

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155608	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  04/29/2016
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NAME OF PROVIDER OR SUPPLIER  WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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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: 04/28-29/16</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>At this Life Safety Code survey, Wittenberg Lutheran 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>The original one story building with a partial basement identified as building 01 was determined to be to be of Type II (000) construction and was fully sprinklered. The one story Chapel/Fellowship Hall addition identified as building 02 was determined to be Type V (000) construction and occupies a 1990 wing addition to the</p>	K 0000	<p>Please accept this POC as our response to our annual LSC survey and as our allegation of compliance</p> <p>This plan of correction is being submitted for the purpose of complying with regulatory compliance and in no way should be deemed as an admission of any of the allegations contained within the survey findings</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>facility. The facility is surveyed as two buildings due to different construction types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 128 at the time of this survey.</p> <p>All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p> <p>Quality Review completed on 05/10/16 - 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</p>				

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	<p>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.</p> <p>19.3.6.3</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 Kitchen and 1 of 1 Basement Janitor's Closet corridor doors had no impediment to closing into the door frame. This deficient practice could affect staff and up to 20 residents.</p> <p>Findings include:</p> <p>Based on observation and interview on 04/28/16 at 2:02 p.m., the Plant Operations Manager and the Maintenance Supervisor acknowledged the corridor door to the Kitchen had a wood door stop that prevented the corridor door from closing and latching into the door frame.</p> <p>Based on observation and interview on 04/29/16 at 10:05 a.m., the Plant Operations Manager and the Maintenance Supervisor acknowledged the corridor door to the Basement Janitor's Closet had a wood door stop that prevented the corridor door from closing and latching into the door frame.</p> <p>3.1-19(b)</p>	K 0018	<p>WittenbergVillage K_tag-18_____</p> <p>·what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; <b>All wood door wedge stops have been removed from the building effective May 2nd,2016.</b></p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>All other residents have the potential to be affected had they not been removed.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>This specific item will be added to the Director of Maintenance monthly auditdocument. The Executive Director will in-service all employees attending the town hall meetings that fire rated doors to corridors can never be proppedopen.</b></p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and</p>	05/29/2016

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K 0025 SS=E Bldg. 01	<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>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</p>	K 0025	<p><b>The Director of Maintenance will make weekly rounds with the audit document and will survey distinct areas of the building. Within the month, all weekly areas will comprise the entire building. Audit documents will be reviewed at the monthly QA meetings until QA chairperson is satisfied.</b></p> <p>- By what date the systemic changes will be completed. <b>Compliance will be achieved no later than May 29, 2016.</b></p> <p>Wittenberg Village</p> <p>Ktag 25 _____ - what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; <b>All four unsealed penetrations were immediately sealed with quality fire caulk.</b></p> <p>- how other residents having the potential to be affected by the same deficient practice will be</p>	05/02/2016

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	<p>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 staff and at least 67 residents.</p> <p>Findings include:</p> <p>Based on observations with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 1:27 p.m., the 500 Hall smoke barrier wall had four separate unsealed penetrations ranging from a quarter of an inch to one inch above the ceiling tile. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p>		<p>identified and what corrective action(s) will be taken; <b>The entire building was reviewed by the maintenance Director in search of similarsituations. All residents had the potential to be affected but no other similarsituations were found.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Shouldany doors be considered for any hallway location the maintenance Director willfirst review the adjoining walls above the ceiling to insure they have nopenetrations.</b></p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and <b>TheMaintenance Director has ordered hard copy books of the NFPA 101. An annualNFPA audit will be performed in January of each year using the books as areference tool.</b></p> <p>·bywhat date the systemic changes will be completed. <b>The date certain on this correction is May 2nd 2016.</b></p>	

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K 0029 SS=E Bldg. 01	<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 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Laundry Room, a hazardous area, would latch into the frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/29/16 at 2:32 p.m., the Laundry room contained fuel fired dryers. The corridor door in the Laundry room failed to latch into the door frame when tested. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0029	<p>WittenbergVillage</p> <p>K_-tag29____ ·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Allself closing doors required to latch were immediately adjusted to insurelatching.</b></p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Noresidents had the potential to be affected as this door was in an area notaccessible to residents.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Properdoor latching will be</b></p>	05/02/2016			

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K 0044 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets were arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with	K 0044	<b>added to the monthly audit tool completed by the Director of Maintenance. Additionally, training will be done with all maintenance staff on how and why door latching is so critically important.</b>  ·how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; <b>The audit tool aforementioned will monitor the proper latching of all doors required to latch. This audit tool will be entered into the QA program until three months of perfect satisfaction is achieved and the QA chairperson and committee deems satisfactory compliance.</b>  ·By what date the systemic changes will be completed. <b>The date certain for this tag is May 2nd 2016.</b>  Wittenberg Village  Ktag-44____ ·what corrective action(s) will be accomplished for those residents	05/02/2016

