

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155719	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922
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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: 03/01/16</p> <p>Facility Number: 000559 Provider Number: 155719 AIM Number: 100267170</p> <p>At this Life Safety Code survey, George Ade Memorial Health Care Center 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 II (222) construction and was sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors; spaces open to the corridors and resident rooms. The facility has a capacity of 70 and had a census of 58 at the time of this survey.</p>	K 0000	<p>March 14, 2016 Miriam Buffington, Enforcement Manager Division of Long Term Care Indiana State Department of Health 2 North Meridian, Section 4-B Indianapolis, IN 46204-3006 Re: Survey Event ID: 31CO21</p> <p>Dear Miriam: This letter is in regards to the 3/1/2016 Life Safety Survey conducted at George Ade Memorial Health Care Center, Brook, IN. The following plan of correction is being submitted as our allegation of substantial compliance. We further submit that the facility is in substantial compliance as of the 18th of March, 2016. We would request that the compliance date serve as our date to clear the survey findings and to stop any and all proposed or implemented remedies that have been presented to date. If you have any questions or need further information, call 219-275-2531 or email admin@georgeade.org, and we would be available to assist you. Thank you, W R Scott James, HFA GAMHCC Life Safety</p> <p>The preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of</p>	
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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 0025 SS=E Bldg. 01	<p>All areas where residents have customary access were sprinklered. Areas providing facility services were sprinklered.</p> <p>Quality Review completed on 03/03/16 - DA</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.</p>		<p>Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of the federal and state law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents, nor are they of such character as to limit this provider's capacity to render adequate resident care.</p> <p>Furthermore, the operation and licenser of the long term care facilities, and this plan of correction in its entirety, constitutes this provider's allegation of compliance. Completion dates are provided for the procedural preceding purposes to comply with state and federal regulations, and correlate with the most recent contemplated or accomplished corrective action. These dates do not necessarily correspond chronologically to the date the provider is under the opinion it was in with requirements of participation or that the corrective action was necessary.</p>	

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	<p>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>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 5 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to 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 up to 45 residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/01/16 at 12:30 p.m., the smoke barrier wall by room 32 had a half inch unsealed penetration around a wire. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the penetration and</p>	K 0025	<p>K025</p> <p>The smoke barrier wall by room #32 has had the half inch area repaired to seal the noted penetration. As well as the ceiling in the activities closet and office has been repaired so as to prevent further safety issues. Upon completion of the inspection, no other areas were found and the maintenance staff will follow up with any services that may have needed to drill passages to assure that they are properly sealed so as to prevent further safety issues. The maintenance department will follow up any times services are provided that may cause penetration that need to be sealed.</p> <p>The maintenance supervisor or designee will accompany service providers to assure that penetrations are properly sealed, as well will check whenever services are provided to prevent further safety issues.</p> <p>Done as of 3/2/2016.</p>	03/02/2016

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	<p>provided the measurement.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to 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 10 residents in the activities room.</p> <p>Findings include:</p> <p>Based on observation during the tour of the facility with the Maintenance Supervisor on 03/01/16 between 10:50 a.m. and 11:00 a.m., the following unsealed penetrations were noted:</p> <p>a.) in the ceiling of the junk closet located in the activities room, there was an unsealed vent open to attic measuring three by six inches.</p> <p>b.) in the ceiling of the activities office</p>						

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K 0029 SS=E Bldg. 01	<p>there were four unsealed holes measuring one half inch in diameter.</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged and provided the measurements of the penetrations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors to a soiled utility room, a hazardous area, was provided with self-closing devices causing the doors to automatically close and latch into the door frame. This deficient practice could affect 18 residents in Oak Blvd. hall.</p> <p>Findings include:</p> <p>Based on an observation during a tour of</p>	K 0029	<p>K029</p> <p>The door closer and latch have been repaired on the soiled utility room by room #39 so as to prevent further safety concerns.</p> <p>Door latches are checked during walking rounds and repaired as needed. Staff also make maintenance aware through repair slips.</p> <p>The maintenance department will be responsible to see that the doors are working properly at all times, this is</p>	03/02/2016

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K 0038 SS=E Bldg. 01	<p>the facility with the Maintenance Supervisor on 03/01/16 at 11:40 a.m., the dirty utility room door by room 39 did self-close but failed to latch into the frame. The dirty utility room contained barrels of trash and hazardous waste. Based on interview, this was acknowledged by the Maintenance Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 7 exit discharge paths was readily accessible at all times. LSC Section 7.1 requires means of egress for buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires a ramp with a rise greater than 6 inches shall have handrails. LSC Section 7.2.2.4.2 Exception #3 states existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect 18 residents evacuated through the Oak Blvd. hall exit in the event of an emergency.</p> <p>Findings include:</p>			K 0038	<p>done via walkinggrounds and staff provided repair slips. This is ongoing.</p> <p>Done as of 3/2/2016.</p> <p>K038</p> <p>The hand railing in question has been replaced with newsections that are secured properly and can support a person using the handrail.</p> <p>This is the only area of railing at or around thefacility. The maintenance departmentwill be responsible to see that it is maintained properly.</p> <p>The completion of the repair will be observed with anyother repairs made as needed.</p> <p>This is done as of 3/18/2016.</p>		03/18/2016

