

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2015
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NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 303 NOTRE DAME, IN 46556
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 7/13/15</p> <p>Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990</p> <p>At this Life Safety Code survey, Holy Cross Village at Notre Dame Inc. 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 with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The original building built in 1964 with the Dujarie Wing added in 1980, the Murphy Wing in 1985 and the Quinn Wing, which is a noncertified comprehensive care unit, in 2007. The</p>	K 0000	<p>Holy Cross Village at Notre Dame, Inc. (Provider)</p> <p>submits this Plan of Correction (POC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits the POC with the intention that it be in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 0025 SS=E Bldg. 01	<p>facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors and hard wired smoke detectors in resident sleeping rooms. The facility has a capacity of 39 and had a census of 32 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered exit. All areas which provide facility services are sprinklered.</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 conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the</p>	K 0025	<p>increase in future remedies, whether such remedies are imposed by then Centers for Medicare and Medicaid Services (CMS), the state of Indiana, or any other entity; or (2) serve, in anyway, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis. Please accept this plan of correction as our credible allegation of compliance for the Life Safety Survey conducted by the Indiana State Department of Health on 7/13/15. We respectfully ask for a desk review and opportunity for paper compliance.</p>	07/24/2015

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	<p>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 staff and 4 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Plant Operations Manager, Director of Plant Operations and the Administrator in Training on 07/13/15 from 12:52 p.m. to 2:54 p.m. the following was discovered:</p> <p>a) Two inch penetration around conduit sealed with insulation in the Soiled Utility room in Memory Care.</p> <p>b) A six square inch penetration around sprinkler pipe in the Electrical Closest near resident room 111.</p> <p>c) A three quarter inch penetration near fire wall next to resident room 216.</p> <p>Based on interview at the time of each observation, the Plant Operations Manager, Director of Plant Operations and the Administrator in Training acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>		<p>We found no residents, staff, or visitors were affected by this deficiency. Provider sealed all deficient areas with approved fire barrier sealant. (See attachment 1). Monthly inspections of Dujarie will be completed, per LSC 8.3.2, over a period of nine months. (See attachment 8). These inspections will be recorded and reported to the Quality Assurance Committee for the next three quarterly meetings. Corrections were completed on 7/24/15. (See attachment 7 for reference of the material data sheets).</p>	

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K 0044 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Horizontal exits, if used, are in accordance with 7.2.4. 19.2.2.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 6 fire door sets was arranged to automatically close and latch. LSC 19.2.2.5 requires horizontal exits to be in accordance with 7.2.4 and 7.2.4.3.8 requires fire doors to be self closing or automatic closing in accordance with 7.2.1.8. In addition NFPA 80, Standard for Fire Doors and Windows at 2-1.4.1 requires all closing mechanisms shall be adjusted to overcome fire resistance of the latch mechanism so that positive latching is achieved on each door operation. This deficient practice could affect at least 20 residents and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/13/15 at 1:44 p.m. with the Plant Operations Manager, Director of Plant Operations and the Administrator in Training, the fire door near the transfilling oxygen room failed to latch into the frame. Based on interview at the time of observation, the Plant Operations Manager, Director of Plant Operations and the Administrator in Training acknowledged the aforementioned condition. The Plant</p>	K 0044	<p>We found no residents, staff, or visitors were affected by this deficiency. Provider installed a new door closer to ensure that the door is self-closing and has a positive automatic latch. (See attachment 2). Monthly inspections of the fire doors will be done, per LSC 19.2.2.5, for nine months. (See attachment 8). These inspections will be recorded and reported to the Quality Assurance Committee for the next three quarterly meetings. Correction will be completed on 7/27/15.</p>	07/27/2015

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K 0062 SS=D Bldg. 01	<p>Operations Manager confirmed these were fire doors.</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 observation and interview, the facility failed to replace 1 of 1 corroded sprinklers in the walk-in refrigerator and 1 of 1 frozen sprinkler heads in the walk-in freezer. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice was not located in a patient treatment area but could affect any kitchen staff in the area.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager on 07/13/15 at 1:52 p.m., an automatic sprinkler in the</p>	K 0062	<p>We found no residents, staff, or visitors were affected by this deficiency. The sprinkler heads will be replaced with stainless steel heads. They will be insulated from the head in the attic to the actual sprinkler to prevent ice build-up. Monthly inspections of the sprinkler heads will be completed, per LSC 9.7.5, for nine months. (See attachment 8). These inspections will be recorded and reported to the Quality Assurance Committee for the next three quarterly meetings. Correction will be completed on 7/27/15.</p>	07/27/2015

