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

PRINTED: 04/30/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/16/2015
NAME OF PROVIDER OR SUPPLIER: MOUNTAIN VIEW NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 39 FERNDALE APARTMENTS ROAD, PINEVILLE, KY 40977	

RECEIVED MAY 12 2015 Division of Health Care Southern Enforcement Branch

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F 000	INITIAL COMMENTS	F 000		
	A standard health survey was conducted on 04/14-16/15. Deficient practice was identified with the highest scope and severity at "D" level.		Mountain View Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and purposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of the quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Mountain View Nursing & Rehabilitation Centers's response to this Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor is that any deficiency accurate. Further, Mountain View Nursing & Rehabilitation Center reserves the right to refute any of the Deficiencies through Informal Dispute Resolution, formal appeal procedures and/or any other administrative or legal proceeding.	
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS	F 257		
	The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F			
	This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the ambient air temperature levels were maintained at a comfortable level, between 71 and 81 degrees Fahrenheit, in the resident dining room during the lunch meal service. Observation in the resident dining area on 04/15/15 revealed the temperature was 67 degrees Fahrenheit.			
	The findings include:			
	Interview with the facility Administrator on 04/16/15 at 3:30 PM revealed the facility did not have a written policy related to air temperatures in areas utilized by residents.			
	Observation of the air temperature in the resident dining room during the lunch meal service on 04/15/15 at 11:14 AM revealed the temperature was 67 degrees Fahrenheit and was measured by the Maintenance Supervisor.		**F257** 1. Temperature in the dining room was raised to acceptabable level of 74 on 04/15/2015.	5/15/15
	A review of the medical records for Resident #9			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly M. Gaudin | TITLE: Administrator | (X6) DATE: 5/8/15

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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F 257	Continued From page 1 and two unsampled residents (Residents A and B) revealed the facility assessed the residents to be cognitively intact. Interviews with Resident #9, Resident A, and Resident B on 04/15/15 from 11:12 AM thru 11:14 AM revealed the residents stated the dining room temperature was too cold and uncomfortable. Interview with the Maintenance Supervisor on 04/15/15 at 11:15 AM revealed the goal was to maintain temperatures in the facility with a minimum temperature of 72 degrees Fahrenheit and a maximum temperature of 75 degrees Fahrenheit.	F 257 CONT	2. All other resident areas were checked for comfortable levels, and all areas were between 71-81 degrees Fahrenheit. 3. Staff re-education was initiated, by the Staff Facilitator & Administrator, for all maintenance staff and Administrative staff on 04/21/2015 related to comfortable temperature levels & who and when to notify if not acceptable. Staff not attending this education on 4/21/15, will be in-serviced on 4/23/2015. This education will be reviewed during orientation for newly hired licensed staff. 4. The plant QI or QI nurse will review any resident complaints about the temperature if any to ensure the appropriate measures are in place. Any identified issues will be corrected with immediate one on one reeducation. These audits will be conducted weekly during April May and June 2015 and then per a schedule established by the QI committee. 5. May 15, 2015	5/15/15
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services in accordance with the written plan of care for one (1) of eighteen (18) sampled residents (Resident #4). Resident #4's comprehensive care plan included an intervention to provide catheter care per facility protocol. However, facility staff failed to ensure the resident's catheter tubing was secured to prevent trauma as required per facility policy. The findings include:	F 282		

