

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155200	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2014
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1564 S UNIVERSITY BLVD UPLAND, IN 46989
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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: 06/19/14</p> <p>Facility Number: 000107 Provider Number: 155200 AIM Number: 100290330</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, University Nursing 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 V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridors with battery operated smoke detectors in the resident rooms. The</p>	K010000	<p>Dear Ms. Rhoades, Attached is University Nursing Center's Plan of Correction for the recent annual Life Safety Code inspection. Please accept the plan as written. Thank you, Stephanie Allen, HFA, MHA Executive Director University Nursing Center</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>facility has a capacity of 75 and had a census of 60 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/30/14.</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 there were no impediments to the closing of 1 of 11 resident room doors protecting corridor</p>	K010018	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The wedge propping open room 112 was	07/19/2014			

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	<p>openings on the 100 hall. This deficient practice could affect residents in 1 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 06/19/14 at 1:07 p.m., the corridor door to resident room 112 was propped open with a wedge. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>		<p>removed from the door. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the deficient practice. The Environmental Services Manager or designee will conduct a whole facility round looking for wedges propping open doors and will remove any wedges propping open doors immediately. All staff will be inserviced by 7/19/14 by the ED pertaining to not using door wedges. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round to ensure no wedges propping open doors exist within the facility. Any wedges propping open doors will be immediately removed. Documentation by the Environmental Services Manager will exist to ensure rounds are occurring per the POC. How the corrective action will be monitored to ensure the deficient practice will not recur: The Environmental Services Manager or designee will conduct a daily round for four weeks and a weekly round for six months to ensure no wedges propping open doors exist within the facility with results of the audit reported to the monthly CQI meeting. Executive Director or</p>		

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K010025 SS=E	<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 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 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. This deficient practice could affect residents in 1 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 06/19/14 at 2:20 p.m., the attic access panel had been</p>	K010025	<p>designee will audit Environmental Services round weekly to ensure compliance. If 100% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date will the systemic changes will be completed: 7/19/2014</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The attic access panel was replaced and the ceiling penetrations were fixed by the Environmental Services Manager. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the deficient practiced. The Environmental Services Manager or designee will conduct a whole facility round looking for missing</p>	07/19/2014	

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K010027	<p>removed and not replaced. There were also two ceiling penetrations above ceiling tile near the service hall fire barrier door. The first penetration measured one inch around a telephone line and the second measured two inches around electrical conduit. Measurements were provided by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>attic access panels and ceiling penetrations; any issues will be immediately fixed. What measures will be put into place or whay systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round to ensure no missing attic access panels or ceiling penetrations exist. Any missing attic access panels or unsealed ceiling penetrations will be immediately fixed. Documentation by the Environmental Services Manager will exist to ensure rounding is occurring per POC. How the corrective action will be monitored to ensure the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round for four weeks and a weekly round for six months to ensure no ceiling penetrations and missing attic access panels exist with results of the audit reported monthly to CQI. Executive Director or designee will audit the Environmental Services round weekly to ensure compliance. If a 100% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date the systemic changes will be completed: 7/19/2014</p>		

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SS=E	<p>LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.6 requires doors in smoke barriers shall comply with LSC Section 8.3.4. LSC 8.3.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. The deficient practice could affect residents in 2 of 5 smoke compartments.</p> <p>Finding include:</p> <p>Based on observation with the Environmental Supervisor on 06/19/14 at 1:30 p.m. when the smoke barrier doors in the Cottage were closed, there was a one half inch gap between the two doors. At the time of observation, the Environmental Supervisor stated the unit was recently remodeled and the smoke</p>	K010027	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Cottage smoke barrier doors were fixed to ensure a gap greater than 1/8 inch does not exist. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the deficient practiced. The Environmental Services Manager or designee will conduct a whole facility round looking for gaps greater than 1/8 inch in smoke barrier doors and will immediately fix any issues. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round to ensure no smoke barrier doors have a gap greater than 1/8 inch and any issues will be immediately fixed. Documentation</p>	07/19/2014			

