

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155136	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/11/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1900 ANDREW AVE LA PORTE, IN 46350
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K010000	<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: 08/11/14</p> <p>Facility Number: 000061 Provider Number: 155136 AIM Number: 100288620</p> <p>Surveyor: Bridget Brown, Life Safety Code Surveyor</p> <p>At this Life Safety Code survey, Golden Living Center-Fountainview Terrace 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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in spaces open to the corridors with battery operated smoke</p>	K010000	<p>This Plan of Correction shall serve as this facility's credible allegation of compliance. Preparation, submission and implementation of the Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. Please consider allowing the submission of living center audits and education as evidence of compliance with the state and federal requirements identified in this survey. Beth Ingram Executive Director</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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K010018 SS=E	<p>detectors in the resident sleeping rooms. The facility has a capacity of 176 and had a census of 141 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the maintenance garage and storage shed.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure doors protecting</p>	K010018	Step One: The door to the coat closet was replaced with a door that positively latches into the	09/10/2014

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K010025 SS=E	<p>corridor openings in 1 of 14 smoke compartments could automatically latch into the door frame. This deficient practice affects staff, visitors and 10 or more residents in entry smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 2:15 p.m., double doors opening into the exit corridor near the DON's office for a storage closet were equipped with roller latches at the top of the doors which could not secure the doors tightly into the door frame. The maintenance director acknowledged at the time of observation, each door could be easily pulled open without disengaging a positive latch.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air</p>		<p>frame.Step Two: All doors were inspected to assure proper latching. All were found to properly latch.Step Three: The Executive Director will inspect all building improvements to assure compliance. Maintenance staff were educated regarding the life safety code. Step Four: The Executive Director or designee will report the results of building improvement audits to the QAPI team monthly for no less that six months. The QAPI team will determine the need for ongoing monitoring.</p>	

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	<p>conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings in a smoke partition such as a wall or ceiling, were sealed to limit the transfer of smoke in 1 of 14 smoke compartments. LSC 8.2.4.1 requires smoke partitions shall limit the transfer of smoke . This deficient practice could affect visitors, staff and 10 or more residents in the smoke compartment where the beauty shop is located.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 between 2:00 p.m. and 5:00 p.m.:</p> <p>a. Two conduits and a water line penetrated the ceiling behind the washers in the laundry. The cutouts for the materials were unsealed leaving two, one half by two inch gaps into the attic space above. The maintenance director said at the time of observation, he hadn't known the penetrations were unsealed.</p> <p>b Two cutouts in the drywall ceiling of the mechanical room were unsealed leaving an eight by eight inch and twelve by twelve inch opening into the space above the mechanical room. The maintenance director said at the time of observation, the cutouts were made to</p>	K010025	<p>Step One: The two conduits and water line penetrations in the ceiling were sealed properly, the two cutouts in the drywall ceiling in the mechanical room were sealed with drywall. The gap around the sprinkler head was sealed.</p> <p>Step Two: Walls, ceilings, sprinkler heads and other breakers in the ceiling were inspected to identify gaps and repaired if needed.</p> <p>Step Three: The Executive Director will inspect all building improvements or repairs to assure appropriate smoke barriers are maintained. Maintenance staff were educated regarding the life safety code.</p> <p>Step Four: The Executive Director or Designee will report compliance to the QAPI monthly for no less than six months. The QAPI team will determine the need for ongoing monitoring.</p>	09/10/2014

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K010029 SS=E	<p>repair water lines six or eight weeks ago. c. A one inch annular gap was unsealed in the ceiling around a sprinkler head protecting the dryer side of the laundry. The maintenance director acknowledged at the time of observation, the gap should have been sealed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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>1. Based on observation and interview, the facility failed to ensure doors to hazardous areas, closed automatically or</p>	K010029	Step One: An automatic closer was added to the door of the soiled utility room on the Villa. the gap in the wall between the	09/10/2014

