

Statement of Deficiencies	(X1) Provider/Supplier/CLIA Identification Number 010007	(X3) Date Survey Completed 12/12/2024
Name of Provider or Supplier Mizell Memorial Hospital	Street Address, City, State 702 N Main St, Opp, AL	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

(X4) ID Prefix Tag	Summary Statement of Deficiencies (Each deficiency should be preceded by full regulatory or LSC identifying information)
A0000	A recertification survey was conducted on 12/10/24 to 12/12/24 at Mizell Memorial Hospital, a 99 bed acute care hospital, which resulted in condition level deficiencies at CFR 482.41, Physical Environment and related standards.
A0117	<p>PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s): 482.13(a)(1)</p> <p>A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.</p> <p>This STANDARD is not met as evidenced by: Based on medical record (MR) review and staff interview, it was determined the facility failed to ensure twenty-six of thirty patients were informed of the patient's rights prior to receiving care at the facility. This had the potential to negatively affect all patient's served by this facility. Review of the MR's of Patient Identifier (PI) # 1, PI # 2, PI # 3, PI # 4, PI # 5, PI # 6, PI # 7, PI # 8, PI #9, PI # 14, PI # 15, PI # 16, PI # 17, PI # 18, PI #19, PI # 20, PI # 21, PI # 22, PI # 23, PI # 24, PI # 25, PI # 26, PI # 27, PI # 28, PI # 29, and PI # 30 revealed there were no verbal or signed patient rights completed. An interview was conducted on 12/12/24 at 11:17 AM with Employee Identifier (EI) # 4, Interim Chief Executive Officer who confirmed there were no verbal or signed patient rights completed.</p>
A0144	<p>PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2)</p> <p>The patient has the right to receive care in a safe setting.</p>

This STANDARD is not met as evidenced by:
 Based on observations, facility policy, and interviews, it was determined the facility failed to ensure the Senior Behavioral Care Unit (SBCU) was free of ligature risks. This deficient practice had the potential to negatively affect all patients admitted to this unit. Findings include: Facility Policy: Suicide Assessment and Preventions Policy Number: Not Listed Revised: 9/14/2017 Purpose: To outline the process for the timely assessment and reassessment of patient's suicide risk and to provide guidelines for safety interventions. Policy: It is the policy of Mizell Memorial Hospital Senior Behavioral Care Unit to create an environment of care...and successful management of patients who are at an increased risk of suicide or self destructive behaviors... Procedure: 7. Staff are to maintain a safe and therapeutic environment for all patients. Additional safety interventions are implemented for patients on suicide precautions... Remove all potential ligatures...from the environment... Safety and Environment Rounds: 1. It is the responsibility of all staff to maintain a safe and therapeutic milieu for all patients at all times. 2. Safety and Environment Rounds are to be conducted at regular intervals... 3. ... all staff are to be continually aware of the environment and immediately correct or report any identified risks, damage, ... to their supervisor or Plant Operations personnel for immediate mitigation. 1. A tour of the SBCU unit was conducted on 12/10/24 at 9:45 AM with EI # 3, SBCU Manager. The following patient safety concerns were identified: a. Each of the 14 beds on the 12 bed unit had side rails on the upper half of the beds that could be raised and used as ligature attachment. b. The faucet in the Shower Room was constructed in a manner that could allow for a ligature to be attached. Review of the daily SBCU Environmental Safety Rounds for December 2024 revealed no documentation of these safety risks being identified. An interview was conducted on 12/12/24 at 11:00 AM with EI # 3, who confirmed the side rails and the shower faucet could be used as a ligature attachment.

A0700

PHYSICAL ENVIRONMENT
 CFR(s): 482.41

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

This CONDITION is not met as evidenced by:
 Based on observations and interviews with staff during a tour of the hospital by Life Safety Code and Health surveyors, it was determined the hospital was not constructed, arranged, and maintained to ensure patient safety. This had the potential to negatively affect all patients served by this hospital. Findings include: Refer to tags: K-0133, K-0324, K-0362, K-0372, K-0521, K-0761, K-0918, K-0920, and health survey citation A-701, and A-724.

A0701

MAINTENANCE OF PHYSICAL PLANT
 CFR(s): 482.41(a)

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.