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	<p>7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. These deficient practices could affect staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 2:18 p.m., the "GTS" fire doors separate health care and private suites occupancies failed to latch into the frame when tested. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition and confirmed the set of doors were fire doors.</p> <p>3.1-19(b)</p>		<p>found to have been affected by the deficient practice; <b>This fire door was corrected immediately based on adjusting the electronic setting. The doors now functioned as designed.</b></p> <p>· how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; <b>No other residents will be affected as this is not an area of the Health Care Center. Further, this door was immediately fixed.</b></p> <p>· what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; <b>These fire doors will be checked for the next sixty days, weekly to insure they are functioning properly. The doors will be added to the regular preventive maintenance schedule which calls for monthly checks.</b></p> <p>· how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; <b>The doors will be added to the regular preventive maintenance</b></p>	

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K 0050 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure 12 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.2 requires fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions.</p>	K 0050	<p><b>schedule which calls for monthly checks. Any fire doorirregularities will be reported to the QA committee.</b></p> <p>- bywhat date the systemic changes will be completed. <b>The date certain for correction was May 2nd, 2016</b></p> <p>WittenbergVillage</p> <p>K__tag-50__ whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>The fire alarm drill form the facility uses for all employee fire drills will bemodified to include a section to document verification of transmission to themonitoring station.</b></p>	05/29/2016

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K 0054 SS=F	<p>This deficient practice affects all residents in the facility as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of titled "Fire Drill" with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 10:59 a.m., the documentation for the drills failed to include verification of transmission of the fire alarm signal to the monitoring station. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>		<p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>All other residents have the potential to be affected.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>The new section will include dates, times and who was spoken to at the monitoring station.</b></p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; <b>The Director of Maintenance will beaccountable to update the form, and bring three months of fire drills properlydocumented to the next quarterly QA committee meeting.</b></p> <p>- ·bywhat date the systemic changes will be completed. <b>The date certain is May 29, 2016.</b></p>	

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Bldg. 01	<p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 facility fire alarm system was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <p>(1) Calibrated test method (2) Manufacturer's calibrated sensitivity</p>	K 0054	<p>WittenbergVillage</p> <p>K_tag-54</p> <p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Theevery other year required sensitivity test on all smoke detectors was performedon May 11, 2016.</b></p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Allother residents have the potential to be affected. Future Sensitivity smokedetector test will be done timely.</b></p> <p>·Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>The Director of Maintenance will include this test on all fire systempreventive maintenance requirements. Additionally, the vendor will also use a calendar notification system to notify Wittenberg when this inspection is dueas a double</b></p>	05/11/2016

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	<p>test instrument</p> <p>(3) Listed control equipment arranged for the purpose</p> <p>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</p> <p>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</p> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all staff, resident, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 11:38 a.m., the most recent documentation of a smoke detector sensitivity test was completed on 01/22/14. Based on an interview at the time of record review, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition and confirmed no other documentation was available for review.</p> <p>3.1-19(b)</p>		<p><b>check.</b></p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place; <b>TheDirector of Maintenance will be required to present to the QA committee, thefire system preventive maintenance calendar at the June QA meeting.</b></p> <p>- ·Bywhat date the systemic changes will be completed. <b>The date certain is May 11, 2016</b></p>	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0062 SS=F Bldg. 01	<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 observation and interview, the facility failed to ensure 1 of 3 sprinkler gauges was continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 2:20 p.m., the sprinkler pipe in the sprinkler riser room had three gauges installed. One gauge indicated it was manufactured in 2007. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p>	K 0062	<p>WittenbergVillage</p> <p>K-tag 62_____</p> <p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>The sprinkler pipe in the sprinkler riser room had a gauge that was from 2007. The gaugehas been replaced with a brand new gauge.</b></p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Allresidents have the potential to be affected.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Ayearly inspection by the maintenance department; following the preventivemaintenance calendar will be performed. Also, the sprinkler vendor will play asecondary role to insure this deficient practice does not</b></p>	05/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155608	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____		X3) DATE SURVEY COMPLETED  04/29/2016
NAME OF PROVIDER OR SUPPLIER  WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307		
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K 0066 SS=D Bldg. 01	<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</p>		<p><b>recur.</b></p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;and <b>Yearlylog sheets that indicate the age of the gauges, and when they are scheduled tobe replaced will be given to the Administrator upon the annual LSC auditconducted each January.</b></p> <p>·bywhat date the systemic changes will be completed. <b>Thegauge has been replaced, and the inspection schedule will be completed by May29, 2016.</b></p>		

