

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155199	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/27/2016
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NAME OF PROVIDER OR SUPPLIER  MAPLE PARK VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN 46074
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/27/16</p> <p>Facility Number: 000106 Provider Number: 155199 AIM Number: 100266390</p> <p>At this Life Safety Code survey, Maple Park Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in resident rooms. The facility has a capacity of 106 and had a census of 102 at the time of this survey.</p>	K 0000	<p>May 20th, 2016 Dear Kim Rhoades, Please find the attached Plan of Corrections for the Life Safety Code Survey ID #04W421 performed on April 27th, 2016. The provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review, in lieu of a Post Survey revisit. Attached are credible proof of compliance documents Sincerely, Zach Krumwied, HFA Executive Director Maple Park Village The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p>	

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 0018 SS=E Bldg. 01	<p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except for two detached storage buildings which were not sprinklered.</p> <p>Quality Review completed on 05/06/16/ - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure the 2 of 16 corridor doors on 300 hall and 1 of 8</p>	K 0018	<p>1. No residents were identified as being affected. 2. There were no residents affected. However 44 Residents on halls 300 and 100,</p>	05/27/2016

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K 0025 SS=E Bldg. 01	<p>doors on 100 hall north would latch into its frame. This deficient practice could affect 32 residents on 300 hall and 12 residents on 100 hall north as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 04/27/16 during the tour between 12:30 p.m. to 1:10 p.m. with the Maintenance Supervisor the doors leading into resident rooms 312 and 313 would not latch into their frames and the corridor leading into the Beauty shop on 100 hall north did not have any latching device on the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned resident rooms and Beauty shop would not latch when several attempts were made to close the doors.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p>		<p>visitors, and staff had the potential to be affected. Doors to rooms 312,313, and the beauty shop were secured with effective latching devices. 3. All other doors were inspected and latched appropriately. 4. All doors will be checked weekly by the Maintenance department to ensure that they latch into their frame.</p>	

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	<p>Based on observation and interview, the facility failed to ensure 3 of 6 smoke barriers was protected to maintain the one half hour fire resistance rating of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire be protected, so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect 2 residents on 100 hall north, 16 residents on 300 hall north and 20 residents on 200 north hall if smoke from a fire were to infiltrate the protective barrier.</p> <p>Findings include:</p> <p>Based on observations on 04/27/16 during the tour between 12:30 p.m. to 3:00 p.m. with the Maintenance Supervisor the ceiling in the Mechanical room on 100 hall north had one half inch openings around one inch, two inch, three inch and eight inch diameter copper pipe and fresh air intake pipe which were not firestopped. Furthermore, the ceiling of the Mechanical room adjacent to 300 hall north had one half inch opening around two, two inch and one, one inch diameter</p>	K 0025	<p>1. No residents were identified as being affected. 2. There were no residents affected. However 38 residents on halls 100, 200, and 300, visitors, and staff had the potential to be affected. The openings referenced in the mechanical room ceiling on hall 100 were sealed and firestopped. The holes referenced in the mechanical room adjacent to the 300 hall North were sealed and firestopped. The holes referenced in the smoke wall next to the Director of Nursing's office were sealed and firestopped. All sealing was performed with a fire rated material to maintain a one half hour fire resistance. 3. All smoke barriers were inspected to ensure that a one half hour fire resistance rating is maintained. 4. Smoke barriers will be checked by the Maintenance department once a month to ensure that compliance is maintained.</p>	05/20/2016			

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K 0029 SS=E Bldg. 01	<p>pipe which were not firestopped. Lastly, the smoke wall next to the Director of Nursing office had a one inch opening around two, one inch wires, one, one inch wires and 20 small wires in conduit which were not firestopped. Based on interview on 04/27/16 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned smoke barrier ceilings and wall had openings which were not filled with a fire rated material to maintain a one half hour fire resistance rating.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 doors leading to hazardous areas such as the Kitchen would have doors which would latch into its frame. This deficiency</p>	K 0029	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, 16 residents on hall 300 north as well as staff and visitors had the possibility to</p>	05/20/2016