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F 282	Continued From page 2 Interview with the Director of Nurses (DON) on 04/16/15 at 4:55 PM, revealed the facility did not have a specific policy/procedure related to ensuring care plan interventions were implemented. Review of the medical record revealed the facility admitted Resident #4 on 03/24/15 with diagnoses that included Dementia, Quadriplegia, Paralysis Agitans, and Urinary Retention. Review of the comprehensive Minimum Data Set (MDS) assessment dated 03/31/15 revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status Score of 99, which indicated the resident was unable to be interviewed. The resident was further assessed to require an indwelling catheter and to require total assistance of staff for toileting. Review of the comprehensive care plan dated 03/25/15, revealed the facility addressed a problem related to an altered pattern of urinary elimination with an indwelling catheter related to urinary retention. Interventions included to provide catheter care per facility protocol and to ensure the drainage tubing was secured with an anchoring device, e.g. a leg strap, to prevent tension or accidental removal. Review of the Nurse Aide care plan revealed the resident required an indwelling urinary catheter. Observations conducted of Resident #4 on 04/15/15 at 1:05 PM, revealed the resident was on a pressure-relieving mattress with bilateral upper and lower extremity contractures. Observation of catheter care for Resident #4 on 04/15/15 at 1:20 PM revealed the catheter tubing was not secured according to the plan of care to	F 282	**F282** 1. Resident # 4 catheter tubing was secured according to the plan of care on 04/15/15. 2. QI Audit of all residents whose care plan indicates catheter tubing must be secured was completed on 04-15-15 no issues found. 3. Nursing staff was re-educated on 04/15/15 by the Staff Facilitator on routine catheter care, securing catheter tubing and following the plan of care.Anyone that didn't receive the in-service received it on 05/07/15. 4. A weekly QI audit will be conducted by the QI Nurse to ensure that catheter tubing is secure. Any identified issues will be corrected with immediate one on one reeducation. These audits will be conducted weekly during May and June 2015 and then per a schedule established by the QI committee. 5. May 15, 2015	5/15/15

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F 282	Continued From page 3 prevent potential tension/trauma for the resident. Interview with Certified Nurse Aide (CNA) #2 on 04/15/15 at 1:55 PM revealed he was responsible to follow the care plan directives on the CNA care plan, which included routine catheter care for Resident #4 daily and as needed. The CNA further stated he was also responsible to ensure the catheter tubing was secure to prevent tugging or pulling. CNA #2 stated he had last performed catheter care for the resident at approximately 12:00 PM on 04/15/15 and failed to secure the catheter tubing. Interview with Licensed Practical Nurse (LPN) #2 on 04/16/15, at 4:45 PM, revealed he was a charge nurse and was responsible to monitor resident care needs to ensure care plan interventions were implemented. The LPN stated he "usually" checked the indwelling catheters daily to make sure they were secured, but had not had an opportunity to check Resident #4 on 04/15/15. Interview with the DON on 04/16/15, at 4:55 PM, revealed CNAs were responsible to follow directives on the CNA care plan to provide care for residents. The DON stated administrative rounds were to be made daily and administrative staff as well as the staff nurses was responsible to monitor to ensure resident care needs were being consistently implemented per each resident's plan of care. The DON further stated no problems had been identified related to catheter tubing not being secured.	F 282		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 4 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and facility policy review, the facility failed to ensure residents who utilized an indwelling catheter received appropriate treatment and services for one (1) of eighteen (18) sampled residents (Resident #4). The facility failed to ensure the indwelling urinary catheter was secure in an effort to prevent pulling, pressure, and/or potential trauma or injury to the resident's urinary tract. Observations for Resident #4 revealed the resident's indwelling catheter was not secured. The findings include: Review of the facility's Catheter Care policy (dated August 2012) revealed the perineal area would be cleaned during routine care for residents with a catheter. However, the facility did not address how the catheter tubing would be secured to protect the resident from potential pulling, pressure, and/or potential trauma or injury to the resident's urinary tract. Review of the medical record revealed the facility admitted Resident #4 on 03/24/15 with diagnoses	F 315	**F315** 1. On 04/15/15 resident #4's catheter was secured. 2. QI Audit of all residents whose care plan indicates catheter tubing must be secured was completed on 04-15-15 no issues found. 3. Nursing staff was re-educated on 04/15/15 by the Staff Facilitator on routine catheter care, securing catheter tubing to prevent tension or accidental removal.. Anyone that didn't receive the in-service received it on 05/07/15. 4. A weekly QI audit will be conducted by the QI Nurse to ensure that catheter tubing is secure. Any identified issues will be corrected with immediate one on one reeducation. These audits will be conducted weekly during May and June 2015 and then per a schedule established by the QI committee. 5. May 15, 2015	5/15/15