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	<p>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 and interview, the facility failed to ensure 2 of 2 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Plant Operations Manager and the Maintenance Supervisor on 04/29/16 at 10:12 a.m., there were at least 50 cigarette butts on the ground in the South designated smoke area and at least 50 cigarette butts on the ground in the North designated smoke area. The North smoking location had an open top metal bucket where some cigarettes were stored. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0066	<p>WittenbergVillage</p> <p>K-tag 66_____</p> <ul style="list-style-type: none"> <li>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Theoutside smoking area has been reconfigured. Additionally approved cigarettebutt disposal containers have been ordered. Compliance signage has beeninstalled to indicate the reconfigured smoking area.</b></li> <li>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Noresidents have the potential to be affected as this is an outside location inthe rear of the building that is not accessible to residents.</b></li> <li>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Weeklymonitoring of the reconfigured smoking area will be done by the Director</b></li> </ul>	05/25/2016

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K 0069 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 commercial kitchen fire suppression coverage was maintained. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations at 1.3.1 requires cooking equipment shall be maintained per the standard including the fire suppression	K 0069	<p><b>ofMaintenance to insure that the deficient practice does not recur.</b></p> <p>·Howthe corrective action(s) will be monitored to ensure the deficient practice willnot recur, i.e., what quality assurance program will be put into place. <b>Thecorrective action will be monitored weekly by housekeeping staff and theDirector of Maintenance. Any negative trend will result in a smoke free campus.</b></p> <p>·Bywhat date the systemic changes will be completed. <b>Theapproved container has been ordered and the signage has been installed the datecertain will be May 25, 2016.</b></p> <p>Ktag-69_____</p> <p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Thenozzle for the Kitchen hood spray system was reconfigured to point exactly atthe tilt skillet.</b></p>	05/25/2016	

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	<p>system during all periods of operation of the cooking equipment. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 2:52 p.m., the hood system spray nozzles were pointing at the wall instead of pointing at the "tilt skillet." Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Allresidents have the potential to be affected.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Nochanges of kitchen equipment will be allowed without certifying that thenozzles are correctly aimed at the equipment.</b></p> <p>·Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place. <b>Monthlyinspections by the culinary Director will insure that the nozzles are alwayscorrectly aimed at the kitchen equipment. The Maintenance Director will includethis on his annual January LSC audit inspection.</b></p> <p>- ·Bywhat date the systemic changes will be completed. <b>Thenozzle has been reconfigured, and the inspection will be included in themonthly hazardous rounds by May 25, 2016.</b></p>		

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K 0130 SS=F Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review and interview, the facility failed to maintain 97 of 97 single station smoke detectors per manufacturer's recommendation. This deficient practice affects all residents.</p> <p>Findings include:</p> <p>Based on record review with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 11:05 a.m., the "Resident Smoke Detector Log" indicated the single station smoke detectors were tested monthly. The documentation failed to include information indicating when the battery was replaced for each of the single station smoke detectors. Furthermore, manufacture's recommendation required monthly cleaning and weekly testing. Based on interview at the time of record review, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition and confirmed no other documentation is available for review.</p> <p>3.1-19(b)</p>	K 0130	<p>WittenbergVillage</p> <p>Ktag-130 _____</p> <ul style="list-style-type: none"> <li>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Thesmoke detectors will be cleaned on a weekly basis as recommended by themanufacture. Batteries will be replaced as recommended by the manufacturer.</b></li> <li>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Allresidents have the potential to be affected.</b></li> <li>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Thesmoke detector inspections will change from monthly to weekly to insure thatthe deficient practice does no recur.</b></li> <li>·Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur,</li> </ul>	05/25/2016

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K 0144 SS=F Bldg. 01	<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 NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections of the starting batteries for the generator was maintained for 52 of 52 weeks. Chapter 3-4.4.1.3 of NFPA 99 requires storage batteries used in connection with essential electrical systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon</p>	K 0144	<p>i.e., what quality assurance program will be put into place. <b>The corrective action will be monitored on the check off sheets that are currently used to insure the deficient practice will not recur. These check off sheets will be turned in and monitored by the Director of Maintenance.</b></p> <p>- ·By what date the systemic changes will be completed. <b>The date certain will be May 25, 2016.</b></p> <p>Wittenberg Village</p> <p>Ktag-144_____</p> <p>·what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; <b>The generator inspection log will be modified to include: transfer time, cool downtime, and time that the alarm was received at the monitoring service</b></p> <p>·how other residents having the</p>	05/02/2016