This STANDARD is not met as evidenced by:

Based on observations, review of Maintenance Work Orders, facility policy and procedures, and interviews, it was determined the facility failed to ensure required maintenance of the physical plant was completed. This deficient practice affected patient care areas on the Medical Surgical Unit and in the Dietary Department. Findings include: Facility Policy: Routine Work Request Department: Plant Operations Policy Number: 1001 Revised/Reviewed: 1/4/24 Purpose: To provide guidelines for submitting, receiving and scheduling routine work requests. Policy: A work order request should be emailed/called in for any repair or maintenance needed.

a. Those that fall under Urgent/High priority will be handled as "Emergency Maintenance." b. All others will be scheduled for accomplishment by Plant Operations by priority level as: 1. Low 2. Normal 3. Medium Procedure: ...The employee entering the work order will be notified by email when the work order is received, assigned to a mechanic, in progress, placed on hold, and upon completion...

1. A tour of the Medical Surgical Unit was conducted with Employee Identifier (EI) # 9 on 12/11/24 at 9:03 AM. The unit had 31 patient rooms with 36 available beds. Out of the 31 patient rooms, eight patient rooms had signs on the doors indicating the rooms were out of service. This impacted 16 beds. The following patient rooms had signs on the door stating they were out of service due to maintenance issues including rooms 321 and 323. An interview was conducted with EI # 6, Registered Nurse, who stated the rooms listed had been out of service for at least a year. Review of the Maintenance Work Orders revealed: Review of Work Order # 3795 revealed the work order was placed on 3/18/24 for repair of room 321 wall flange. The status was listed on the work order as resolved on 3/18/24. Review of Work Order # 4129 revealed the work order was placed on 5/3/24 due to room 323 being hot. The due date was listed as 5/6/24 with comments, resolved. An interview was conducted on 12/11/24 at 2:15 PM with EI # 9, Maintenance Supervisor, who stated Room 321 remained out of service due to a broken drill auger and Room 323 remained out of service due to coils in the air conditioner being clogged.

2. A tour of the Dietary Department, dishwashing area, was conducted on 12/11/24 at 11:45 AM with EI # 1, Chief Operating Officer. The following items were observed in need of repair: Observation of the dishwashing area revealed the right side of the wall at the entry way were missing 33 four inch square tile pieces exposing the subwall. On the left side of the room, the lower section of the wall extending under the dish machine had peeling paint and broken drywall. Additionally, the three foot light casing on the ceiling had peeling paint and was rusted half way the length of the light casing. The surveyor requested work orders for the dishwashing area repairs with none provided. An interview was conducted with EI # 1, who confirmed the facility failed to ensure the required maintenance of the dietary area was completed.

A0724

FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE
CFR(s): 482.41(c)(2)

Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.

This STANDARD is not met as evidenced by:
Based on observations, and staff interviews, it was determined the facility failed to ensure expired supplies were not available for patient use. This had the potential to negatively affect all patients served by the hospital. Findings include: 1. A tour of the surgical suite was conducted on 12/10/24 at 10:05 AM with Employee Identifier (EI) # 8, Surgical Services Manager. The following supplies were found to be expired and available for patient use: Operating Room (OR) # 1 anesthesia cart: One Melker

Emergency Cricothyrotomy Catheter Set with an expiration date of 7/2015. OR # 2 anesthesia cart: Two Becton Dickinson (BD) Insyte Autoguard Shielded Intravenous (IV) Catheters with an expiration date of 8/31/23 One Rusch Endotracheal Tube Oral /Nasal 6.5 millimeter (mm) with an expiration date of 2/28/21. OR # 2: Eight Cultures with an expiration date of 11/29/24. The "Issue" (medical supply room) Room: Twelve Cautery Tip Polishers with an expiration date of 8/31/24 and four with an expiration date of 4/30/24. OR Hallway: Nine BD 20 gauge (g) x (by) 3.5 mm Spinal Needles with an expiration date of 8/31/24. Six BD 25 g x 3.50 mm Spinal Needles with an expiration date of 9/30/24. Crash Cart # 2: Two green top laboratory tubes with an expiration date of 10/30/24. Block Cart: Two ICUmedical Extension Sets with an expiration date of 1/1/24. Malignant Hyperthermia Cart: One Bard Latex Free Foley Catheter Tray with an expiration date of 7/31/24. An interview was conducted on 12/10/24 with EI # 8, Surgical Services Manager, who confirmed at the time of the tour, the above items were expired and available for patient use.

E0000

A recertification survey was conducted on 12/10/24 to 12/12/24 at Mizell Memorial Hospital. Standard level deficiencies were cited for Emergency Preparedness which will require an acceptable Plan of Correction.

