SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

{K 000} INITIAL COMMENTS

This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13.


Outpatient Buildings Include:

Building #1: West Charleston Clinic (Administrative and Outpatient Services); Single story, Type V (000) without fire sprinkler system; Located at 6161 West Charleston Blvd., Las Vegas, Nevada 89146.

Building #2: Pharmacy Services; Single story, Type V (000) with fire sprinkler system; Located at 6161 West Charleston Blvd., Las Vegas, Nevada 89146.

Dietary Building: Single story, Type V (000) with fire sprinkler system; Located at 6161 West Charleston Blvd., Las Vegas, Nevada 89146.

East Las Vegas Clinic (Outpatient Services): Two Story, Type V (000) without fire sprinkler system; Located at 1785 East Sahara Blvd., Las Vegas, Nevada 89121.

Henderson Clinic (Outpatient Services): Single story, Type V (000) without fire sprinkler system; Located at 1690 West Sunset Road, Henderson,
Continued From page 1 Nevada 89014.

The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.

No deficiencies were identified with these outpatient buildings. No further action is necessary with the Statement of Deficiencies (SOD). Please retain this SOD for your records.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>(X) Provider/Supplier/Clinical Laboratory Improvement Amendments (CLIA) Identification Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>294002</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X) Multiple Construction</th>
<th>(X) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Building 02 - 3</td>
<td>11/09/2013</td>
</tr>
<tr>
<td>B. Wing</td>
<td></td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier**  
**Southern Nevada Adult Mental Health Services**

**Street Address, City, State, ZIP Code**  
6161 W Charleston Blvd  
Las Vegas, NV 89146

<table>
<thead>
<tr>
<th>(K) Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13.</td>
</tr>
<tr>
<td>Your facility was surveyed using Chapter 19, Existing Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 131, Life Safety Code.</td>
</tr>
<tr>
<td>Building #3 - Two Story, Type II (111) with fire sprinkler system (undergoing extensive remodeling, currently no patient occupants).</td>
</tr>
<tr>
<td>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</td>
</tr>
<tr>
<td>This building was not in service at the time of the survey due to construction.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(K) Provider's Plan of Correction</th>
</tr>
</thead>
</table>

**Laboratory Director(s) or Provider/Supplier Representative's Signature**  
**Title**  
**Date**

Chesley Klayn  
Hospital Administrator  
1-21-19

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.
**SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES**

**STREET ADDRESS, CITY, STATE, ZIP CODE**
6161 W CHARLESTON BLVD
LAS VEGAS, NV 89146

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(K 000) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(K 000) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(K 000) INITIAL COMMENTS</td>
<td>This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13.</td>
<td>(K 000)</td>
<td>Tag K022: The exit sign in question near room B171 was removed. The maintenance department performs monthly rounds to verify exit lights and signs are appropriate and operating properly. The Facility Supervisor monitors monthly/quarterly reports. The Facilities Director is responsible for this item.</td>
<td>1/6/13</td>
</tr>
<tr>
<td>K 022 NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants.</td>
<td>K 022</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Hospital Administrator 1-01-14

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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.
K 022
Continued From page 1
This STANDARD is not met as evidenced by:
NFPA 101, 7.10.2 Directional Signs. A sign
complying with 7.10.3 with a directional indicator
showing the
direction of travel shall be placed in every location
where the direction of travel to reach the nearest
exit is not apparent.

Based on observation, the facility failed to ensure
that all exit signs were provided with directional
indicators.

Findings include:

On 10/5/13 at 3:05 PM, an exit sign was
observed to be tacked to a wall near room
number B 171. This sign was not provided with a
directional arrow. The true path of egress was to
the loft of the sign (No arrow suggested that
egress was directly ahead).

{K 062} 
NFPA 101 LIFE SAFETY CODE STANDARD

Required automatic sprinkler systems are
continuously maintained in reliable operating
condition and are inspected and tested
periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25,
9.7.5

This STANDARD is not met as evidenced by:
NFPA 13 (1996 ed.) 4-5.5 Obstructions to
Sprinkler Discharge. 4-5.5.2 Obstructions to
Sprinkler Discharge Pattern Development.
4-b.5.2.1 Continuous or noncontinuous
obstructions less than 18 in. (457 mm) below
the sprinkler deflector that prevent the pattern from
fully developing shall comply with this section.