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	<p>upon activation of the fire alarm system in 1 of 14 smoke compartments. This deficient practice affects visitors, staff and 10 or more residents in the Villa smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 3:40 p.m., the corridor door separating the soiled linen storage room on the Villa unit had no self closer. The room housed eight soiled linen receptacles, each with the capacity for 32 gallons or more, and each half or more full. The maintenance director said at the time of observation, the room was recently renovated to house the soiled linen receptacles and the door had not been equipped with the means to self close.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure a sprinklered hazardous area in 1 of 14 smoke compartments such as a storage room larger than 50 square feet was separated from an adjacent space by a smoke resistant partition. This deficient practice affects visitors, staff and 10 or more residents in the smoke compartment housing the beauty shop and</p>		<p>supply room and the locker room was closed. Step Two: All doors and partition walls were checked to assure compliance. No issues were identified. Step Three: The Executive director will inspect all building improvements to assure compliance. Maintenance staff were educated regarding the life safety code. Step Four: The Executive Director or Designee will report the results of building improvement audits to the QAPI team monthly for no less than six months. The QAPI team will determine the need for ongoing monitoring.</p>	

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K010038 SS=E	<p>administrative services offices.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 3:15 p.m., the wall partition between the central supply room and the adjacent locker room gapped 1/4 to 1/2 inches where the meeting edge of the wall and lay in ceiling did not meet. The room was larger than 50 square feet and housed medical equipment wrapped in plastic, paper and cardboard materials. The maintenance director acknowledged at the time of observation, the drywall had been cut unevenly and the edge between the wall and ceiling could not meet to provide a smoke tight partition.</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 exits for 2 of 14 smoke compartments were arranged to minimize tripping hazards in accordance with LSC Section 7.1. LSC Section 7.1 requires means of egress for existing buildings shall comply with Chapter 7.</p>	K010038	<p>Step One: Bids have been obtained to repair all identified trip hazzards. Work will be completed by 9/30/14. Step Two: All Exits have been inspected and will have repairs made if needed by 9/30/14 Step Three: The Maintenance department will inspect all walkways once weekly</p>	09/10/2014
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	<p>LSC Section 7.1.6 requires walking surfaces in the means of egress shall comply with 7.1.6.4. LSC 7.1.6.4 requires walking surfaces to be nominally level. This deficient practice could affect visitors, staff, and 10 or more residents using the corridor and dining room exits from the Memory Lane unit and the corridor exit from the Gardens unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 between 2:00 p.m. and 5:00 p.m., the concrete exit discharge surfaces for emergency exterior exits from the Memory Lane corridor, the Memory Lane dining room and the Gardens unit were each damaged by pitting and multiple irregular cracks across the width of the surface which made the surface uneven. The maintenance director said at the time of observation, the damage was weather related from the past winter and he had requested a quote for replacement or repair but nothing was scheduled to correct the problems.</p> <p>3.1-19(b)</p>		<p>to identify potential trip hazzards and schedule repair as needed. Maintenance staff were educated regarding the life safety code. Step Four: Results of the weekly inspections will be reported to QAPI monthly for no less than six months. The QAPI team will determine if audits may be discontinued.</p>		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to maintain the minimum distance between sprinklers in 1 of 14 smoke compartments. NFPA 13, 1999 Edition, at 5-7.3.4 requires sprinklers shall be spaced not less than 6 feet on center. This deficient practice affects staff, visitors and 10 or more residents on the Serenity unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 3:00</p>	K010056	<p>Step One: One of the sprinkler heads was removed for the space identified. Step Two: All areas of the building were inspected to identify sprinklers that are too close to each other. None were found. Step Three: The Executive Director will inspect all building improvements to assure compliance. Maintenance staff were educated regarding the life safety code. Step Four: the Executive Director or designee will report the results of building improvement audits to the QAPI team monthly for no less than six months. The QAPI team will determine the need for ongoing</p>	09/10/2014	