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K010029 SS=E	barrier doors had been replaced. 3.1-19(b) 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		by the Environmental Services Manager will exist to ensure rounding is occurring per POC. Any new construction on fire doors will be inspected immediately by Environmental Service Manager to ensure no gap greater than 1/8 inch. How the corrective action will be monitored to ensure the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round for four weeks and a weekly round for six months to ensure no gaps greater than 1/8 inch exist in smoke barrier doors with results of the audit reported monthly to CQI. Executive Director or designee will audit the Environmental Services round weekly to ensure compliance. If a 100% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date the systemic changes will be completed: 7/19/2014		

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	<p>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 the corridor doors to 1 of 1 kitchens, a hazardous area, self closed and latched into the door frame. This deficient practice affect residents in 1 of 5 smoke compartments.</p> <p>Findings includes:</p> <p>Based on observation with the Environmental Supervisor on 06/19/14 at 2:10 p.m., the kitchen was designed with double corridor doors. One door was equipped with a manual latching device that would latch into the door frame and the remaining door was designed to latch into the stationary door. Each door could not latch automatically, and independent of the other door, into the door frame. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010029	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The kitchen corridor doors will by fixed to ensure automatic latching and ability to independently latch into the door frame.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the deficient practiced. The Environmental Services Manager or designee will conduct a whole facility round to ensure all corridor doors automatically latch and independently latch into door frames; any issues will be immediately fixed.What measures will be put into place or whay systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round to ensure all corridor doors automatically latch and independently latch into door frames; issues will be immediately fixed. Documentation by the Environmental Services Manager will exist to ensure rounding is occuring per POC.How the corrective action will be monitored to ensure the deficient practice does not recur:</p>	07/19/2014	

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K010038 SS=F	<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>1. Based on observation and interview, the facility failed to ensure 7 of 7 exit doors in the path of egress equipped with a magnetic locking system remained unlocked with activation of the building fire protective signaling system. LSC 19.2.1 requires every corridor and exit be in compliance with Chapter 7. LSC 7.2.1.6.2.(d) requires actuation of the fire alarm system shall unlock the doors in the direction of egress and the doors shall remain unlocked until the fire alarm system has been manually reset. This deficient practice affects all occupants.</p>	K010038	<p>The Environmental Services Manager or designee will conduct a daily round for four weeks and a weekly round for six months to ensure all corridor doors automatically latch and independently latch into the door frame with results of the audit reported monthly to CQI. Executive Director or designee will audit the Environmental Services round weekly to ensure compliance. If a 100% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date the systemic changes will be completed: 7/19/2014</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The main entrance and 100 hall exit doors with magnetic locking systems were fixed to disengage when the fire alarm system activates and is silenced. Room 210 door lock was replaced with a knob that does not require a key. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: All residents have the potential to be affected by the</p>	07/19/2014

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	<p>Findings include:</p> <p>Based on an observation with the Environmental Supervisor on 06/19/14 from 3:10 p.m. to 3:20 p.m., the main entrance and the 100 hall exit doors which were equipped with a magnetic locking system failed to disengage when the fire alarm system was activated. All seven exit doors which were equipped with a magnetic locking system failed to remain unlocked when the fire alarm system was placed in silence mode. The magnetic locking system on each of the exit doors did released by entering the code. At the time of observation, the Environmental Supervisor acknowledged the main entrance and the 100 hall exit doors did not release upon activation of the fire alarm system and none of the seven exit doors released when the fire alarm system was placed in silence mode.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress from 1 of 41 resident room corridor doors serving as a means of egress was readily accessible for instant use in the event of fire. LSC Section 19-2, Means of Egress Requirements, requires every exit and access shall be in</p>		<p>deficient practiced. The Environmental Services Manager or designee will conduct a whole facility round ensuring all exit doors with magnetic locks disengage when fire alarm system is activate and silenced, with any issues being immediately fixed. The Environmental Services Manager or designee will also conduct a whole facility round to ensure all doors to rooms do not have a knob requiring a key to enter and exit, with any issues immediately fixed. What measures will be put into place or whay systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round to ensure all exit doors with magnetic locking systems disengage when fire alarm system is activated and silenced. The Environmental Services Manager or designee will also conduct a whole facility round to ensure all doors to rooms do not have a knob requiring a key to enter and exit. Any issues will be immediately fixed. Documentation by the Environmental Services Manager will exist to ensure rounding is occuring per POC. How the corrective action will be monitored to ensure the deficient practice does not recur: The Environmental Services Manager or designee will conduct a daily round for four weeks and a</p>				