E0037

EP Training Program

403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 460.84(d)(1), 482.15(d)(1), 483.73(d)(1), 483.475(d)(1), 484.102(d)(1), 485.68(d)(1), 485.542(d)(1), 485.625(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1). *[For RNCHIs at 403.748, ASCs at 416.54, Hospitals at 482.15, ICF/IIDs at 483.475, HHAs at 484.102, REHs at 485.542, "Organizations" under 485.727, OPOs at 486.360, RHC/FQHCs at 491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at 418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at 441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at 460.84(d):] (1) The PACE

organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at 483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at 485.68 (d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at 485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at 485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.

This STANDARD is not met as evidenced by:

Based on review of the personnel files, and staff interviews, it was determined the hospital failed to ensure all staff completed Emergency Preparedness (EP) training initially upon hire and every two years. This deficient practice did affect seven out of eight personnel files reviewed and had the potential to negatively affect all staff and patients served by the hospital. Findings include: A review of seven out of eight personnel files revealed no documentation of initial EP training upon hire in two out of eight files. Further review of the personnel files revealed, no documentation of EP training every two years in five out of the eight files reviewed for the years 2019

through 2024, respectively. An interview was conducted on 12/12/2024 with Employee Identifier (EI) # 5, Administrative Assistant, who confirmed there was no documentation the staff received EP training initially upon hire and every two years.

K0000

This STANDARD is not met as evidenced by:
. K3 Building: 0203 K6 Plan Approval: 1946 (renovated in 1988) K7 Survey Under: 2012 Existing K8 HOSP Generator: One Diesel, Marathon, 180 kW (installed 02 /2021) FACP: Simplex 4005 (installed 1998) Locking Devices: Full time magnetic on 2nd floor Geri-Psych Unit Smoke Detection: Corridor Beds: 99 Census: 19 Type of Structure: 1946 (renovated in 1988) single story unprotected noncombustible, Type II (000) with a partial basement. The building has a partial automatic sprinkler system. During a routine recertification survey conducted on this date, the requirements of 42 CFR, Subpart 482.41 were not met as evidenced by the following deficiencies of the 2012 NFPA 101 Life Safety Code (LSC), the 2012 NFPA 99 Health Care Facilities Code and the standards referenced by these codes, as observed by the LS Surveyor while accompanied by the facility maintenance personnel. .

K0133

Multiple Occupancies - Construction Type
CFR(s): NFPA 101

Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows:
* The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3

This STANDARD is not met as evidenced by:
. Based on observation, the facility failed to maintain the separation between construction types per the requirements of: 2012 NFPA 101, 19.1.3.5, and 8.2.1.3 (1) This deficiency affects the only 2-hour fire barrier in this building. Findings include: During a tour of the facility, the surveyor observed the door between the Kitchen and Dining Room, in the 2-hour fire barrier separating Building 0103 and Building 0203, had a self-closing device but was propped open with a wood wedge and would not self-close in and emergency. A member of the maintenance staff was present when this deficiency was identified. .

K0324

Cooking Facilities
CFR(s): NFPA 101

Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under

18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2

This STANDARD is not met as evidenced by:

. Based on observation, the facility failed to provide an approved method to ensure appliances that are protected under the hood, if they are moved, they are returned to the approved design location per the requirements of: 2012 NFPA 101, 19.3.2.5.1, and 9.2.3 2011 NFPA 96, 12.1.2.2, 12.1.2.3, and 12.1.2.3.1 This deficiency affects the kitchen only. Findings include: During a tour of the facility, the surveyor observed that the facility failed to provide an approved method to ensure appliances that are protected under the hood, if they are moved, they are returned to the approved design location. A member of maintenance staff was present when this deficiency was identified. .

K0362

Corridors - Construction of Walls
CFR(s): NFPA 101

Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7

This STANDARD is not met as evidenced by:

. Based on observation, the facility failed to provide ceilings required for the pendant sprinklers in the facility per the requirements of: 2012 NFPA 101, 19.3.6.2.4 This deficiency affects Laundry Room only . Findings include: During a tour of the facility, the surveyor observed four, 2' x 4' ceiling tiles missing in the folding area of Laundry Room. A member of the maintenance staff was present when this deficiency was identified. .

K0372

Subdivision of Building Spaces - Smoke Barrie
CFR(s): NFPA 101

Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.