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K010062 SS=C	<p>p.m., two pendant ceiling sprinkler heads were spaced four and one half feet from one another in the Serenity unit pantry. The maintenance director said at the time of observation, a wall had been removed and the sprinkler protection had not been reevaluated by the contractor.</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 ensure sprinkler waterflow alarm devices were tested quarterly for 1 of 4 quarters. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, at 2-3.3 requires waterflow alarm devices including, but not limited to mechanical water motor gongs, vane-type waterflow devices, and pressure switches that provide audible or visual signals shall be tested quarterly. NFPA 25, 9-4.4.2.1 requires that the priming level shall be tested quarterly. NFPA 25, 9-7.1 requires that the fire department connections shall be</p>	K010062	<p>monitoring.</p> <p>Step One: The Sprinkler inspections were found in a difference section of the Life Safety book and are dated as follows 5/22/13, 8/12/13, 11/21/13, 2/19/14, 5/7/14 and 8/11/14. The documents have been attached for review. Step Two: Subsequent inspection reports are in place. Step Three: Sprinkler inspections will be placed in the Life Safety Book promptly to avoid miss filing and a copy will be maintained in a file in the maintenance offices as back up.. Maintenance staff were re-educated regarding the life safety code. Step Four: Results of the spinkler inspections will be reported the QAPI team on an</p>	09/10/2014

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K010064 SS=E	<p>inspected quarterly. NFPA 25, 1-8.1 requires that records shall indicate the procedure performed (inspection, test, or maintenance), the organization that performed the work, the results and the date. Finally, NFPA 25, 1-8 requires records of inspection, test, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to valve inspections, flow, drain, and pump tests; and trip tests of dry pipe, deluge and preaction valves. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on a review of sprinkler inspection reports with the maintenance director on 08/11/14 at 4:25 p.m., a quarterly sprinkler inspection report for the period between 08/12/13 and 02/19/14 was not found. The maintenance director said at the time of record review, there was no quarterly sprinkler inspection record for the fourth quarter of 2013.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all</p>		ongoing basis. The QAPI team will determine if more stringent oversight is required.		

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	<p>health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observation and interview, the facility failed to ensure 1 of 24 portable fire extinguishers was installed as required. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 1, 1-6.10 requires that the top of portable fire extinguishers weighing 40 pounds or less should be no more than five feet (60 inches) above the floor and those weighing more than 40 pounds should be no more than three and one half feet (42 inches) above the floor. This deficient practice affects visitors, staff and and 10 or more residents on the Rainbow unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 2:50 p.m., the portable fire extinguisher was measured at 68 inches above the finished floor in the Rainbow Lane exit corridor. The maintenance director said at the time of observation, he was unaware there was a 60 inch height limit for mounting a fire extinguisher.</p> <p>3.1-19(b)</p>	K010064	<p>Step One: The portable fire extinguisher was remounted to meet the code. Step Two: All fire extinguisher were inspected for proper mounting and were remounted as needed. Step Three: The Maintenance Director or Designee will inspect the fire extinguishers weekly for one month, then monthly for no less than five months to assure proper mounting. Maintenance staff were educated regarding the life safety code. Step Four: Audit results will be reported to the QAPI team monthly. The QAPI team will determine the need for ongoing audit.</p>	09/10/2014			

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K010076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 cylinders of nonflammable gases in the oxygen supply storage room were properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 10 or more residents on the Memory Lane unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 4:00 p.m., two oxygen cylinders were stored without support in the oxygen supply storage room with four liquid oxygen containers. The maintenance director</p>	K010076	<p>Step One: The Oxygen tanks were removed from the storage room. Step Two: Remaining Oxygen storage rooms were inspected for unsecured Oxygen tanks and none were found. Step Three: All Oxygen storage rooms will be inspected weekly for thirty days to identify unsecured Oxygen tanks. Inspections will be reduced to monthly for no less than five months if no tanks are found to be stored incorrectly. Corrective action will be taken immediately if tanks are found to be stored incorrectly. All staff will be educated to the proper storage of Oxygen Tanks. Step Four: Results of the inspections will be reported to QAPI monthly for no less than six months. The QAPI team will determine the need for a change in audits.</p>	09/10/2014			

