

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155166	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  09/04/2015
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NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383
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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: 09/04/15</p> <p>Facility Number: 000083 Provider Number: 155166 AIM Number: 100289670</p> <p>At this Life Safety Code survey, Valparaiso Care and Rehabilitation 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 II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in resident sleeping rooms. The facility has a capacity of 164 and had a census of 124</p>	K 0000	<p>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 9/4/15. We respectfully ask for a desk review and opportunity for paper compliance.</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=F Bldg. 01	<p>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 two garages and one shed used for facility storage.</p> <p>Quality Review completed 09/10/15 - DA</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 and 1 of 1 smoke barrier walls were maintained to provide a one 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 all occupants.</p> <p>Findings include:</p>	K 0025	<p>K 025-</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>It is the practice of Valparaiso Care and Rehab to ensure ceiling smoke barriers and smoke barrier walls are maintained to provide a one hour fire resistance rating. We found no residents, staff, or visitors were</p>	10/04/2015

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	<p>Based on observations with the Maintenance Supervisor on 09/04/15 from 10:58 a.m. to 12:56 p.m., the following smoke barrier wall penetration and unsealed ceiling penetrations were noted:</p> <p>a) a two inch by two inch ceiling penetration in the West Wing Mechanical Room</p> <p>b) a three inch and a two inch penetration around cables in the smoke barrier above the drop ceiling near resident room 201</p> <p>c) a one eighth inch penetration above the drop ceiling in the smoke barrier near resident room 111</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged and provided the measurements for each unsealed penetration.</p> <p>3.1-19(b)</p>		<p>affected by this deficiency.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken;</b></p> <p>All residents have the potential to be affected by this deficiency, in the event of a fire, and if the deficiency is not corrected. However, we found no residents, staff, or visitors to have been affected by this deficiency and corrections have been made to correct the problem.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The ceiling penetration in the West Wing Mechanical Room, resident room 201 and resident room 111 have been sealed with fire caulk. An inspection of all fire walls have been inspected by the Maintenance Director and are sealed appropriately. Corrections were completed on 9/16/15.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>Maintenance Director will routinely audit all fire walls to ensure smoke</p>		

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K 0052 SS=F Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 1 of 1 smoke detectors systems were maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the</p>	K 0052	<p>barriers are maintained to provide a one hour fire resistance. These inspections will be recorded and reported to the Quality Assurance Committee for the next three quarterly meetings.</p> <p><b>Systemic changes will be completed by October 4, 2015</b></p> <p>K052</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>It is the practice of Valparaiso Care and Rehab to ensure the smoke detector systems are maintained in accordance with National Fire Code. We found that no resident, staff, or visitor was affected by this deficiency. The smoke detector sensitivity will be checked within 1 year after installation and every alternating year thereafter.</p> <p><b>How other residents having the potential to be affected by the</b></p>	10/04/2015

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	<p>frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method</li> <li>(2) Manufacturer ' s calibrated sensitivity test instrument</li> <li>(3) Listed control equipment arranged for the purpose</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction</li> </ol> <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review of Vanguard Alarm Service smoke detector record</p>		<p><b>same deficient practice will be identified and what corrective action (s) will be taken;</b></p> <p>All residents have the potential to be affected by this deficient practice. The vendor contracted with Valparaiso Care and Rehab to perform the smoke detector sensitivity test completed the testing on 9-10-15. The "Smoke Detector Sensitivity Test Report" is available for review.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Director will note the due date for upcoming smoke detector sensitivity tests in his Annual Preventative Maintenance Manual to monitor for completion.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>The Maintenance Director will note the due date for upcoming smoke detector sensitivity tests in his Annual Preventative Maintenance Manual to monitor for completion.</p> <p><b>Systemic changes will be completed by October 4, 2015</b></p>				

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K 0056 SS=D Bldg. 01	<p>titled "Smoke Detector Sensitivity Test Report" with the Maintenance Supervisor on 09/04/15 at 9:51 a.m., the last smoke detector sensitivity test on all hard wired smoke detectors occurred on 06/05/13. Based on an interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on observation and interview, the facility failed to ensure a complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Edition, Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. NFPA</p>	K 0056	<p>K056 –</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p>	10/04/2015