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K 0046 SS=F Bldg. 01	<p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/01/16 at 12:15 p.m., near the bottom of the exit 4 discharge ramp two of the five foot sections of the handrail was cracked, broken, loose, and leaning to one side instead of upright and secure. The hand railing would not support a person using a hand rail. Based on an interview at the time of observation, the Maintenance Supervisor stated that a car backed in to the railing breaking the railing and making it lean to one side.</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 observation, records and interview; the facility failed to ensure 2 of 2 emergency light fixtures for the generator room and 2 of 2 emergency exits light fixtures were tested annually for 1 1/2 hour duration and monthly for 30 second duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on</p>	K 0046	<p>K046</p> <p>It should be noted that the log for the emergency batterypowered lights has been maintained and the 90 minute annual test was brought toour attention at the time of the survey and has since been completed. The scope and severity for this tag should bereconsidered.</p>	03/10/2016

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K 0052	<p>every required battery powered emergency lighting system for a minimum of 1 ½ hour duration and every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on records review of the Battery Operated Emergency Light Test Log with the Maintenance Supervisor on 03/01/16 at 09:37 a.m., a 30 second monthly test was documented, but no 90 minute annual test was documented on two emergency battery powered light for the generator room and two emergency battery powered light for two exits. Based on interview at the time of record review, the Maintenance Supervisor stated a 90 minute annual test was not conducted for the emergency battery powered lights in the last year.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>The battery operated emergency light test log has been updated as of 3/10/16 to reflect the 90 minute annual test for the emergency battery powered light for our annual test for 2016.</p> <p>The emergency lights are tested and recorded ongoing for proper operation.</p> <p>The emergency lights will be tested regularly and results recorded to show the proper function of the emergency lighting.</p> <p>The maintenance supervisor or designee will be responsible to see that the testing is conducted and documented on an ongoing basis.</p> <p>See attached #1.</p> <p>This is done as of 3/10/2016.</p>		

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SS=F Bldg. 01	<p>LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,</p> <p>Based on observation and interview, the facility failed to maintain and secure 1 of 1 fire alarm systems in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4, 9.6 and 9.6.1.4, as well as, NFPA 72 - 1999 edition, Section 1-5.2.5.2. The fire alarm control panel requires primary power from a dedicated branch circuit. The circuit breaker and connection shall be mechanically protected. The breaker shall be labeled " Fire Alarm Circuit Control." This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/01/16 at 10:15 a.m. the electrical panel located in the sprinkler riser room contained the breaker for the Fire Alarm Control Panel. The door to the room, the panel door, nor the breaker itself was locked. This condition could allow an untrained staff member, visitor, or</p>	K 0052	<p>K052</p> <p>It should be noted that the fire panel control is not readily accessible to the public and no residents have access to the given area of the fire control panel. Thus allowing few if any access to the area, only those known by trained staff.</p> <p>The scope and severity for this tag should be reconsidered.</p> <p>A key lock has been installed on the electrical panel located in the sprinkler control room that contains the breakers for the fire alarm control panel.</p> <p>This panel remains locked at all times unless being serviced so as to maintain and secure zone for the panel.</p> <p>The maintenance supervisor is responsible to see that this is secured and the panel is functional. This is an ongoing point of security.</p> <p>This is done as of 3/2/2016.</p>	03/02/2016
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K 0062 SS=F Bldg. 01	<p>resident access to the power of the Fire Alarm Control Panel. Based on Interview at the time of observation, the Maintenance Supervisor confirmed that the door to the room, the panel door, and the breaker to the Main Fire Alarm Panel was not locked.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to document and conduct weekly tests of the fire pump in accordance with LSC Section 9.7.5 and 19.3.5.1 and NFPA 25. NFPA 25, Table 5-1.1 and then 5-2 through 5-3.2.4.4 requires the following weekly inspections: the pump house conditions-heat is at least 40 degrees F, heating ventilating louvers are free to operate, fire pump system conditions with valves fully open, piping free of leaks, suction line pressure gauge reading is normal, suction reservoir is full. Additionally, 5-3.2.1 requires a no flow, ten minute pump test shall be performed weekly. This deficient practice affects all</p>	K 0062	<p>K062</p> <p>It should be noted that at no time during the period cited, did the fire system or its readiness present any issue. The testing is currently done with no concerns noted.</p> <p>The weekly fire pump records have been received and as of 3/2/2016 are up to date following the indicated review.</p> <p>The weekly fire pump test will be conducted on a timely basis and records will be maintained so as to show the results of the testing conducted. The maintenance supervisor or designee will be responsible to</p>	03/01/2016