This STANDARD is not met as evidenced by:
 . Based on observation, the facility failed to maintain smoke barriers that would provide at least a half hour fire resistance rating and restrict the movement of smoke per the requirements of: 2012 NFPA 101, 19.3.7.3, 8.5.1, 8.5.6.2, 8.5.6.3, and 8.5.4.4 This deficiency affects 2 of 3 smoke barriers. Findings include: During a tour of the facility, the surveyor observed the following: 1. On the 2nd floor, an unsealed 1/2" conduit being used as a cable chase for a gray cable above the ceiling over the cross-corridor doors (at room 230) of the smoke barrier between the Specialty Clinic Nursing Station and the Geri-psych Unit. 2. On the 3rd floor, an unsealed penetration of a 2" copper pipe above the ceiling over the cross-corridor doors (at the stairwell) of the smoke barrier between the ICU and MedSurg Units. A member of the maintenance staff was present when this deficiency was identified. .

K0521

HVAC
 CFR(s): NFPA 101

HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2

This STANDARD is not met as evidenced by:
 . Based on review of documentation, the facility failed to maintain the smoke dampers, combination smoke/fire dampers, and ceiling dampers per the requirements of: 2012 NFPA 101, 19.5.2.1, and 9.2.1 2012 NFPA 90A, 5.4.8.1, and 5.4.8.2 2010 NFPA 80, 19.4, and 19.5 2010 NFPA 105, 6.5.2 This deficiency the complete building. Findings include: During a tour of the facility, the facility failed to provide documentation of testing the smoke dampers, combination smoke/fire dampers, and ceiling dampers within the past 6 years. A member of the maintenance staff was present when this deficiency was identified. .

K0761

Maintenance, Inspection & Testing - Doors

Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)

This STANDARD is not met as evidenced by:
 . Based on the review of documentation and interview, the facility failed to maintain the required fire doors in the two hour fire rated barrier separating the three story construction type II (222) from the one story construction type II (000) (not allowed in a three story building) per the requirements of: 2012 NFPA 101, 19.7.6, and 8.3.3.1 2010 NFPA 80, 5.2, and 5.2.3 This deficiency affects the Kitchen and Dining Room areas. Findings include: During a tour of the facility, the facility failed to provide documentation of its annual fire door inspection and testing within the past 12 months for the kitchen roll down fire assembly doors located in the two hour fire rated barrier separating the Kitchen from the Dining Room at the following locations: 1. At the

dish collection window 2. In front of the Victory Warmer equipment A member of the maintenance staff was present when this deficiency was identified. .

K0918

Electrical Systems - Essential Electric Syste
CFR(s): NFPA 101

Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)

This STANDARD is not met as evidenced by:

. Based on observation, the facility failed to maintain the Level 1 EES diesel emergency generator per the requirements of: 2012 NFPA 101, 19.2.9.1, and 7.9.2.4 2010 NFPA 110, 5.6.5.6, and 5.6.5.6.1 2012 NFPA 99, 6.5.4.1.1.2, and 6.4.4.1.1.3 2010 NFPA 110, 8.3.7.1, 8.4.2, 8.4.2.3, 8.3.8, and 8.3.4 This deficiency affects the only Level 1 EES diesel emergency generator . Findings include: During a tour of the facility, the facility failed to provide the following for the Level 1 EES diesel emergency generator : 1. A remote manual stop station of a type to prevent inadvertent or unintentional operation 2. A label for the remote manual stop station 3. The facility failed to provide the following documentation on the Level 1 EES diesel emergency generator: a. Performing monthly testing on the battery for the past 12 months b. The monthly 30 minute exercise failed to meet the requirements per 8.4.2 and the facility failed to provide documentation on an annual supplemental 1.5-hour load test per 8.4.2.3 c. Annual fuel quality test approved by ASTM standards A member of the maintenance staff was present when this deficiency was identified. .

K0920

Electrical Equipment - Power Cords and Extens
CFR(s): NFPA 101

Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power

strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3 (D) (NFPA 70), TIA 12-5

This STANDARD is not met as evidenced by:

. Based on observation, the facility failed to maintain the electrical equipment per the requirements of: 2012 NFPA 99, 10.2.3.6, and 10.2.4 2011 NFPA 70, 400.8 (1), (2), and (5) This deficiency affects the first floor of this building. Findings include: During a tour of the facility, the surveyor observed an artificial Christmas tree with Christmas tree lights plugged in to an electrical extension cord that was installed above the ceiling and dropped down through the ceiling tile above the tree in the Main Lobby. A member of the maintenance staff was present when this deficiency was identified.