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	<p>discovery of defects. Furthermore, NFPA 110, 6-3.6 requires checking storage batteries, including electrolyte levels, at intervals of not more than 7 days. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on interview and record review of generator documentation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 11:43 a.m., no documentation for weekly generator inspections was available for review.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the alternate source of power from the 1 of 1 emergency generators was capable of automatically connecting to the load within 10 seconds in the event of failure of normal power. NFPA 99, the Standard for Health Care Facilities, Nursing Home requirements requires essential electrical distribution systems to conform to Type 2</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; <b>All residents have the potential to be affected.</b></p> <p>· what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; <b>Therevised log sheets will insure that the deficient practice does no recur.</b></p> <p>· How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. <b>The log sheets will be reviewed by the Director of Maintenance to insure the deficient practice will not recur.</b></p> <p>· By what date the systemic changes will be completed. <b>The date certain was May 2nd, 2016</b></p>	

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	<p>systems as described in Chapter 3 of NFPA 99. NFPA 99, 3-6.3.1.2 requires the emergency system to be arranged so that, in the event of failure of the normal power source, the alternate source of power will automatically connect to the load within 10 seconds. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 11:43 a.m., the emergency generator documentation failed to include a numerical value for the transfer time. Based on an interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>3. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. LSC 19.2.9.1 refers to LSC 7.9 which refers to LSC 7.9.2.3 which requires generators to be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 1999 Edition.</p>						

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K 0147	<p>NFPA 110, 4-2.4.8 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's Emergency Generator monthly testing log with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 11:43 a.m., the generator log form documented the generator was tested monthly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>				

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SS=E Bldg. 01	<p><b>LIFE SAFETY CODE STANDARD</b> 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>Based on observation and interview, the facility failed to ensure 1 of 1 extension cord was used for temporary use and 4 of 4 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 wiring of a structure. This deficient practice affects staff and up to 10 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 between 12:11 p.m. to 12:56 p.m. the following was discovered:</p> <p>a) an extension cord was powering a laptop in Therapy b) a surge protector powering another surge protector powering phone equipment in the Phone room c) two separate surge protectors were powering separate refrigerators in the Nursing Supervisor office</p> <p>Based on interview at the time of each</p>	K 0147	<p>WittenbergVillage</p> <p>Ktag-147_____</p> <p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Theextension cord was removed immediately from service, and the power strips werereconfigured so as not to power another power strip.</b></p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Allother residents have the potential to be affected.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Allareas will be monitored by the hazardous inspection rounds performed by theDirector of Maintenance or designee to insure that the deficient practice doesnot recur.</b></p> <p>·Howthe corrective action(s) will be monitored to ensure the</p>	05/25/2016	

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K 0000  Bldg. 02	<p>observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <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: 04/28-29/16</p> <p>Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820</p> <p>At this Life Safety Code survey, Wittenberg Lutheran 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,</p>	K 0000	<p>deficient practice will not recur, i.e., what quality assurance program will be put into place, <b>A summary log will be created to monitor, track and trend to insure the deficient practice does not recur. This log will be brought to the QA committee if negative trends are noted.</b></p> <p>- By what date the systemic changes will be completed. <b>The date certain will be May 25, 2016</b></p> <p>Please accept this POC as our response to our annual LSC survey and as our allegation of compliance. This plan of correction is being submitted for the purpose of complying with regulatory compliance and in no way should be deemed as an admission of any of the allegations contained within the survey findings.</p>	

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K 0015 SS=E Bldg. 02	<p>Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The original one story building with a partial basement identified as building 01 was determined to be to be of Type II (000) construction and was fully sprinklered. The one story Chapel/Fellowship Hall addition identified as building 02 was determined to be Type V (000) construction and occupies a 1990 wing addition to the facility. The facility is surveyed as two buildings due to different construction types.</p> <p>The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 128 at the time of this survey.</p> <p>All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155608	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED  04/29/2016
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NAME OF PROVIDER OR SUPPLIER  WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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	<p>ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2</p> <p>Based on observation, interview and record review; the facility failed to ensure materials used as an interior finish for 1 of 1 Chapel had a flame spread rating of Class A or Class B. LSC 101 10.2.3.2 states products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following classes in accordance with their flame spread and smoke development.</p> <p>(a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.</p> <p>(b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.</p> <p>(c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke</p>	K 0015	<p>POC for K 015 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? In a letter from ISDH dated 05/24/2016 Mr. Denise Austill states; (exhibit B, C, and D submitted with the POS sufficiently demonstrate the wood ceiling supports our classified as meeting a class B interior finish. With this documentation, no further correction is necessary and a temporary waiver is also not necessary). 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. No deficient practice exists. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? No deficient practice exists. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? No deficient practice exists. 5. By what date the systemic changes will be completed? The completion date is 05/25/2016</p>	05/25/2016

