

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E064	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2011
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NAME OF PROVIDER OR SUPPLIER BROOKSIDE HAVEN	STREET ADDRESS, CITY, STATE, ZIP CODE 505 N GAVIN ST MUNCIE, IN47303
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K0000	<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: 11/14/11</p> <p>Facility Number: 000311 Provider Number: 15E064 AIM Number: 100285520</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Brookside Haven 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 spaces open to the corridors. The facility has a capacity of 42 and had a census of 38 at the time of this survey.</p>	K0000	K-000This Plan of Correction is prepared and executed because it is required by the provisions of the State and Federal regulations, and not because Brookside Haven agrees with the allegations and citations listed on this statement of deficiencies. This Plan of Correction shall operate as Brooksdie Haven's written credible allegation of Compliance.	

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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K0018 SS=E	<p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/18/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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 1 of 18 doors on east hall had no impediment to closing. This deficient practice could affect 18 residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/14/11 at 1:00 p.m. with the Maintenance Supervisor, the door leading into the Employee</p>	K0018	K-0181.) We immediately removed metal door stop from employee break-room on east hall to ensure closure.2.) All residents have the potential to be affected.3.) Maintenance supervisor will monitor facility throughout and will be placed on the preventive maintenance routine rounds.4.) This citation will be monitored by all staff and maintenance supervisor will report to the Q.A. Committee quarterly for 6 months to ensure	12/12/2011

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K0027 SS=F	<p>breakroom on east hall was prevented from closing because the door was held open with a metal doorstop. Based on interview on 11/14/11 at 1:05 p.m. with the Maintenance Supervisor, it was acknowledged the breakroom door had an attached doorstop which held the door open.</p> <p>3.1-19(b)</p> <p>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 Based on observation and interview, the facility failed to ensure 2 of 2 sets of smoke barrier doors were equipped with the appropriate hardware to allow the door which must close first, to always close first so both doors will always close completely as a pair. The Centers for Medicare & Medicaid Services (CMS) requires sets of smoke barrier doors which swing in the same direction and are equipped with an astragal to have a</p>	K0027	<p>compliance.5.) Date Completed 12/12/11.</p> <p>K-0271.) We immediately scheduled to have coordinators placed on 2 of 2 sets of smoke barriers doors.2.) All residents have the potential to be affected.3.) Maintenance supervisor will monitor door closure during regular scheduled inspections and monthly fire drills and will document results on fire drill report form.4.) This will be reported to the quarterly Q.A. Committee to ensure</p>	12/12/2011	

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	<p>coordinator to ensure the door without the astragal always closes first. This deficient practice could affect 38 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 11/14/11 during the tour between 12:01 p.m. and 12:59 p.m. with the Maintenance Supervisor, the set of smoke barrier doors on east hall and the set of smoke barrier doors on west hall which swung in the same direction and were equipped with an astragal, lacked a coordinator. Based on interview on 11/14/11 at the time of the observations with the Maintenance Supervisor, it was acknowledged the aforementioned sets of smoke doors which swung in the same direction and lacked a coordinator to allow the door without the astragal to close first.</p> <p>3.1-19(b)</p>		compliance.5.) Date Completed 12/12/11.		

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K0029 SS=E	<p>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>Based on observation and interview, the facility failed to ensure 2 of 4 doors leading to hazardous areas such as a laundry or a kitchen were provided with self closing devices which would cause the door to automatically close and latch into the door frame. This deficient practice affects 18 residents on east hall and 6 residents observed in the dining room adjacent to the kitchen as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 11/14/11 at 2:00 p.m. with the Maintenance Supervisor, the laundry corridor door and the kitchen corridor door were not provided with a self closing device. Based on interview on 11/14/11 at 2:20 p.m. with the Maintenance Supervisor, the aforementioned corridor doors leading into hazardous areas were not equipped with a self closing device.</p>	K0029	<p>K-0291.) We immediately installed the self closing devices on laundry and kitchen doors.2.) All residents have the potential to be affected.3.) Maintenance supervisor will monitor to ensure closers are in place and in good working order weekly, K-029 placed on preventive maintenance check list.4.) This will be reported to the quarterly Q.A. Committee to ensure compliance for 6 months.5.) Date Completed 12/12/11.</p>	12/12/2011			