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K010046 SS=B	<p>accordance with LSC Chapter 7. LSC 7.1.10, Means of Egress Reliability, requires the means of egress be maintained free of impediments to full instant use in case of fire or other emergency. This deficient practice affects 2 residents in room 210.</p> <p>Findings include:</p> <p>Based on observation with the Environmental Supervisor on 06/19/14 at 1:37 p.m., resident room 210 was equipped with a door lock that required a key to open from the corridor side. At the time of observation the Environmental Supervisor was asked how the door would be opened from the corridor if it were closed and locked. He said he did not know the door had a lock and did not know the location of the key.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p>		<p>weekly round for six months to ensure all exit doors with magnetic locking systems disengage when the fire alarm is activated and silenced; along with ensuring resident rooms doors do not have a knob requiring a key to enter and exit with results of the audit reported monthly to CQI. Executive Director or designee will audit the Environmental Services round weekly to ensure compliance. If a 100% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date the systemic changes will be completed: 7/19/2014</p>		

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	<p>Based on observation and interview, the facility failed to ensure 1 of 8 battery powered emergency lighting fixtures would operate. LSC 7.9.2.5 requires battery operated emergency lights shall be capable of repeated automatic operation. This deficient practice could affect residents in the 100 hall.</p> <p>Findings include:</p> <p>Based on observation with Environmental Supervisor on 06/19/14 at 1:15 p.m., the battery operated emergency light near resident room 116 failed to illuminate when tested. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>	K010046	<p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The battery operated emergency light near room 116 was fixed to illuminate when tested. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All resident shave the potential to be affected by the deficient practice. The Environmental Services Manager or designee will conduct a whole facility round looking for battery operated lights that do not illuminate when tested. Any issues will be immediately fixed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager of designee will conduct a daily round to ensure all battery operated lights worked when tested. Any issues will be immediately fixed. Documentation by the Environmental Services Manager will exist to ensure rounds are occurring per the POC. How the corrective action will be monitored to ensure the deficient practice will not recur: The Environmental Services Manager or designee will conduct a daily round for four weeks and a weekly round for six months to ensure all battery operated lights illuminate when tested with results of the audit</p>	07/19/2014	

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K010050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the "Monthly Fire Drill Report" with the Environmental Supervisor on 06/19/14 at 11:30 a.m., there was no record of a third shift fire drill for the fourth quarter of 2013.</p>	K010050	<p>reported to the monthly CQI meeting. Executive Director or designee will audit Environmental Services round weekly to ensure compliance. If 100% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date will the systemic changes will be completed: 7/19/2014</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: A third shift fire drill was held on 6/30/2014. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All resident shave the potential to be affected by the deficient practice. The Environmental Services Manager or designee will conduct a 3rd shift fire drill every quarter on altering dates and times. What meaures will be put into place or</p>	07/19/2014	

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K010130 SS=E	<p>Based on an interview with the Environmental Supervisor at the time of record review, no other documentation was available for review to verify this drill was conducted.</p> <p>3.1-19(b) 3.1-51(c)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetrations in 4 of 4 fire barrier walls were maintained to ensure the fire resistance of</p>	K010130	<p>what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager of designee will conduct a third shift fire drill once per quarter on alternating dates and times. Documentation by the Environmental Services Manager will exist to ensure fire drills are occurring per the POC. ED will review documentation of fire drills quarterly to ensure fire drills are occurring on alternating days, shifts, and times. How the corrective action will be monitored to ensure the deficient practice will not recur: The Environmental Services Manager or designee will conduct a 3rd shift fire drill quarterly for six months with results of the drill reported to the monthly CQI meeting. Executive Director or designee will audit Environmental Services round weekly to ensure compliance. If 100% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date will the systemic changes will be completed: 7/19/2014</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The unsealed penetrations were fixed</p>	07/19/2014	