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F 315	Continued From page 5 that included Dementia, Quadriplegia, Paralysis Agitans, and Urinary Retention. Review of the MDS assessment dated 03/31/15 revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status Score of 99, which indicated the resident was unable to be interviewed. The resident was further assessed to require an indwelling catheter and to require total assistance of staff for toileting. According to the comprehensive care plan dated 03/25/15, the facility addressed the use of the indwelling catheter for Resident #4 with interventions which included ensuring the drainage tubing was secured to prevent tension or accidental removal. Resident #4 was observed on 04/15/15 at 1:05 PM to be lying in bed on a pressure-relieving mattress with bilateral upper and lower extremity contractures and a urinary drainage bag was connected to the rail of the bed. Facility staff was observed to perform catheter care for Resident #4 on 04/15/15, at 1:20 PM. After completion of the catheter care, the catheter tubing was not secured to prevent potential tension/trauma for Resident #4. Interview with Certified Nurse Aide (CNA) #2 on 04/15/15, at 1:55 PM, revealed he was responsible to provide catheter care for Resident #4 daily and as needed. CNA #2 stated he had provided catheter care earlier on 04/15/15 and failed to secure the catheter tubing. The CNA further stated he had been trained to secure the tubing to prevent tugging. Interview with Licensed Practical Nurse (LPN) #2 on 04/16/15, at 4:45 PM, revealed he was a	F 315		

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F 315	Continued From page 6 charge nurse and was responsible to monitor residents with indwelling catheters to ensure the tubing was secured. However, the LPN stated he had not had an opportunity to check Resident #4 on 04/15/15. Interview with the DON on 04/16/15, at 4:55 PM, revealed CNAs were responsible to secure the catheter tubing when doing catheter care for residents. The DON further stated the staff nurses were responsible to monitor to ensure the catheters were secured and the catheter tubing should have been secured.	F 315		

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K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1976 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111(000) SMOKE COMPARTMENTS: Five COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) EMERGENCY POWER: Type II Diesel generator A life safety code survey was initiated and concluded on 04/14/15. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Mountain View acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Mountain View's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Mountain View reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029	**ID Prefix Tag K029** 1. Magnetic Device was removed from Social Services Room on 04/15/2015.	5/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kelly M. Gwidow	Administrator	05/8/15

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K 029	Continued From page 1 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 interview, the facility failed to ensure that hazardous area doors were maintained as required. This deficient practice affected one (1) of five (5) smoke compartments, staff, and seven (7) residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey. The findings include: During the Life Safety Code tour on 04/14/15 at 10:40 AM, with the Director of Maintenance (DOM), a corridor door to the Social Services room was observed to have a magnetic device that held the door open. Hazardous area doors cannot be held open in this manner unless connected to the fire alarm system. An interview with the DOM on 04/14/15 at 10:40 AM revealed he was not aware of the requirements pertaining to hazardous area doors. The findings were revealed to the Administrator upon exit.	K 029	2. Maintenance staff checked throughout facility for any other magnetic devices holding hazardous doors, none identified. 3. Maintenance staff was re- in serviced by the Administrator on NFPA Life Safety Code Standards specifically K0 29. 4. Plant QI will make monthly rounds to ensure there are no doors utilizing magnetic devices to hold them open that are not connected to the fire alarm system. 5. May 15, 2015	5/15/15

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K 029	Continued From page 2 Reference: NFPA 101 (2000 Edition). 19.2.2.2.6* Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier, or hazardous area enclosure shall be permitted to be held open only by an automatic release device that complies with 7.2.1.8.2. The automatic sprinkler system, if provided, and the fire alarm system, and the systems required by 7.2.1.8.2 shall be arranged to initiate the closing action of all such doors throughout the smoke compartment or throughout the entire facility.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were properly identified according to National Fire Protection Agency (NFPA) standards. Observation revealed an exterior door that led to an enclosed courtyard was marked as an exit. This deficient practice affected one (1) of five (5) smoke compartments, staff, and occupants of the building. The facility has the capacity for 115 beds with a census of 88	K 038		

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K 038	Continued From page 3 on the day of the survey. The findings include: During the Life Safety Code tour on 04/14/15 at 10:30AM, with the Director of Maintenance (DOM), an exit sign was observed above the dining room entrance door. Further observation revealed occupants unfamiliar with the building would be led through the dining room to an exterior door that led to an enclosed courtyard gate that did not have an obvious method of operation for exiting. Exit travel cannot pass through intervening rooms. Exits have to be marked in such a way that occupants have a safe and uninterrupted travel to the public way. Doors that can be mistaken for an exit should be marked "not an exit." An interview with the DOM on 04/14/15 at 10:30AM revealed he was not aware of the improper exit. The findings were revealed to the Administrator upon exit. Reference: NFPA 101 (2000 Edition). 19.2.5.9* Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an	K 038	**ID Prefix Tag K038** 1. Exit sign by the dining room door was removed. Door going out to the courtyard was marked as" not an exit". 2. Director of Maintenance made rounds and checked to ensure all exits were properly identified. 3. Director and Assistant Director of Maintenance were in serviced by Administrator on exits and they have to be marked in a way that can be safely and clearly understood. 4. The Physical Plant QI Team will make monthly rounds to assess for any needed signs or changes to signs 5. May 15, 2015	5/15/15