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K0038 SS=F	<p>3.1-19(b)</p> <p>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 3 of 3 exit doors with electromagnetic locks unlocked while the fire alarm system was activated. LSC 19.2.1 requires every aisle, passageway, corridor, exit discharge, exit location, and access to be in accordance with Chapter 7. LSC 7.2.1.6(a) requires doors with special locking arrangements such as electromagnetic locks to unlock upon actuation of an approved fire alarm system installed in accordance with LSC 9.6. LSC 9.6.1.4 requires a fire alarm system to be installed, tested and maintained in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72, 3-9.7.2 requires all emergency exits connected to the fire alarm system unlock upon receipt of any fire alarm signal by the fire alarm system serving the protected premises. This deficient practice could affect 38 residents as well as staff and visitors utilizing the east, west and main exits.</p>	K0038	<p>K-0381.) Immediately during survey Koorsen Fire and Security replaced Relay Switch to ensure 3 of 3 exit doors with elctromagnetic locks unlocked while the fire alarm was sounding.2.) All residents have the potential to be affected.3.) (A) Maintenance supervisor will monitor during monthly fire drills and regular scheduled inspections with Koorsen Fire and Security to ensure electromagnetic locks unlock when fire alarm system is activated and documented on report form. (B) One of the two locks on each office door of the Administrators office and the Activity office was immediately removed to ensure compliance.4.) This will be reported on by the maintenance supervisor to the Q.A. Committee for 6 months.4.) Date Completed 12/12/11.</p>	12/12/2011

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	<p>Findings include:</p> <p>Based on observation on 11/14/11 at 3:10 p.m. during a fire alarm test with the Maintenance Supervisor, the electromagnetic locks on the east, west and main exits remained locked when the fire alarm was activated. Based on interview on 11/14/10 at 3:20 p.m. it was acknowledged by the Maintenance Supervisor the aforementioned exit doors equipped with electromagnetic locks did not unlock when the fire alarm system was activated.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure exit access was arranged so 2 of 45 exit access doors were not equipped with 2 locking devices on the doors. Section 19.2.2.2.5 requires means of egress are permitted to be locked, but only one locking device shall be permitted on each door. This deficient practice could affect 18 residents on east hall and 8 residents observed on center hall as well as visitors and staff in the facility.</p> <p>Findings include:</p> <p>Based on observations on 11/14/11 at 1:22 p.m. and 1:45 p.m. with the</p>			

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K0048 SS=E	<p>Maintenance Supervisor, the Administrator's office on center hall and the Activities office on east hall had a door knob lock and a deadbolt lock for each door leading out the offices. Based on interview on 11/14/11 concurrent with the observations with the Maintenance Supervisor, it was acknowledged there were two locking devices on each door which provided a means of egress from the Administrator's and the Activities offices.</p> <p>3.1-19(b)</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for 	K0048	K- 0481.) Immediately updated Fire Disaster Plan to include K Class Fire extinguisher in relationship with the use of the overhead extinguishing system.Maintenance supervisor in-serviced all staff on location and use of the K Class extinguisher.2.) All residents have the potential to be affected.3.) Maintenance supervisor will monitor fire extinguishers daily, and to enclude K Class extinguisher to ensure compliance.4.) This citation will continue to be monitored and maintenance supervisor will report to the Q. A. Committee quarterly for 6 months.5.) Date	12/12/2011	

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	<p>evacuation (8) Extinguishment of fire This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen.</p> <p>Findings include:</p> <p>Based on a review of the facility's written fire disaster plan on 11/14/11 at 2:45 p.m. with the Maintenance Supervisor, the fire disaster plan did not include the use of the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system.</p> <p>Based on an interview on 11/14/11 at 2:50 p.m. with the Maintenance Supervisor, it was acknowledged the written fire safety plan for the facility did not include mention of the K class fire extinguisher.</p> <p>3.1-19(b)</p>		Completed 12/12/11.		