Tag K062:
The light fixtures that impede the
clearance of the sprinkler heads were
lowered to the appropriate level.
(Attachment A)

Environment rounds are performed
monthly. Reports are submitted to the
facility supervisor. The Facilities Director is
responsible for this item.
Continued From page 2

Based on observation the facility failed to insure that there were no obstructions 18 in. or less below the sprinkler deflector.

Findings include:

Observed on 10/5/13 at 3:00 PM, were suspended light fixtures hung below sprinkler heads with a clearance of ten inches or less. The rooms in which sprinkler patterns could have been affected were: B173, B178, B179, B169, B168, B167, B169b, B187, B164, B163.

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. 18.7.4

Tag K066:
The ashtrays at the designated staff smoking area and the visitor smoking area have been replaced with appropriate ashtrays. (Attachment B)

Environment rounds are performed monthly. Reports are submitted to the facility supervisor.

The Facilities Director is responsible for this item.
Continued From page 3

This STANDARD is not met as evidenced by:
Based on observation, the facility failed to ensure that smokers utilized only ashtrays of safe design.

Findings include:

On 11/5/13 at 3:40 PM, it was observed that in the designated staff smoking area, between Buildings D and B, there was a picnic table with an open, ten-inch diameter, metal bowl with a rock in the center of it to hold it down. The bowl was being used as an ashtray. Remnants of cigarettes were not protected from being blown out of the bowl by the wind.

On 11/7/13 at 7:00 AM, it was observed that in the visitor smoking area, north of the main entrance, there was a similar metal bowl located on top of a picnic table. This area was covered by a small canopy which provided little protection from the wind.

NFPA 101 LIFE SAFETY CODE STANDARD

Procedures for laboratory emergencies are developed. Such procedures include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with NFPA 99, 10.2.1.3.1, 18.3.2.2.

Tag K136:
The citation indicated that through interview, the staff members indicated that there was no written policies and procedures for handling laboratory emergencies.

1. The laboratory is part of the physical plant of Rawson-Neal Psychiatric hospital, therefore will follow under any Agency Emergency Operations for Rawson Neal.
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X9) COMPLETION DATE</th>
</tr>
</thead>
</table>
| K 136               | Continued From page 2  
This STANDARD is not met as evidenced by: Based on staff interview the facility failed to ensure that it had developed written policies and procedures for emergencies specific to the laboratory. Findings include: On 10/5/13 at 9:30 AM, the Director of Laboratory and Infection Control staff member indicated that there was no written policies and procedures for handling laboratory emergencies. 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. | K 136 | Hospital. The laboratory had in place the Laboratory Safety Plan—Under policy and procedure, effective October 2006 “Laboratory Safety 001”. In section D-Instrument and Equipment Safety, #9 and #10 state: #9. In case of fire, electrical outages, all of the electrical laboratory equipment is on “hospital generator power”, and will continue to run as normal. #10. Each instrument has a 4 hour “back-up battery”, that will automatically continue providing power to instruments. This window allows enough time to complete any pending assays, and to shut down the instrument manually and if necessary, or for the hospital generators to activate. 2. This policy was reviewed and updated on January 10, 2014 to reflect command tree, and integrated into the Agency’s Emergency Planning Operations. Plan Responsibilities: (Attachment C) 1. Medical Director: The Director of Laboratories maintains overall responsibility for all safety programs under his or her direction. 2. Administrative Laboratory Director: a. The Administrative Laboratory Director is the safety officer for the laboratory, and the representative to the Environment of Care (Safety) Committee. b. Implemets the plan and ensures compliance by staff of all the appropriate safety policies in the laboratories. | 12/4/13 |
| K 144               | This STANDARD is not met as evidenced by: NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating... 8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads. | K 144 | | |

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**Note:** The text above is a natural representation of the document's content. It includes the summary of deficiencies and the provider's plan of correction for the identified issues. The document details the failure to meet safety standards, particularly in the areas of emergency preparedness and equipment safety. The provider outlines the steps taken to correct the deficiencies, emphasizing the importance of maintaining emergency power supplies and ensuring adherence to NFPA 101 standards.
K 136

Continued From page 4

This STANDARD is not met as evidenced by:
Based on staff interview the facility failed to ensure that it had developed written policies and procedures for emergencies specific to the laboratory.