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K 0046 SS=F Bldg. 01	<p>could affect 16 residents on 300 hall north as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/27/16 at 12:35 p.m. with the Maintenance Supervisor, the southwest kitchen door would not latch into its frame. Based on interview on 04/27/16 concurrent with the observation with the Maintenance Supervisor it was acknowledged the aforementioned hazardous area door would not latch into its frame.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.</p> <p>Based on record review and interview, the facility failed to provide documentation of a 30 second monthly functional test or a 90 minute annual functional test for 16 of 16 battery operated lights. NFPA 110, 5-3-1 requires lighting at the emergency generator. LSC Section 7.9.3 requires a functional test be conducted monthly for 30 seconds on every required emergency</p>	K 0046	<p>be affected. The southwest kitchen door was repaired to ensure that it latched to its frame.</p> <p>3. All doors that lead to hazardous areas were inspected to ensure that they latch to their frame. 4. All doors that lead to hazardous areas will be checked weekly by the Maintenance department to ensure that they latch into their frame.</p> <p>1. There were no residents identified as being affected. 2. There were no residents affected. However, all occupants including staff, visitors, and residents could be affected. All backup emergency lights were tested for 90 minutes to ensure that they function properly. The subsequent monthly tests will last at least 30 seconds. 3. All backup emergency lights will be</p>	05/20/2016

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K 0056 SS=E Bldg. 01	<p>lighting system and annually for not less than 1 1/2 hours. This deficient practice could affect all occupants in the facility including staff, visitors and residents if emergency battery powered lights were not available.</p> <p>Findings include:</p> <p>Based on Fire Safety Record review on 04/27/16 at 4:08 p.m. with the Maintenance Supervisor the facility tested the battery backup emergency lights located throughout the facility, but only documented a fifteen second monthly test and a forty five minute annual test. Based on interview concurrent with record review with the Maintenance Supervisor it was acknowledged the battery backup emergency light was checked monthly and annually, but the documentation was deficient for the duration of the monthly and annual test time.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper</p>		<p>tested for 90 minutes annually to ensure that they function properly. The monthly tests will last at least 30 seconds. 4. The Maintenance directors documentation of the emergency backup light testing will be reviewed by the ED monthly to ensure compliance.</p>				

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	<p>switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>Based on observation and interview, the facility failed to ensure sprinkler heads were spaced a minimum of 6 feet apart for 1 of 1 automatic sprinkler systems. NFPA 13, Section 5-6.3.4, " Minimum Distance between Sprinklers ", states sprinklers shall be spaced not less than 6 feet on center. This deficient practice could affect 28 residents on 100 hall south as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 04/27/16 at 1:59 p.m. with the Maintenance Supervisor, two pendant sprinkler heads located in the ceiling of the MDS office on 300 hall south was measured to be five feet apart. Based on interview concurrent with the observation with Maintenance Supervisor, it was acknowledged the aforementioned sprinkler heads observed were less than six feet apart.</p> <p>3.1-19(b)</p>	K 0056	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, 28 residents on hall 100 south as well as staff and visitors had the possibility to be affected. The pendant sprinkler heads referenced in the MDS office on hall 300 south were adjusted to ensure that they were at least 6 feet apart. 3. All sprinkler heads were inspected to ensure that they were a minimum of 6 feet apart. 4. All sprinkler heads will be inspected monthly by the Maintenance department to ensure that they were a minimum of 6 feet apart</p>	05/20/2016	