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K0051 SS=F	<p>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>1. Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/14/11 at 3:10 p.m. with the Maintenance Supervisor, the</p>	K0051	<p>K-0511.) We immediately placed the red markings on the fire alarm circuit control for identification and locked for security, (authorized personnel only).2.) All residents have the potential to be affected.3.) Control box placed on preventive maintenance check list daily and the maintenance supervisor will report to the administrator any noted changes.4.) Administrator and maintenance supervisor will monitor daily and maintenance supervisor will report to the Q.A. Committee quarterly for 6 months.5.) Date Completed 12/12/11.</p>	12/12/2011

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	<p>fire alarm system circuit breaker located next to the reception desk on center hall lacked identification and was accessible to anyone. Based on interview on 11/14/11 at 3:15 p.m. with the Maintenance Supervisor, he was not aware the fire alarm circuit breaker was to be identified and the panel box should be locked.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 4 smoke detectors on center hall and 1 of 3 smoke detectors on east hall were installed in a location which would allow the smoke detectors to function to its fullest capability. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 5 residents observed on center hall and 18 residents on east hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 11/14/11 during the tour between 12:45 p.m. to 1:10 p.m. with the Maintenance Supervisor, smoke detectors number four and eight on center hall and smoke detector number nine on east hall were within two feet of an air</p>			

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K0062 SS=F	<p>supply ceiling vent. Based on interview on 11/14/11 concurrent with the observations with the Maintenance Supervisor, it was acknowledged the aforementioned smoke detectors were installed within three feet from an air supply vent in the ceiling which would interfere with the smoke detector's ability to detect smoke to its fullest capability.</p> <p>3.1-19(b)</p> <p>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 1 of 1 dry sprinkler systems was maintained in reliable operating conditions. This deficient practice could affect 38 residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on Sprinkler System Inspection record review on 11/14/11 at 3:30 p.m. with the Maintenance Supervisor, an inspection report of the sprinkler system done on 11/07/11 indicated in the</p>	K0062	<p>K-0621.) We immediately notified Koorsen Fire and Security for inspection/repair of 1 of 1 dry sprinkler systems to maintain in reliable operating conditions.2.) All residents have the potential to be affected.3.) Maintenance supervisor and administrator will review scheduled fire and security inspections to ensure if repairs are required that they are scheduled immediately and completed.4.) Maintenance supervisor will report to Q.A. Committee quarterly fro 6 months.5.) Date Completed 12/12/11.</p>	12/12/2011	

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K0064 SS=E	<p>comments section the water motor gong did not work. Based on interview on 11/14/11 at 3:33 p.m., it was acknowledged by the Maintenance Supervisor he was unsure if repairs had been made and was unable to provide any documentation to verify such repairs.</p> <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all 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 maintain 1 of 2 portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will automatically shut off the fuel source to</p>	K0064	<p>K-0641.) Immediately had Koorsen Fire and Security place label for the Class K fires conspicuously near the extinguisher in the kitchen.2.) All residents have the potential to be affected.3.) Maintenance supervisor will monitor to ensure compliance with the Class K extinguisher weekly.4.) Maintenance supervisor will monitor placement and posting for the Class K extinguisher and will report to the Q.A. Committee any follow any recommendations.5.) Date Completed.</p>	12/12/2011

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	<p>the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 11/14/11 at 2:08 p.m. with the Maintenance Supervisor, there was a K class extinguisher conspicuously placed on the east wall of the kitchen, but it lacked a placard. Based on interview on 11/14/11 at 02:10 p.m. with the Maintenance Supervisor, it was acknowledged the K class portable fire extinguisher was not provided with a placard.</p> <p>3.1-19(b)</p>				

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K0066 SS=F	<p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation, record review and interview; the facility failed to ensure cigarette butts were deposited into a noncombustible container provided for 2 of 2 areas where smoking was permitted and to ensure a metal container with a self closing lid was provided for 1 of 2 smoking areas. This deficient practice could affect 18 residents on east hall and 20 residents on west hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/14/11 during</p>	K0066	K-0661.) Immediately removed plastic thirty gallon trash container from the west end. A noncombustible container with lid has been placed in designated smoking areas. Immediately in-serviced staff as to cigarette butts being tossed on the grounds and reviewed smoking policy.2.) All residents have the potential to be affected.3.) maintenance supervisor will monitor facility grounds, all entrance daily to ensure cigarette butts are disposed of per policy.4.) Maintenance supervisor will monitor grounds to ensure compliance with facility smoking policy and will report to the	12/12/2011	

