

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  11/23/2015
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NAME OF PROVIDER OR SUPPLIER  BEN HUR HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 S GRANT AVE CRAWFORDSVILLE, IN 47933
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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: 11/23/15</p> <p>Facility Number: 000461 Provider Number: 155401 AIM Number: 100275290</p> <p>At this Life Safety Code survey, Ben Hur Health and Rehabilitation 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 facility, which consisted of one story building additions with a partial basement to a two story facility, was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in resident Room 612 and 613 in Wing 9. The</p>	K 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Ben Hur Health and Rehabilitation that the allegations contained in this survey report are accurate, or reflect accurately the provision of service to the residents of Ben Hur Health and Rehabilitation.	
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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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K 0025 SS=E Bldg. 01	<p>facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 110 and had a census of 84 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached equipment storage and maintenance building.</p> <p>Quality Review completed 12/01/15 - 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 2 ceiling smoke barriers was maintained to provide at least a one half hour fire resistance rating. This deficient practice could affect 10 residents, staff and visitors in Wing 10.</p>	K 0025	I. Please note no residents were affected by the opening in the Wing 10 ceiling smoke barrier. The light fixture which had been removed pending renovations of this area has been reinstalled to correct this and ensure the appropriate one half hour fire resistance rating for the	12/09/2015

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K 0048 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:20 p.m. on 11/23/15, a six inch long by one inch wide hole was noted in the ceiling smoke barrier in the corridor near the Wing 10 storage room by the lounge. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned hole in the Wing 10 ceiling smoke barrier failed to maintain at least a one half hour fire resistance rating for the ceiling smoke barrier.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 document a complete written health care occupancy fire safety</p>			K 0048	<p>ceiling smoke barrier is in place. Please see photograph attached – Attachment #1. II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other areas to ensure there are no other ceiling smoke barrier issues. III. The Environmental Services Supervisor will check monthly during building preventative maintenance rounds to ensure there are no breaches in ceiling smoke barriers. If issues are identified, they will be repaired as expeditiously as possible. IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided – See Attachment #2. Results of the monitoring by the Environmental Services Supervisor will be provided to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of fire resistance ratings of ceiling areas. V. Due to evidence submitted, facility requests desk review and paper compliance of K025.</p> <p>I. Please note no residents were affected by the lack of identification of the location of smoke barrier doors/fire doors in</p>		12/09/2015

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	<p>plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2.</p> <p>(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 evacuation (8) Extinguishment of fire</p> <p>This deficient practice affects all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Plan" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 11/23/15, the written health care occupancy fire safety plan for the facility did not identify the location of smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. Section E.1a "Fire/Explosion Emergency Action Plan" of the aforementioned written fire safety plan stated "Keep all smoke/fire doors closed". Under Section 1.b "Fire Procedure" states "Continue moving in</p>		<p>the facility "Disaster Preparedness Plan." Revisions have been made to the plan to specify the location of all smoke barrier/fire doors in the facility – see evidence provided by attachment of revision of page 43 of the facility Disaster Preparedness Plan (Attachment#3). II. As all residents have the potential to be affected, all copies of the facility "Disaster Preparedness Plan" have been revised as noted above. III. As routine reviews are made to the facility Disaster Preparedness Plan, the Executive Director will ensure that smoke barrier/fire doors are noted appropriately for staff reference. IV. The Executive Director will be responsible to review the facility Disaster Preparedness Planas required, and will report to the Quality Assurance Committee any necessary revisions during monthly meetings for the next quarter, and then annually thereafter if changes are made. V. Due to evidence submitted, facility requests desk review and paper compliance of K048.</p>	

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K 0062 SS=F Bldg. 01	<p>sequence all people in the area until all are past the fire compartment doors. Do not go back through fire doors". Based on interview at the time of record review, the Maintenance Supervisor acknowledged the location of smoke barrier doors and fire doors are not identified in the written fire safety plan for the facility for evacuation purposes.</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 Based on record review, observation and interview; the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and</p>	K 0062	I. Please note no residents were affected by the lapse in timely sprinkler inspections. The agency responsible for completion of the quarterly sprinkler systems will no longer be providing services to our facility, as a new agency has been contracted beginning in January, 2016. II. As all residents have the potential to be affected, the newly contracted agency will supply a schedule for completion of all required testing of the facility's sprinkler system	12/09/2015