Findings include:

On 10/5/13 at 9:30 AM, the Director of Laboratory and Infection Control staff member indicated that there was no written policies and procedures for handling laboratory emergencies.

K 144

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:
NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:
1. Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating...

8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads.
K 136 Continued From page 1

This STANDARD is not met as evidenced by:
Based on staff interview the facility failed to ensure that it had developed written policies and procedures for emergencies specific to the laboratory.

Findings include:

On 10/5/13 at 9:30 AM the Director of Laboratory and Infection Control staff member indicated that there was no written policies and procedures for handling laboratory emergencies.

NFPA 101 LIFE SAFETY CODE STANDARD

Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA99. 3.4.4.1.

This STANDARD is not met as evidenced by:
NFPA 110, 8.4.2 Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:
(1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating...

8.4.2.3 Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads.
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<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>K136</td>
<td>Continued From page 4</td>
<td></td>
<td>This STANDARD is not met as evidenced by: Based on staff interview the facility failed to ensure that it had developed written policies and procedures for emergencies specific to the laboratory. Findings include: On 10/5/13 at 9:30 AM, the Director of Laboratory and Infection Control staff member indicated that there was no written policies and procedures for handling laboratory emergencies. 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.</td>
<td>K136</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K144</td>
<td>Tag K144:</td>
<td></td>
<td>The contracted vendor performed the appropriate load bank test per NFPA 110 on 12/5/13. (Attached D) Monthly reports are submitted by the contractor to the facility supervisor. The Facilities Supervisor is responsible for this item.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by: NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating...

8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads...
Continued From page 5

at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.

Based on record review, the facility failed to ensure that the required, annual load bank test met the requirements of the Code.

Findings include:

On 10/6/13, during a review of maintenance documents, it was revealed that the emergency generator was not being properly tested. The Rawson Neal building receives emergency power from an on-site, 1800 kilowatt (kW), diesel generator. A private vendor performed a load bank test on 5/29/13, for one hour and forty-five minutes at 16.9-20.1% of the nameplate rating. On 6/3/13, the same vendor tested the equipment for one hour and forty-five minutes at 30.5% of the nameplate rating.
<table>
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<tr>
<th>(X1) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
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<tbody>
<tr>
<td>{K 000}</td>
<td>INITIAL COMMENTS</td>
<td>11/03/2013</td>
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</table>

This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13.

Your facility was surveyed using Chapter 19, EXISTING Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code.

Building 3A - Single Story, Type V (000) with fire sprinkler system (undergoing extensive remodeling, currently no patient occupants).

The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims or relief that may be available to any party under applicable federal, state, or local laws.

This building was not in service at the time of the survey due to construction.

Laboratory Director's or Provider/Supplier Representative's Signature: [Signature]

Title: Hospital Administrator

Date: 1-21-19

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

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**  
**(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:**  
294002

**(X2) MULTIPLE CONSTRUCTION**  
**A. BUILDING 04 - SOUTH (EFG) RAWSON NEAL.**

**B. WING**

**(X3) DATE SURVEY COMPLETED**  
F 11/08/2013

**NAME OF PROVIDER OR SUPPLIER**  
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
6161 W CHARLESTON BLVD  
LAS VEGAS, NV  89146

**(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**

### INITIAL COMMENTS

This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13.

Your facility was surveyed using Chapter 18, NEW Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code.

Building 4 - Single Story, Type II (111) with fire sprinkler system; South Building (Sections E, F, and G) of the Rawson Neal Complex.

The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any crime or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.