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	<p>a tour of the facility between 1:02 p.m. to 2:15 p.m. with the Maintenance Supervisor, a plastic thirty gallon trash container used for paper goods in the smoking area just outside the west exit was used for the disposal of thirty three cigarette butts. Furthermore, the smoking area outside the east exit had nineteen cigarette butts strewn about the ground and an employee was observed smoking without a metal container with a self closing lid. Based on review of the smoking policy on 11/14/11 at 3:32 p.m. with the Maintenance Supervisor, the smoking policy did address the proper disposal of extinguished cigarette butts. Based on interview on 11/14/11 at 3:38 p.m. with the Maintenance Supervisor, it was acknowledged the facility's employees disposed of cigarette butts into an unapproved plastic container with paper goods, or on the ground.</p> <p>3.1-19(b)</p>		<p>quarterly Q.A. Committee.5.) Date Completed 12/12/11.</p>		

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K0143 SS=F	<p>Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage rooms where oxygen transfer occurs was separated within a one hour fire barrier enclosure. This deficient practice could affect 18 residents on east hall as well as visitors and staff near the oxygen storage room.</p> <p>Findings include:</p> <p>Based on observation on 11/14/11 at 1:22 p.m. with the Maintenance Supervisor, the door to the oxygen transfer room on east hall lacked a manufacturer's tag to verify its fire rating. Based on interview on 11/14/11 at 1:23 p.m. with the Maintenance Supervisor, oxygen transfer occurs in the storage room and the fire rating of the corridor door to the oxygen transfer room could not be found, or</p>	K0143	K- 01431.) Immediately scheduled for door replacement to ensure fire rating of a min. of one hour for storage and transfer of oxygen.2.) All residents have the potential to be affected.3.) Maintenance supervisor will monitor the oxygen door to ensure security.4.) Maintenance Supervisor will report on this citation to the Q. A. Committee quarterly. 5.) Date Completed 12/12/11.	12/12/2011	

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K0147 SS=E	<p>verified with any other documentation.</p> <p>3.1-19(b)</p> <p>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 1 of 1 multiplug adapters and 1 of 1 powerstrips were not used as a substitute for fixed wiring. This deficient practice could affect 2 residents in room 8 and residents in the dining room as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on observations on 11/14/11 between 1:15 p.m. and 2:25 p.m. with the Maintenance Supervisor, one multiplug adapter was connected to a dual prong outlet next to the fireplace in the main dining room and a six prong powerstrip was used to power a Unimac washing machine in the laundry room. Based on interview on 11/14/11 at 2:27 p.m. with the Maintenance Supervisor, it was acknowledged a six prong multiplug and a</p>	K0147	<p>K-1471.) Immediately removed one of one multi-plug adapters in dining room and one of one power-strips in laundry. Maintenance supervisor made a thorough facility round to ensure there were no further multi-plugs or power strips and re-educated maintenance supervisor.2.) All residents have the potential to be affected.3.) Daily rounds are made by the facility administrator, Director of Nursing and the maintenance supervisor to ensure multi-plugs and power strips are not in use.4.) Maintenance supervisor will report to the Q.A. Committee quarterly and will follow any recommendations.5.) date Completed. 12/12/11.</p>	12/12/2011	

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	<p>powerstrip was used as a substitute for fixed wiring in the main dining room and the laundry room.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 electrical wires observed protruding from the ceiling in the laundry room were confined in a junction box with a cover. NFPA 70, National Electrical Code, 1999 Edition, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice could affect 18 residents on east hall as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 11/14/11 at 2:25 p.m. with the Maintenance Supervisor, two electrical wires were jutting out of the ceiling next to the vent in the laundry room without being confined in a junction box with a cover. Based on interview on 11/14/11 at 2:27 p.m. with the Maintenance Supervisor, it was acknowledged the electrical wires jutting out of the ceiling were not protected within a junction box.</p> <p>3.1-19(b)</p>				

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