _____ B. WING _____	10/28/2009

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JONESBORO HUMAN DEVELOPMENT CENTER	4701 COLONY DRIVE JONESBORO, AR 72404

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W 249	Continued From page 9 On 10/27/09 at 9:15 a.m., Staff #2 was interviewed about evening active treatment. She stated that it was free time and there were things available for them to do. She also stated, "Yes, there is a list of things to do in her house."	W 249		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the Self-Administration of Medication (SAM) program was implemented for for 3 (Client #3, #10 and #11) of 5 (Client #3, 4, 8, 10, and 11) sampled clients who were assessed for SAM training. The findings are: 1. Client #3 had diagnoses of Mild Mental Retardation, Seizure Disorder, History of Cerebrovascular Accident, Benign Prostatic Hypertrophy, Chronic Urinary Tract Infection, Neurogenic Bladder, Intermittent Explosive Disorder, Hypertension, and Macrocytic Anemia a. Individual Program Plan (IPP) dated 4/23/09 documented under Interpretive Summaries: "Self Administration of medication; [Client #3] was assessed for self administration of medication on April 1, 2009. [Client #3] possesses the cognitive and physical ability to actively participate in his medical. A self administration program objective	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G005	A. BUILDING _____ B. WING _____	10/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 371	Continued From page 10 will be initiated. " b. The Self Administration of Mediation Assessment dated 4/1/09 documented the client was in level 2 and #5 under Skill documented "Recognizes medications given by color or shape" and #6 "Has number concept of 1 through 5." Neither #5 or #6 were demonstrated by the client. c. On 10/22/09 at 7:05 a.m., during medication pass, Licensed Practical Nurse (LPN) #1, had the clients in a line in the hall. The clients were coming into the medication room as desired. The door was open and it was noisy. The client used alcohol gel, but did not rub it into his hands. The client got his meds, swallowed them and left the room. LPN #1 did not train the client in SAM. 2. Client #10 had diagnoses of Profound Mental Retardation, Chronic Mouth Ulcers, Reflux, Osteoporosis, Constipation, and a History of Seizures a. The IPP dated 1/14/09 documented under Interpretive Summaries "[Client #10] was assessed on December 1, 2008... [Client #10] posses the necessary skills to participate in self administration of medication program. [Client #10] will wash his hands with hand sanitizer prior to medication administration..." b. On 10/22/09 at 7:25 a.m., during the medication pass with LPN #2, the LPN did not attempt SAMS training with the client. The LPN squirted hand sanitizer in client's hand and the client rubbed it off on his pants, with no verbal prompts given or any teaching conducted by the LPN. The door was open and it was noisy,	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G005	A. BUILDING _____ B. WING _____	10/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 371	Continued From page 11 creating an environment that was not conducive for training. 3. Client #11 had diagnoses of Profound Mental Retardation, General Tonic Clonic disorder, Dandruff, Chronic Sinusitis, Hyperglycemia, Anxiety Disorder, Seborrhea, and Osteoarthritis a. The IPP dated 2/23/09 documented under Interpretive Summaries, "Self-Administration of Medication: [Client #11] will continue training in order to more actively participate in self-administration of medication." Service Objective #16 documented, "I will demonstrate active participation in my medical care, by washing my hands with hand sanitizer prior to medication administration...". b. On 10/22/09 at 6:40 a.m., during the medication pass, LPN #2 handed medications to the client. The LPN did not provide any SAM training to the client. There was no privacy and the clients were coming in and out of the Medication room wanting their meds at the same time.	W 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04G005	A. BUILDING 01 B. WING _____	10/27/2009

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K 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. The findings on this Statement of Deficiencies demonstrates noncompliance with Title 42, Code of Federal Regulations 483.470(j), life safety from fire. The requirement is not met as evidenced by the facility's failure to meet the National Fire Protection Association code(s) cited.	K 000		
K 018	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		

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 requisite to continued program participation.

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, the facility failed to ensure exit corridor doors to bedrooms latched when closed. This failed practice had the potential to affect 38 clients who resided in building 1100, 1500, and 1400 according to a list dated 10/9/09 and 7 clients who resided in building 400 according to a list dated 10/19/09. The findings are: 1. On 10/26/09 at 12:07 p.m., in building 1100, the corridor exit door to bedroom 2 and 4 did not latch when closed. 2. On 10/26/09 at 12:18 p.m., in building 1500 the corridor exit door to bedroom 4 and 5 did not latch when closed. 3. On 10/26/09 at 12:38 p.m., in building 1400 the corridor exit door to bedroom 4 did not latch when closed. 4. On 10/26/09 at 1:10 p.m., in building 400 the corridor exit door to bedroom 1 did not latch when closed.	K 018		
K 053	NFPA 101, 483.70(a)(7) LIFE SAFETY CODE STANDARD In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas	K 053		

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K 053	Continued From page 2 (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. 42 CFR 483.70(a)(7) This STANDARD is not met as evidenced by: Based on observations, the facility failed to ensure room smoke detectors were installed in all client bedrooms. This failed practice had the potential to affect 3 residents who resided in client bedrooms 5, 6 and 8 in building 400 according to a list dated 10/19/09. The findings are: On 10/26/09 at 1:12 p.m., single station smoke detectors were not installed in building 400 client bedrooms 5, 6 and 8.	K 053		
K 054	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure the sensitivity tests were conducted on smoke detectors. This failed practice had the potential to affect all 112 clients. The findings are: On 10/26/09 at 1:30 p.m., records requested from the maintenance man of the sensitivity test	K 054		

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K 054	Continued From page 3 of the smoke detectors were not available.	K 054		
K 064	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on observations, the facility failed to ensure portable fire extinguishers were inspected. This failed practice had the potential to affect 67 residents who resided in building 1100, 1400, 1600, 1700, and 1800 according to a list dated 10/9/09. The findings are: On 10/26/09 from 12:09 p.m. to 12:32 p.m., the following observation were made of the fire extinguishers: a. The inspection tag on the portable fire extinguishers in the kitchen of buildings 1100, 1600, 1700 and 1400 documented that the last required annual inspection by a licensed individual was in 08/2008. b. The portable fire extinguisher in the kitchen of building 1800 did not have an inspection tag.	K 064		
K 147	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:	K 147		

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K 147	Continued From page 4 Based on observations, the facility failed to ensure there were ground fault circuit interrupters installed in electrical outlets that were within 6 feet of a sink. This failed practice had the potential to affect 112 residents. The findings are: On 10/26/09 from 12:09 p.m. to 1:24 p.m., the following observations were made of electrical outlets that were within six feet of a sink and did not have a Ground Fault Circuit Interrupter installed: a. The nurse's station and kitchen in buildings 110, 1500, 1600, 1700, 1800 and 1400. b. The kitchen in building 400. c. The restroom in the library. d. The restroom and classroom in building 200. e. Three classrooms and two restrooms in building 100.	K 147		