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K010130 SS=E	<p>said at the time of observation, he did not know the cylinders had been stored there.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on record review, observation and interview; the facility failed to maintain 1 of 1 rolling fire doors in accordance with NFPA 80, 1999 Edition, Standard for Fire Doors and Fire Windows, 15-2.4.3 which requires all horizontal or vertical sliding and rolling fire doors shall be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice affects staff, visitors and and 30 or more residents in the dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 3:05 p.m., a vertical rolling fire door protected the service window to the kitchen. The last contracted inspection and testing report reviewed on 08/11/14 at 4:45 p.m.,</p>	K010130	<p>Step One: The vertical rolling fire door was inspected on 8/12/14. Te inspection has been attached for your review.The hangers were removed from the pipe and a do not hang sign was place near the gas pipe.Step Two: Vertical rolling fire doors are not used in any other part of the building. All other gas pipes were inspected for attachments and none were found.Step Three: The Inspection of the Vertical Rolling Door is scheduled on the Building Engines Preventative Maintenance Schedule and will remind the Maintenance Director of the inspection timing. Maintenance will inspect gas pipes for attachments once weekly, then twice monthly for no less than six months. Maintenance staff were educated regarding the life safety code.Step Four: Results of the fire door inspection will be reviewed by QAPI on an ongoing basis. Results of the pipe inspections will be reviewed by the QAPI team monthly for no less than six months. QAPI will determin the need for a change in</p>	09/10/2014
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	<p>noted an inspection was done on 03/08/13. The maintenance director said at the time of record review, he could find no more recent documentation of an inspection of the door. He immediately called the service contractor to request a more recent report. None was provided.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 natural gas supply pipes in the laundry was maintained to prevent physical damage. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring evacuation of occupants. This deficient practice could affect staff, visitors and 10 or more residents in the laundry smoke compartment shared with the dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 3:10 p.m., a natural gas pipe ran into the laundry and above the dryers. A two foot section of pipe was used as a hanger for the weight of 30 hangers which were hung there to dry. The maintenance director agreed at the time of observation,</p>		the audit process.				

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K010147 SS=E	<p>the natural gas pipe hangers supporting the installation was not designed to carry an additional load which could dislodge the pipe.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>1. Based on observation and interview, the facility failed to ensure electrical wiring and equipment was in compliance with NFPA 70, National Electrical Code in 1 of 14 smoke compartments. NFPA 70, Article 348.12(7) requires flexible metal conduit shall not be used where it is subject to physical damage. This deficient practice could affect staff, visitors and 10 or more residents in the laundry smoke compartment shared with the resident dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 3:10 p.m., flexible metal conduit was secured to the ceiling over the dryers in the laundry. Two wires at four intervals were used as the support for a metal pipe.</p>	K010147	<p>Step One: The flexible metal conduit was replaced. Power strips, multi plug adapters and extension cords were removed from the identified areas. Step Two: All electrical outlets were inspected to identify improper use of adapters, extension cords and power strips. Corrections were made as identified. Step Three: All staff were educated regarding the requirement that no power strips, multi plug adapters and extension cords may not be used. Maintenance will inspect four electrical outlets per week for one month, then four monthly for no less than five months. Step Four: Audit results will be reported to QAPI monthly for no less than six months. QAPI will determine if the audis schedule requires adjustment.</p>	09/10/2014			

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	<p>The maintenance director agreed at the time of observation, the conduit was not meant to be used as a hanger for pipe.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure extension cords including powerstrips and nonfused multiplug adapters were not used as a substitute for fixed wiring in 4 of 14 smoke compartments. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 10 or more residents in the Villa, Garden, Rainbow Lane and Fireside Smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 between 2:00 p.m. and 5:00 p.m., power strips, multiplug adapters or extension cords were located:</p> <ul style="list-style-type: none"> a. In the Rainbow Lane medicine room to power a refrigerator; b. On the bedside wall in room 26 to power an oxygen concentrator; c. In the resident lounge on Rainbow 			

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	<p>Lane to power an air conditioning unit installed in the wall (extension cord);</p> <p>d. Under the head of the bed in room 31;</p> <p>e. Under the desk in the housekeeping services office accessed through the laundry (extension cord);</p> <p>f. In the Clean Supply room and the business office (multi-plug adapters);</p> <p>g. In the Villa Pantry to power a refrigerator.</p> <p>The maintenance director acknowledged at the time of observations, this equipment was in use.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to maintain an electrical outlet in 1 of 14 smoke compartments. 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 visitors, staff and 10 or more residents in Rainbow Lane smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/11/14 at 2:35 p.m., an electric receptacle in the Rainbow Lane medicine room was</p>			

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	uncovered exposing the wiring. The maintenance director acknowledged at the time of observation, the wiring should have been protected by a face plate. 3.1-19(b)				