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K 0068 SS=D Bldg. 01	<p>walk-in refrigerator was corroded with a green substance. An automatic sprinkler in the walk-in freezer had a large build-up of ice that would affect the spray pattern if activated. Based on interview at the time of each observation, the Plant Operations Manager acknowledged the condition of the sprinkler heads.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 1 main laundry rooms was provided with intake combustion air from the outside for rooms containing fuel fired equipment in accordance with LSC Section 19.5.2.2. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for staff in the laundry room.</p> <p>Findings include:</p> <p>Based on an observation with the Plant Operations Manager, Director of Plant Operations and the Administrator in Training on 07/13/15 at 2:06 p.m., the</p>	K 0068	We found no residents, staff, or visitors were affected by this deficiency. All fuel fired dryers were removed and replaced with electric dryers. (See attachment 3). The correction occurred on 7/21/15.	07/21/2015

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K 0072 SS=D Bldg. 01	<p>laundry room had fuel fired dryers with no fresh air intake. Based on interview at the time of observation, the Plant Operations Manager, Director of Plant Operations and the Administrator in Training acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and interview, the facility failed to ensure the means of egress was continuously maintained free of all obstructions or impediments to full instant use for 1 of 5 exits. This deficient practice could affect 10 residents and staff.</p> <p>Findings include:</p> <p>Based on observation on 07/13/15 at 11:57 a.m. with the Plant Operations Manager, Director of Plant Operations and the Administrator in Training, the egress path from the exit near resident room 133 was impeded by a zip tie</p>	K 0072	<p>We found no residents, staff, or visitors were affected by this deficiency. The child-proof cabinet lock was removed from the exterior gate near room 133. (See attachment 4). Monthly inspections of gate exits will be completed, per LSC 7.1.10, for nine months. (See attachment 8). The inspections will be recorded and reported to the Quality Assurance Committee for the next three quarterly meetings. Correction was completed on 7/13/15.</p>	07/13/2015

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K 0130 SS=D Bldg. 01	locking the courtyard gate. Based on interview at the time of observation, the Plant Operations Manager acknowledged the deficiency and explained it was to prevent residents from wandering off. 3.1-19(b) NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 6 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose.	K 0130	We found no residents, staff, or visitors were affected by this deficiency. Openings in fire wall were sealed with approved fire stop material. (See attachment 5). (See attachment 7 for reference of the material data sheets). Monthly inspections of the fire wall will be completed, per LSC 8.2.3.2.4.2, for nine months. (See attachment 8). Inspections will be recorded and reported to the Quality Assurance Committee for the next three quarterly meetings. The correction was completed on 7/17/15. The rolling fire door between the kitchen and main dining room will be serviced and inspected by a certified contractor. The door will be tagged, approved, and fully operational. The inspection of the door will be documented and added to the annual inspection log. Correction will be completed on 8/10/15.	08/10/2015

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	<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 residents in 2 of 5 smoke compartments.</p> <p>Findings include:</p> <p>Based on an observation with the Plant Operations Manager, Director of Plant Operations and the Administrator in Training on 07/13/15 at 2:46 p.m., there was two separate three quarter inch and one single half inch penetrations around cables in the fire wall near resident room 216. Based on interview at the time of observation, the Plant Operations Manager, Director of Plant Operations and the Administrator in Training acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review</p>			

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	<p>and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment, or system required for compliance with this Code shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to 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 could affect any resident, staff or visitor in the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the Plant Operations Manager, Director of Plant Operations and the Administrator in Training on 07/13/15 during the tour from 11:38 a.m. to 2:49 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room and based on interview with the Plant Operations Manager, Director of Plant</p>			

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K 0147 SS=E Bldg. 01	<p>Operations and the Administrator in Training no documentation of an annual inspection was available for review.</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 2 of 2 multiplug adapters, 3 of 3 extension cords, and 3 of 3 surge protectors was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 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 1 resident in resident room 119, 1 resident in resident room 154, 4 residents and staff in Therapy, staff.</p> <p>Findings include:</p> <p>Based on an observation with the Plant Operations Manager, Director of Plant Operations and the Administrator in</p>	K 0147	<p>We found no residents, staff, or visitors were affected by this deficiency.</p> <p>A) Adapter was removed on 7/13/15.</p> <p>B) Extension cord was removed on 7/13/15.</p> <p>C) Surge protector was removed and a new outlet was installed. Completed on 7/20/15.</p> <p>D) One of the surge protectors will be removed. Items will be placed on a single surge protector. Correction will be completed on 7/31/15.</p> <p>E) Refrigerator was removed from the surge protector on 7/13/15. A new circuit will be installed on 8/3/15.</p> <p>F) Multi-plug adapter was removed on 7/13/15. A new</p>	08/03/2015