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K 038	Continued From page 4 exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs. A.7.10.8.1 The likelihood of occupants mistaking passageways or stairways that lead to dead-end spaces for exit doors and becoming trapped governs the need for exit signs. Thus, such areas should be marked with a sign that reads as follows: NO EXIT Supplementary identification indicating the character of the area, such as TO BASEMENT, STOREROOM, LINEN CLOSET, or the like, is permitted to be provided. (See A.7.10.2.)	K 038		
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.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED
	185243		04/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 5 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the emergency generator was being maintained according to National Fire Protection Agency Standards. This deficient practice affected five (5) of five (5) smoke compartments, staff, and all the residents. The facility has the capacity for 115 beds with a census of 88 on the day of the survey. The findings include: During the life safety code tour on 04/14/15 at 10:20 AM, an interview and record review was conducted with the Director of Maintenance (DOM). The DOM revealed the generator was being maintained on a monthly schedule instead of a weekly schedule as required. The DOM stated he was not aware a routine weekly maintenance schedule was required to maintain the emergency generator. The interview further revealed the DOM was not manually exercising the transfer switch monthly as required. The DOM stated the generator operated automatically and he was not aware the transfer switch was required to be exercised manually on a monthly basis. The findings were revealed to the Administrator upon exit. Reference: NFPA 110 (1999 Edition). 6-1.1* The routine maintenance and operational testing program shall be based on the manufacturer's recommendations, instruction manuals, and the minimum requirements of this chapter and the authority having jurisdiction.	K 144	**ID Prefix Tag K144** 1. The generator log was changed from monthly to weekly on 04/14/2015. The transfer switch was manually exercised. 2. The Director of Maintenance inspected the generator and updated logs on April 20, 2015 they also check instruction manuals for any other manufactor recommendations, none noted. 3. All maintenance staff was in serviced by the facility Administrator on April 23, 2015 on Life Safety Code Standards specifically K 144. 4. Plant QI team will check the generator logs sheets to ensure they are being completed timely and correctly for 3 months. 5. May 15, 2015	5/15/15

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K 144	Continued From page 6 6-3.3 A written schedule for routine maintenance and operational testing of the EPSS shall be established. 6-4.1* Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		
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 interview, the facility failed to ensure that electrical wiring and standards met National Fire Protection Agency (NFPA) requirements. Observations revealed the electrical cords to resident beds had exposed wiring and were improperly repaired. This deficient practice affected two (2) of five (5) smoke compartments, staff, and thirty-three (33) residents. The facility has the capacity for 115 beds with a census of 88 on the day of the	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
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K 147	Continued From page 7 survey. The findings include: During the Life Safety Code tour on 04/14/15 at 9:20 AM with the Director of Maintenance (DOM), a cord to an electric bed in resident room 140 was observed to be damaged with exposed electrical wiring. Further observations revealed an electric bed in resident room 105 had the electrical cord spliced together using electrical wire caps and black electrical tape. Electrical cords and wiring should be maintained to prevent damage and repaired properly. An interview with the DOM on 04/14/15 at 9:20 AM revealed he was not aware the cord was damaged. The findings were revealed to the Administrator upon exit.	K 147	**K147** 1. Electrical cords in rooms 140 and 105 were repaired properly on April 14, 2015. 2. Complete audit of all resident rooms and resident beds was completed on April 14, 2015 to ensure there were no other improperly repaired wires. 3. Maintenance staff was in serviced onNFPA life safety code K147 4. Plant QI committee will look for any damaged wires or improper wiring weekly upon their rounds and Admin staff will add that to their daily round sheets to ensure there are no damaged cords. Any concerns will be addressed immediately. 5. May 15, 2015	5/15/15