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	<p>13, Section 5-6.3.4, " Minimum Distance between Sprinklers " , states sprinklers shall be spaced not less than 6 feet on center. In addition, LSC 19.1.1.4.5 requires minor renovations, alterations, modernizations, or repairs shall not reduce life safety below the level that previously existed. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation and interview on 09/04/15 at 11:51 a.m. with the Maintenance Supervisor, two of the ten sprinkler heads in the Kitchen were less than four feet apart. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurement.</p> <p>3.1-19(b)</p>		<p>A local contractor will relocate the sprinkler head in the Kitchen in order to create the sprinkler protection coverage necessary to provide adequate sprinkler protection. The work will be completed prior to October 4, 2015. No residents reside in this area. No residents were affected by this deficiency.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken;</b></p> <p>All residents have the potential to be affected by this deficient practice. We found no residents, staff, or visitors were affected by this deficient practice</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Director will perform audits of sprinker heads and to ensure they are free from corrosion 1x/week for 3 months and 1x/month thereafter as part of our Preventative Maintenance Program.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p>	

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K 0062 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace 1 of 6 painted sprinkler heads and 2 of 10 corroded sprinkler heads in the Kitchen. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected 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</p>	K 0062	<p>The Maintenance Director will perform audits of sprinkler heads and to ensure they are free from corrosion 1x/week for 3 months and 1x/month thereafter as part of our Preventative Maintenance Program. The Maintenance Director or designee will monitor sprinkler heads on routine rounds. The results of the audit will be recorded bi-annually as they are tested. Sprinkler heads will be reviewed as part of the CQI program.</p> <p><b>Systemic changes will be completed by October 4, 2015</b></p> <p><b>K062 –</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>It is the practice of Valparaiso Care and Rehab to ensure the automatic sprinkler heads are free from paint, corrosion and/or damage and to ensure all sprinkler heads are attached and contain escutcheons.</p>	10/04/2015

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	<p>shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation on 09/04//15 at 11:51 a.m. then again 12:16 p.m., two Kitchen sprinkler heads were corroded. Then again one sprinkler head was painted in the East Day room. Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each of the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Dietary Kitchen and 1 of 1 water softener room sprinkler heads in the facility were maintained. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations on 09/04/15 at 11:01 p.m. then again at 11:45 a.m., one West Wing Dietary Kitchen sprinkler heads was missing an escutcheon. Then again one Water Softener room sprinkler head was missing an escutcheon. Based</p>		<p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken;</b></p> <p>No residents reside in the areas identified to be deficient. This deficiency has the potential to affect staff who work in this area. The vendor contracted with the facility for maintenance and repairs of sprinkler system will perform inspection and repairs by October 4, 2015.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Director or designee will audit the sprinkler heads throughout the facility at least monthly as part of the preventative maintenance program and the results of those audits will be documented for 6 months. These results will be reviewed as part of the CQI program. Contractor will also supply facility with additional sprinkler heads and escutcheons for replacement and repair as needed throughout the year.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p>	

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K 0064 SS=E Bldg. 01	<p>on interview at the time of each observation, the Maintenance Supervisor acknowledged each of the aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 1 fire extinguisher in the West Wing South Hall was maintained. NFPA 10 4-2.1 requires a "quick check" that a fire extinguisher is available and will operate. It is intended to give reasonable assurance that the fire extinguisher is fully charged and operable. This is done by verifying that it is in its designated place, that it has not been actuated or tampered with, and that there is no obvious or physical damage or condition to prevent its operation. This deficient practice could affect staff and up to 18 residents.</p> <p>Findings include:</p>	K 0064	<p>The Maintenance Director or designee will record the results of these audits of the sprinkler heads in the Preventative Maintenance Manual. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately.</p> <p><b>Systemic changes will be completed by October 4, 2015</b></p> <p><b>K064 –</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>It is the practice of Valparaiso Care and Rehab to ensure fire extinguishers are in designated place, that it has not been actuated or tampered with and that there is no obvious or physical damage or condition to prevent its operation. The Maintenance Director inspected the portable fire extinguisher in the West Wing South Hall and installed a supportive hanger.</p> <p><b>How other residents having the</b></p>	10/04/2015

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	<p>Based on observation with the Maintenance Supervisor on 09/03/15 at 11:22 a.m., the one fire extinguisher in the West Wing South Hall was not hung up on its supporting hanger. Further observation revealed that the pin that prevents the extinguisher from discharging was bent around the handle, preventing removal during an emergency. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and immediately replaced the fire extinguisher.</p> <p>3.1-19(b)</p>		<p><b>potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken;</b></p> <p>All residents have the potential to be affected. The Maintenance Director inspected all portable fire extinguishers on 9-15-15 and documented that they had been inspected to ensure that they are available, secured appropriately and will operate.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Director or designee will complete the "Preventative Maintenance Performed This Month" auditing tool and reference "Fire Extinguishers" monthly as part of the preventative maintenance program and will update tags accordingly. The "Preventative Maintenance Performed This Month" tool will be reviewed as part of the CQI program.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>If the audit results in anything lower than 100% then the Director or</p>	