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K 0064 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6</p> <p>Based on observations and interview, the facility failed to ensure 1 of 6 portable ABC class fire extinguisher pressure gauge readings was in the acceptable range on 200 hall. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 20 residents on 200 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/27/16 at 3:00 p.m. with the Maintenance Supervisor, the gauge on the ABC Class portable fire extinguisher on 200 hall south showed the extinguisher to be discharged and another fire extinguisher was not available to replace it. Based on</p>	K 0064	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, 20 residents on hall 200 south as well as staff and visitors had the possibility to be affected. The fire extinguisher on hall 200 south was replaced with an ABC class portable fire extinguisher with a pressure gauge in the acceptable range. 3. All fire extinguishers were inspected to ensure that the pressure gauges were in the acceptable range. A spare fire extinguisher with a pressure gauge in the acceptable range was acquired for the facility. 4. All fire extinguishers will be inspected monthly by the Maintenance department to ensure that they have a pressure gauge reading the acceptable range.</p>	05/20/2016			

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K 0066 SS=E Bldg. 01	<p>interview on 04/27/16 at 3:01 p.m. with the Maintenance Supervisor it was agreed the gauge reading was not in the normal operating range and did not have a replacement available.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(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.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation, record review and interview, the facility failed to adhere to a non-smoking policy which should ensure cigarette butts were not deposited onto the ground at 1 of 10 exits. This deficient practice could affect 24</p>	K 0066	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, 24 residents on hall 200 south as well as staff and visitors had the possibility to be affected. The 20 cigarette butts that were discarded outside</p>	05/20/2016

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K 0070 SS=E Bldg. 01	<p>residents on 200 hall south as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/27/16 at 2:25 p.m. with the Maintenance Supervisor, twenty cigarette butts were observed deposited on the ground outside the 200 east exit. Based on review of the smoking policy on 04/27/16 at 4:32 p.m. with the Maintenance Supervisor, the smoking policy stated the facility was a smoke free facility. Based on interview on 04/27/16 concurrent with the observation with the Maintenance Supervisor it was acknowledged the facility's employees were throwing their cigarette butts on the ground in an area where smoking was not allowed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation, interview and record review, the facility failed to</p>	K 0070	<p>the 200 east exit were cleaned up and the area was inspected to ensure that no further cigarette butts were present. 3. Multiple no-smoking signs were placed in at the 200 east exit to inform staff and visitors of the non-smoking designated area. A designated smoking area is provided on the outer edge of the facility property. A cigarette butt receptacle is present at the designated smoking area. 4. All exits and the facility perimeter will be inspected weekly by the Maintenance and housekeeping department to ensure that no cigarette butts are present and that no smoking is occurring in non-designated areas</p> <p>1. There were no residents identified as being affected. 2. There were no residents</p>	05/20/2016			

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	<p>regulate the use of 1 of 1 portable space heaters observed in non-resident rooms. This deficient practice could affect 16 residents on 300 hall north as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 04/27/16 at 12:25 p.m. with the Maintenance Supervisor, one portable space heater was plugged in and ready for use in the Admissions office on 300 hall north. Based on interview on 04/27/16 concurrent with the observation, it was acknowledged by the Maintenance Supervisor the portable heater was not allowed in the facility and no documentation pertaining to the portable space heater was available for review.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4</p> <p>Based on observation and interview, the facility failed to ensure 1 of 8 resident rooms on 300 hall north remain free of combustible decorations. This deficient practice affects up to 16 residents on 300</p>		<p>affected. However, 16 residents on hall 300 north as well as staff and visitors had the possibility to be affected. The portable space heater that was referenced as being plugged in and ready for use in the Admissions office on hall 300 North was discarded.</p> <p>3. The facility was inspected to ensure that no other portable space heaters are in use or present in the facility. 4. The maintenance director will inspect the facility monthly to ensure that no portable heaters are present in the facility.</p>				
K 0073 SS=E Bldg. 01		K 0073	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, 16 residents on hall 300 north as well as staff and visitors had the possibility to</p>	05/20/2016			