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K 0029 SS=E Bldg. 02	<p>development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect staff, visitors, and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 1:59 p.m., wood ceiling support was exposed in the Chapel. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition and was unable to provide flame spread documentation.</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</p>			

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NAME OF PROVIDER OR SUPPLIER  WITTENBERG LUTHERAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307		
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	<p>door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Fellowship Mechanical Room, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 2:32 p.m., the Fellowship Mechanical room contained fuel fired Boiler and Water Heater. The corridor door in the Mechanical room failed to self-close and latch when tested. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0029	<p>WittenbergVillage</p> <p>K_-tag29____</p> <p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Allself closing doors required to latch were immediately adjusted to insurelatching.</b></p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Noresidents had the potential to be affected as this door was in an area notaccessible to residents.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Properdoor latching will be added to the monthly audit tool completed by the Directorof Maintenance. Additionally, training will be done with all maintenance staffon how and why door latching is so critically important.</b></p> <p>·howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place;</p>	05/02/2016	

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NAME OF PROVIDER OR SUPPLIER  WITTENBERG LUTHERAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 E LUTHER DR CROWN POINT, IN 46307
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K 0075 SS=E Bldg. 02	<p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1 Fellowship Hall Staff Dining Room. This deficient practice could affect staff and up to 12 residents.</p>	K 0075	<p><b>The audit tool aforementioned will monitor the proper latching of all doors required to latch. This audit tool will be entered into the QA program until three months of perfect satisfaction is achieved and the QA chairperson and committee deems satisfactory compliance.</b></p> <p>- By what date the systemic changes will be completed. <b>The date certain for this tag is May 2nd 2016.</b></p> <p>Wittenberg Village</p> <p>Ktag-75 _____ what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; <b>The 55 gallon waste receptacle has been removed.</b></p>	05/25/2016

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	<p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 2:06 p.m., the Fellowship Hall Staff Dining Room contained a 55 gallon barrel of trash. The dining room is open to the Chapel and exit corridors. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Noresidents have the potential to be affected as this area is an employee onlyarea and not a part of the health care center.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Wastreceptacles larger than 32 gallons will not be allowed in this area so that thedeficient practice does no recur.</b></p> <p>·Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place. <b>Monthlyhazardous rounds by the Director of culinary or designee will be performed toinsure the deficient practice will not recur. The Maintenance Director willinclude this on his annual January LSC audit inspection.</b></p> <p>- ·Bywhat date the systemic changes will be completed. <b>The date certain will be may 25, 2016</b></p>	

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K 0147 SS=E Bldg. 02	<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 and interview, the facility failed to ensure 8 of 8 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 wiring of a structure. This deficient practice affects staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 between 2:09 p.m. and 2:23 p.m., the following was discovered:</p> <p>a) a surge protector powering three separate surge protectors powering the television system in the IT room b) a surge protector was powering another surge protector powering computer equipment in the Computer Lab c) an extension cord was powering a surge protector powering a piano in the Chapel</p>	K 0147	<p>WittenbergVillage</p> <p>Ktag-147_____</p> <p>·whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; <b>Theextension cord was removed immediately from service, and the power strips werereconfigured so as not to power another power strip.</b></p> <p>·howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken; <b>Allother residents have the potential to be affected.</b></p> <p>·whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur; <b>Allareas will be monitored by the hazardous inspection rounds performed by theDirector of Maintenance or designee to insure that the deficient practice doesnot recur.</b></p> <p>·Howthe corrective action(s) will</p>	05/25/2016

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	<p>Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 1 IT room. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff and up to 12 residents.</p> <p>Findings include:</p> <p>Based on observations with the Plant Operations Manager and the Maintenance Supervisor on 04/28/16 at 2:09 p.m., an outlet was missing a cover in the IT room. Based on interview at the time of observation, the Plant Operations Manager and the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place, <b>A summary log will be created to monitor, track and trend to insure the deficient practice does not recur. This log will be brought to the QA committee if negative trends are noted.</b></p> <p>- By what date the systemic changes will be completed. <b>The date certain will be May 25, 2016</b></p>	