The following deficiencies were identified:

**K 022**

**NFPA 101 LIFE SAFETY CODE STANDARD**

Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4

**K 022**

Tag K022: The exit sign in question in building F was removed on 11/6/13. The maintenance department monthly performs rounds to verify exit lights and signs are appropriate and operating properly. Facility supervisor monitors monthly/quarterly reports.

11/6/13

**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**  
Chen Wang

**TITLE**  
Hospital Administrator

**DATE**  
1-3-14

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.
**K 022** Continued From page 1
This STANDARD is not met as evidenced by:
NFPA 101, 7.10.2 Directional Signs. A sign complying with 7.10.3 with a directional indicator showing the
direction of travel shall be placed in every location
where the direction of travel to reach the nearest
exit is not apparent.

Based on observation, the facility failed to ensure
that all exit signs were properly located and
correctly indicated the true direction of egress.

Findings include:

On 10/5/13 at 12:20 PM, it was observed that one
door in Building F had exit signage installed on
both sides of this same door, presenting
opposing directions of egress. On one side of the
door was an enclosed courtyard, on the other
side of the door was a corridor between Buildings
G and E. Directly across from the aforementioned
door was another door with an exit sign directing
occupants to a public way.

Note: On 10/6/13 during the afternoon, one of the
two exit signs over the door between the
courtyard and the corridor had been removed,
and the remaining sign directed building
occupants to a true exit.

**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: NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:

(1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating...

8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.

Based on record review, the facility failed to ensure that the required annual load bank test met the requirements of the Code.

Findings include:

On 10/6/13, during a review of maintenance documents, it was revealed that the emergency generator was not being properly tested. The Rawson Neal building receives emergency power from an on-site, 1800 kilowatt (kW), diesel generator. A private vendor performed a load bank test on 5/29/13, for one hour and forty-five minutes at 16.9-20.1% of the nameplate rating. On 6/3/13, the same vendor tested the equipment for one hour and forty-five minutes at 30.5% of the nameplate rating.
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: NFPA 70, ARTICLE 408 Switchboards and Panelboards, 408.38 Enclosure. Panelboards shall be mounted in cabinets, cutout boxes, or enclosures designed for the purpose and shall be dead front.

NFPA 70, 408.7 Unused Openings. Unused openings for circuit breakers and switches shall be closed using identified closures, or other approved means that provide protection substantially equivalent to the wall of the enclosure.

Based on observation, the facility failed to ensure that open spaces in an electrical panel box were properly covered.

Findings include:

On 11/6/13 at 9:30 AM, it was observed that one electrical panel box (Panel L1) had open space from slot #32 through slot #40.
INITIAL COMMENTS

This Statement of Deficiencies was generated as a result of a Center for Medicare and Medicaid Services (CMS) Regional Office directed full Medicare Life Safety Code (LSC) Survey conducted in your facility from 11/05/13 through 11/08/13.

Your facility was surveyed using Chapter 18, NEW Health Care Occupancies, of the 2000 Edition of the National Fire Protection Association's (NFPA) 101, Life Safety Code.

Building 5 - Single Story, Type II (111) with fire sprinkler system; West Building (Section H) of the Rawson Neal Complex.

The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.

The following deficiencies were identified:

**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 no met as evidenced by:

Tag K144:

The contracted vendor performed the appropriate load bank test per NFPA 110 on 12/5/13. (Attachment D)

Monthly reports are submitted by the contractor to the facility supervisor.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>K 144</td>
<td>Continued From page 1</td>
<td>NFPA 110, 8.4.2* Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating...</td>
<td>K 144</td>
<td></td>
<td></td>
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</tbody>
</table>

8.4.2.3* Diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours.

Based on record review, the facility failed to ensure that the required, annual load bank test met the requirements of the Code.

Findings include:

On 10/6/13, during a review of maintenance documents, it was revealed that the emergency generator was not being properly tested. The Rawson Neal building receives emergency power from an on-site, 1800 kilowatt (kW), diesel generator. A private vendor performed a load bank test on 6/20/13, for one hour and forty-five minutes at 16.9-20.1% of the nameplate rating. On 6/3/13, the same vendor tested the equipment for one hour and forty-five minutes at 30.5% of the nameplate rating.