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K 0000 Bldg. 02	<p>Training on 07/17/2015 between 11:57 a.m. and 2:08 p.m. the following was discovered:</p> <ul style="list-style-type: none"> a) Multiplug adapter in resident room 119 powering a clock and a lamp b) Extension cord in resident room 154 powering a clock and a lamp c) Surge protector powering a treadmill in Therapy d) Surge protector powering another surge protector in the Basement IT room e) Surge protector powering a fridge in the Director of Nursing office f) Multiplug adapter powering a multiplug extension cord powering speakers and a coffee pot, also an extension cord powering a phone charger in the Administrator office. <p>Based on interview at the time of each observation, the Plant Operations Manager, Director of Plant Operations and the Administrator in Training acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>A Life Safety Code Recertification and State Licensure Survey was conducted by</p>	K 0000	<p>circuit will be installed on 8/3/15.</p> <p>G) Multi-plug adapter was removed and appliances were plugged directly into the wall outlet on 7/13/15.</p> <p>(See attachment 5). Monthly inspections for multi-plug adapters, extension cords, and surge protectors will be completed for nine months. (See attachment 8). Any unapproved items will be removed or corrected as found. Inspections will be documented and reported to the Quality Assurance Committee for the next three quarterly meetings.</p>	
			Holy Cross Village at Notre	

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	<p>the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 7/13/15</p> <p>Facility Number: 002668 Provider Number: 155745 AIM Number: 200325990</p> <p>At this Life Safety Code survey, Holy Cross Village at Notre Dame Inc. 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 with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The original building built in 1964 with the Dujarie Wing added in 1980, the Murphy Wing in 1985 and the Quinn Wing, which is a noncertified comprehensive care unit, in 2007. The facility has a fire alarm system with smoke detection on all levels including in the corridors, in spaces open to the corridors and hard wired smoke detectors in resident sleeping rooms. The facility</p>		<p>Dame, Inc. (Provider)</p> <p>submits this Plan of Correction (POC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits the POC with the intention that it be in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by then Centers for Medicare and Medicaid Services (CMS), the state of Indiana, or</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155745	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>02</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/13/2015
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NAME OF PROVIDER OR SUPPLIER HOLY CROSS VILLAGE AT NOTRE DAME INC	STREET ADDRESS, CITY, STATE, ZIP CODE PO BOX 303 NOTRE DAME, IN 46556
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K 0025 SS=E Bldg. 02	<p>has a capacity of 39 and had a census of 32 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered exit. All areas which provide facility services are sprinklered.</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 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</p>	K 0025	<p>any other entity; or (2) serve, in anyway, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceedings on that basis. Please accept this plan of correction as our credible allegation of compliance for the Life Safety Survey conducted by the Indiana State Department of Health on 7/13/15. We respectfully ask for a desk review and opportunity for paper compliance.</p> <p>We found no residents, staff, or visitors were affected by this deficiency. Provider sealed all deficient areas with approved fire barrier sealant. (See attachment</p>	07/24/2015

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K 0147 SS=D Bldg. 02	<p>be continuous from an outside wall to an outside wall. This deficient practice could affect facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Plant Operations Manager, Director of Plant Operations and the Administrator in Training on 07/13/15 at 1:02 p.m., multiple gaps around conduit partially sealed by fire caulk and fire stop pillows in Housekeeping in Murphy Hall. Based on interview at the time of observation, the Plant Operations Manager, Director of Plant Operations and the Administrator in Training acknowledged the aforementioned condition and were unable to provide documentation for the fire stop pillows used.</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 1 of 1 multiplug adapter was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National</p>	K 0147	<p>1). Monthly inspections of Dujarie will be completed, per LSC 8.3.2, over a period of nine months. (See attachment 8). These inspections will be recorded and reported to the Quality Assurance Committee for the next three quarterly meetings. Corrections were completed on 7/24/15. (See attachment 7 for reference of the material data sheets).</p> <p>We found no residents, staff, or visitors were affected by this deficiency.</p> <p>A) Adapter was removed on 7/13/15.</p>	08/03/2015

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	<p>Electrical Code, 1999 Edition. NFPA 70, 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 facility staff.</p> <p>Findings include:</p> <p>Based on an observation with the Plant Operations Manager, Director of Plant Operations and the Administrator in Training on 07/13//2015 at 12:03 p.m., a multiplug adapter was located in the Dujarie laundry room. A washer and dryer were plugged into a multiplug adapter. Based on interview at the time of observation, the Plant Operations Manager, Director of Plant Operations and the Administrator in Training acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>B) Extension cord was removed on 7/13/15.</p> <p>C) Surge protector was removed and a new outlet was installed. Completed on 7/20/15.</p> <p>D) One of the surge protectors will be removed. Items will be placed on a single surge protector. Correction will be completed on 7/31/15.</p> <p>E) Refrigerator was removed from the surge protector on 7/13/15. A new circuit will be installed on 8/3/15.</p> <p>F) Multi-plug adapter was removed on 7/13/15. A new circuit will be installed on 8/3/15.</p> <p>G) Multi-plug adapter was removed and appliances were plugged directly into the wall outlet on 7/13/15.</p> <p>(See attachment 5). Monthly inspections for multi-plug adapters, extension cords, and surge protectors will be completed for nine months. (See attachment 8). Any unapproved items will be removed or corrected as found. Inspections will be documented and reported to the Quality Assurance Committee for the next three quarterly meetings.</p>	