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K 0066 SS=E Bldg. 01	<p>occupants.</p> <p>Finding include:</p> <p>Based on record review of the weekly fire pump test paperwork with the Maintenance Supervisor on 03/01/16 at 09:22 a.m., the last weekly fire pump test was conducted on 01/04/16 leaving a seven week gap since the last weekly test. Based on interview at the time of records review, the Maintenance Supervisor acknowledge the last weekly test was conducted on 01/04/16.</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</p>		<p>conduct and record this test as required on an ongoing basis.</p> <p>This is maintained at this time. See attached #2 and #3.</p> <p>This is done as of 3/1/16.</p>		

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	<p>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</p> <p>Based on observations and interview, the facility failed to ensure cigarette butts were deposited into a noncombustible container which was provided for 1 of 1 areas where smoking was permitted. This deficient practice could affect up to 10 residents utilizing exit FIVE during a fire emergency.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Maintenance Supervisor on 03/01/16 at 11:03 a.m., the smoking area outside of exit FIVE, which was provided with two approved long neck vessel, had 25 plus cigarette butts in two non-covered plastic ash trays. Furthermore, the smoking area had 30 plus cigarette butts that was observed in a trash container which was full of paper goods and products. Based on interview at the time of observation, the Maintenance Supervisor acknowledged cigarette butts were disposed in a non-approved ash trays, and cigarette butts were disposed into a container full of paper products instead of using the approved long neck vessel which was</p>	K 0066	<p>K066</p> <p>The smoking area has had the noted items removed and appropriate ashtrays and collection containers have been replaced in the noted area.</p> <p>The appropriate ashtrays and container will be maintained so as to provide a safe smoking area and to prevent further safety concerns.</p> <p>The housekeeping and maintenance staff will be responsible to see that this area is maintained in a safe and orderly manner.</p> <p>This is done as of 3/10/2016.</p>	03/10/2016

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NAME OF PROVIDER OR SUPPLIER GEORGE ADE MEMORIAL HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3623 E SR 16 BROOK, IN 47922
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K 0130 SS=E Bldg. 01	<p>provided.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item</p>	K 0130	<p>K130</p> <p>The smoke barrier wall by room #30 has had the half inch area repaired to seal the noted penetration. As well as the ceiling in the activities closet and office has been repaired so as to prevent further safety issues.</p> <p>Upon completion of the inspection, no other areas were found and the maintenance staff will follow up with any services that may have needed to drill passages to assure that they are properly sealed so as to prevent further safety issues.</p> <p>The maintenance department will follow up any times services are provided that may cause penetration that need to be sealed.</p> <p>The maintenance supervisor or designee will accompany service providers to assure that penetrations are properly sealed, as well will check whenever services are provided to prevent further safety issues.</p> <p>Done as of 3/2/2016.</p>	03/02/2016

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K 0147 SS=E Bldg. 01	<p>and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect up to 30 residents in 2 of 6 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/01/16 at 12:20 p.m., there were two unsealed fourth of an inch holes in the fire wall by room 30. Based on interview at the time of observation, the Maintenance Supervisor confirmed the wall was a fire barrier and provided measurements of the penetrations.</p> <p>3.1-19(b)</p> <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</p> <p>1. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe</p>	K 0147	K147 The noted junction box in the biohazard room has been repaired	03/03/2016			

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	<p>operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect 10 residents in the therapy hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/01/16, in the Biohazard room there was a 5 by 7 inch electrical junction box with numerous exposed wire connections without a cover. Based on an interview at the time of observation, the Maintenance Supervisor acknowledged the electrical junction box was without a cover.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed</p>		<p>with the exposed wiring connections covered. The noted power strip and extension cord has been removed from the dietary office.</p> <p>Staff has been reminded that any exposed or open wiring must be covered up on discovery and proper corrections made. Staff has also been reminded that the use of extension cords and or power strips are not to be used in an improper manner or to bypass permanent electrical outlets.</p> <p>The maintenance supervisor or designee will be responsible to see that reported electrical repairs are done on a timely basis so as to prevent accidents and maintain a safe environment.</p> <p>This is an ongoing part of the facility maintenance.</p> <p>This is done as of 3/3/2016.</p>				

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	<p>wiring of a structure. This deficient practice could affect 10 or more residents outside the service hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Maintenance Supervisor on 03/01/16 at 10:20 a.m., a power strip extension cord was plugged into another power strip extension cord supplying power to computer equipment in the Dietary office. Also, an extension cord was providing power to a fan in the Dietary office. Based on interview at the time of observation, the Maintenance Supervisor acknowledge that a power strip was plugged into another power strip and an extension cord was powering a fan.</p> <p>3.1-19(b)</p>			