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K 0143 SS=E Bldg. 01	<p>hall north.</p> <p>Findings include:</p> <p>Based on observation on 04/27/16 at 12:10 p.m. with the Maintenance Supervisor, there was one unlit candle with a wick in resident room #306. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there was a candle with a wick in a resident room.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the</p>	K 0143	<p>be affected. The unlit candle with a wick was removed from room 306. 3. The facility was inspected to ensure that no other candles with wicks are present in the facility. 4. The maintenance director will inspect the facility monthly to ensure that no candles with wicks are present in the facility.</p> <p>1. There were no residents identified as being affected. 2.</p>	05/20/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155199	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  04/27/2016
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K 0144 SS=F Bldg. 01	<p>facility failed to ensure 1 of 2 oxygen storage rooms where oxygen transfer occurs had continuously working, electrically powered mechanical ventilation. This deficient practice could affect 16 residents as well as visitors and staff on 300 hall south.</p> <p>Findings include:</p> <p>Based on observation on 04/27/16 at 1:20 p.m. with the Maintenance Supervisor, the oxygen storage room on 300 hall south used to store and transfer oxygen was provided with electrically powered mechanical ventilation, but it was not working. Based on interview concurrent with the observation, it was acknowledged by the Maintenance Supervisor, the oxygen room was used to transfer oxygen and the electrically powered mechanical vent was not working.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and</p>		<p>There were no residents affected. However, 16 residents on hall 300 south as well as staff and visitors had the possibility to be affected. The electrically powered mechanical vent in the oxygen storage room located on hall 300 south was repaired to working order. 3. The facility was inspected to ensure that all oxygen rooms have working electrically powered mechanical ventilation. 4. The maintenance director will inspect the oxygen transfer rooms monthly to ensure that that all have working electrically powered mechanical ventilation.</p>		

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	<p>NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Based on record review and interview, the facility failed to maintain 1 of 1 generators when repairs are needed. This deficient practice could affect all staff, visitors, and residents.</p> <p>Findings include:</p> <p>Based on record review on 04/27/16 at 4:02 p.m. with the Maintenance Supervisor, the generator block heater was not working. Based on interview concurrent with record review the Maintenance Supervisor acknowledged the generator block heater did not work and the facility was in the process of purchasing a new generator and did not intend to repair the existing block heater.</p> <p>3.1-19(b)</p>	K 0144	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, all residents as well as staff and visitors had the possibility to be affected. The generator block referenced as needing repair was repaired. 3. The generator block referenced as needing repair was repaired and tested to ensure that it was in proper working order. 4. The maintenance director will perform routine weekly generator tests to ensure that it is in proper working order. Any repairs required will be performed as identified.</p>	05/20/2016
K 0147 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 non-fused multiplug adapters, 2 of 5 surge protectors and 1 of 1 extension cords observed were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC</p>	K 0147	<p>1. There were no residents identified as being affected. 2. There were no residents affected. However, 28 residents on Unit 5 as well as staff and visitors had the possibility to be affected. The non-fused multi-plug in the Executive</p>	05/20/2016

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	<p>9.1.1 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice would affect 28 residents on unit 5 hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 04/27/16 during the tour from 11:30 pm. to 3:00 p.m. with the Maintenance Supervisor, the following was noted:</p> <p>a. A non-fused multiplug was used to power computer equipment in the Executive Director's office on Front center hall.</p> <p>b. Surge protectors were used in the Admissions office to power a mini fridge and coffee pot and in the Medical Records office to power mini fridge and an Oxygen concentrator was plugged into surge protector in resident room 204.</p> <p>c. An extension cord was used in the Maintenance shop to power a phone charger.</p> <p>Based on interview with the Maintenance Supervisor at the time of observations during the tour non-fused multiplug adapters, surge protectors and extension</p>		<p>Director's office was removed. The surge protectors in the admissions office, medical records office, and room 204 were removed. The extension cord used in the maintenance shop was removed. 3. The facility was inspected to ensure that no multi plug adapters or surge protectors were being used as a substitute for fixed wiring. 4. The maintenance director will inspect the facility monthly to ensure that no multi plug adapters or surge protectors are being used as a substitute for fixed wiring .</p>	

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	cord were used in the aforementioned resident room and staff offices.  3.1-19(b)				