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	<p>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 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 all occupants.</p>		<p>in the service hall, 100 hall, 300 hall, and 200 hall. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All resident shave the potential to be affected by the deficient practice. The Environmental Services Manager or designee will conduct a whole facility round looking for unsealed penetrations in fire barrier walls with issues to be immediately addressed. What meaures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager of designee will conduct a daily round to ensure all fire barrier walls do not have any unsealed penetrations. Documentation by the Environmental Services Manager will exist to ensure rounds are occuring per the POC. Environmental Services Manager will immediately check fire barrier walls when construction occurs to ensure no unsealed penetrations. How the corrective action will be monitored to ensure the deficient practice will not recur: The Environmental Services Manager or designee will conduct a daily round for four weeks and a weekly round for six months to ensure all fire barrier walls do not have any unsealed penetrations with results of the audit reported to the monthly CQI</p>	

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K010147 SS=E	<p>Findings include:</p> <p>Based on observations with the Environmental Supervisor on 06/19/14 from 2:20 p.m. to 2:45 p.m., the following fire barrier walls in the attic had unsealed penetrations:</p> <p>a. in the service hall, 100 hall and 300 hall measuring one inch around a camera line</p> <p>b. in the 200 hall measuring one inch around IT lines</p> <p>At the time of the observations, the Environmental Supervisor said a new camera system was recently installed.</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>Based on observation and interview, the facility failed to ensure 5 of 5 flexible cords were not used as a substitute for fixed wiring to provide power for medical equipment. 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</p>	K010147	<p>meeting. Executive Director or designee will audit Environmental Services round weekly to ensure compliance. If 100% threshold is not met on any of the above indicators, an internal plan of correction will be devised to ensure compliance. By what date will the systemic changes will be completed: 7/19/2014</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The power strips were removed in rooms 109, 113, 112, and the sprinkler riser room. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents</p>	07/19/2014	

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	<p>wiring of a structure. This deficient practice could affect 5 residents.</p> <p>Findings include:</p> <p>Based on observations with the Environmental Supervisor on 06/19/14 from 1:05 p.m. to 1:19 a.m., the following equipment was plugged in and supplied with electricity by an extension cord power strip:</p> <p>a. a nebulizer in resident room 109 and 113</p> <p>b. a nebulizer and a concentrator in resident room 112</p> <p>c. another power strip supplying electricity to IT equipment and an additional power strip supplying electricity to the camera system in the sprinkler riser room. Both power strips were plugged into the same power strip. This was acknowledged by the Environmental Supervisor at the time of observations.</p> <p>3.1-19(b)</p>		<p>have the potential to be affected by the deficient practice. The Environmental Services Manager or designee will conduct a whole facility round looking for power strips in use with medical equipment and IT equipment and will immediately remove any power strips being inappropriately used. ED will inservice staff regarding not using power strips for any medical equipment by 7/19/2014. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Environmental Services Manager of designee will conduct a daily round to ensure no power strips are being used inappropriately. Any issues will be immediately fixed. Documentation by the Environmental Services Manager will exist to ensure rounds are occurring per the POC. How the corrective action will be monitored to ensure the deficient practice will not recur: The Environmental Services Manager or designee will conduct a daily round for four weeks and a weekly round for six months to ensure no power strips are being inappropriately used with results of the audit reported to the monthly CQI meeting. Executive Director or designee will audit Environmental Services round weekly to ensure compliance. If 100% threshold is not met on any of the above indicators, an internal plan of</p>		

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			correction will be devised to ensure compliance. By what date will the systemic changes will be completed: 7/19/2014		