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K 0143 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD 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</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 liquid oxygen storage areas where oxygen transferring takes place, was provided with continuous mechanical ventilation. This deficient practice could affect staff and at least 22 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 09/04/15 at 10:29 a.m. then again at 10:30 a.m., the</p>	K 0143	<p>designee will correct the deficiency immediately.</p> <p><b>Systemic changes will be completed by October 4, 2015</b></p> <p><b>K143-</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>We found no residents, staff, or visitors to have been affected by this deficient practice.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be</b></p>	10/04/2015

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NAME OF PROVIDER OR SUPPLIER  VALPARAISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383
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	<p>West Wing oxygen storage room then again the West Wing oxygen transfill room both had a switch outside the room to shut the fan in the each room off. Based on interview at the times of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p><b>identified and what corrective action (s) will be taken;</b></p> <p>If gone uncorrected, this deficient practice could potentially affect staff and up to 22 residents. Action was taken to correct the deficiency and to prevent negative impact on residents. The continuous mechanical ventilation system in both the oxygen storage and the oxygen refill rooms are now equipped with keyed switches. The keys are stored in the lock box in the maintenance shop. Correction was completed on 9/18/15.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Ventilation systems in each room are now equipped with keyed switches, which will prevent them from being shut off by anyone other than the Maintenance Supervisor or his designee.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>Routine audits will be conducted to ensure the ventilation in the oxygen rooms is continuous. Audits will be recorded monthly in the Preventative Maintenance Manual.</p>	

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K 0147 SS=E Bldg. 01	<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 32 of 32 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 28 residents.</p> <p>Findings include:</p> <p>Based on observation with Maintenance Supervisor on 09/04/15 between 10:02 a.m. to 12:36 p.m. the following was discovered:</p> <p>a) A surge protector was powering another surge protector powering computer components in the Office Manager office.</p>	K 0147	<p>Findings will be presented to QA committee at the next three quarterly meetings.</p> <p><b>Systemic changes will be completed by October 4, 2015</b></p> <p><b>K147 –</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The Maintenance Director removed the power strip that the refrigerator in the The Maintenance Director removed all deficient power strips or surge protectors. High voltage items such as refrigerators, microwaves, and dehumidifiers were plugged directly into surged protected outlets.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken;</b></p> <p>All residents have the potential to be</p>	10/04/2015

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	<p>b) A surge protector was powering another surge protector powering computer components in the Executive Director's office</p> <p>c) A surge protector was powering a microwave and a coffee pot in the Admissions office</p> <p>d) A surge protector was powering another surge protector powering computer components in the Activities room</p> <p>e) A surge protector was powering a refrigerator in the SDC office</p> <p>f) A surge protector was powering a microwave in resident room 207</p> <p>g) A surge protector was powering a microwave in resident room 203</p> <p>h) A surge protector was powering an extension cord and two other surge protectors powering oxygen equipments in the West Wing Medication Room</p> <p>i) A surge protector was powering another surge protector powering a refrigerator in the West Wing Unit Manager's office</p> <p>j) A surge protector was powering a fridge in resident room 222</p> <p>k) A surge protector was powering a microwave and refrigerator in resident room 213</p> <p>l) A surge protector was powering a microwave and refrigerator in resident room 225</p> <p>m) A surge protector was powering a</p>		<p>affected. The Maintenance Director completed an audit of the entire facility to ensure that there was not any use of power strips that did not comply with LSC K147. The facility was 100% in compliance.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The Maintenance Director or designee will complete an all staff in service to educate the staff not to utilize power strips.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</b></p> <p>The Maintenance Director or designee will perform a Power Strip Audit weekly for 4 weeks and then monthly for 6 months to ensure compliance. This audit will be recorded on the "Power Strip" audit tool. The results of this audit will be reviewed as part of the CQI program. If the audit results in anything lower than 100% then the Director or designee will correct the deficiency immediately.</p> <p><b>Systemic changes will be completed by October 4, 2015</b></p>				

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	<p>refrigerator in resident room 234</p> <p>n) A surge protector was powering a microwave in the MDS office</p> <p>o) A surge protector was powering a microwave and refrigerator in resident room 240</p> <p>p) A surge protector was powering a refrigerator in resident room 238</p> <p>q) A surge protector was powering a refrigerator in resident room 202</p> <p>r) A surge protector was powering a dehumidifier and a refrigerator in the Dietary Office</p> <p>s) A surge protector was powering a refrigerator in resident room 104</p> <p>t) A surge protector was powering a refrigerator in resident room 135</p> <p>u) A surge protector was powering a refrigerator in resident room 133</p> <p>v) A surge protector was powering another surge protector powering computer components in Therapy</p> <p>w) A surge protector was powering a refrigerator in resident room 103</p> <p>x) A surge protector was powering a microwave and a refrigerator in resident room 107</p> <p>Based on interview at the time of observation, the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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