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	<p>Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of Vanguard Alarm Services "Quarterly Sprinkler Inspection Report" documentation dated 05/27/15 and 10/01/15 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 11/23/15, it had been 126 days in between the two quarterly sprinkler inspections. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:20 p.m. on 11/23/15, Armor Fire Protection had affixed a hanging tag to the sprinkler system riser stating water flow alarm testing of the sprinkler system was performed in May 2015 and October 2015. Based on interview at the time of record review and of the observation, the Maintenance Supervisor stated Armor Fire Protection is a subcontractor for Vanguard Alarm Services, no additional sprinkler system inspection</p>		<p>for the calendar year 2016. Please refer to attached information sheets (Attachment #4 A &amp; B) which delineate required inspections for Fire Suppression Systems, Tests and Inspections to be completed by the newly contracted agency throughout 2016. III. The Executive Director will be responsible to verify that the scheduled inspections are completed as scheduled by the newly contracted agency. IV. The Executive Director will be responsible to report to the Quality Assurance Committee on a monthly basis any failure of the newly contracted agency to satisfy obligations for inspection of the facility fire suppression system. V. Due to evidence submitted, facility requests desk review and paper compliance of K062.</p>				

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K 0069 SS=D Bldg. 01	<p>documentation after 05/27/15 but before 10/01/15 was available for review and acknowledged it had been 126 days in between the two aforementioned quarterly sprinkler inspections.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 1. Based on record review and interview, the facility failed to ensure 1 of 1 hood extinguishing systems in the kitchen was inspected and serviced every six months. NFPA 96, the Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 1999 edition, Section 8-2 requires an inspection and servicing of the fire extinguishing system at least every six months. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:  Based on review of Vanguard Alarm</p>	K 0069	<p>1 &amp; 2 I. Please note no residents were affected by the lapse in timely inspection of the kitchen hood extinguishing equipment. The agency responsible for completion of the hood inspection every six months will no longer be providing services to our facility, as a new agency has been contracted beginning in January, 2016. Additionally, a report of service provided on 10/26/15 by Richard's Hood and Duct Cleaning Service was not provided for review to the surveyor, as it was still in processing for payment in the billing office. This report is attached for reference, (Attachment#5) and indicates testing and cleaning of fans,</p>	12/09/2015	

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	<p>Services "Periodic Range Hood &amp; Suppression System Testing &amp; Inspection Report" documentation dated 08/19/14 and 10/01/15 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 11/23/15, documentation of semiannual hood extinguishing systems inspection six months prior to 10/01/15 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated Vanguard Alarm Services performed the two most recent semiannual hood extinguishing systems inspections but acknowledged documentation of semiannual hood extinguishing systems inspection six months prior to 10/01/15 was not available for review.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 1998 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 8-3.1 requires the entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person(s) in accordance with Table 8-3.1. Table 8-3.1, Exhaust System Inspection</p>		<p>electrical systems, and filters for the kitchen hood exhaust system on 10/26/15. II. As all residents have the potential to be affected, the newly contracted agency will supply a schedule for completion of required inspection and cleaning of kitchen hood and fire suppression systems for the calendar year 2016. Please refer to attached information sheets which delineate required inspections for the kitchen hood and fire suppression systems. (Attachments #4 A &amp; B) III. The Executive Director will be responsible to verify that the scheduled inspections are completed as scheduled by the newly contracted agency. IV. The Executive Director will be responsible to report to the Quality Assurance Committee on a monthly basis any failure of the newly contracted agency to satisfy obligations for inspection and cleaning of the facility kitchen hood and exhaust system. V. Due to evidence submitted, facility requests desk review and paper compliance of K069.</p>	

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	<p>Schedule, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 8-3.1.1 says, upon inspection, if found to be contaminated with deposits from grease laden vapors, the entire exhaust system shall be cleaned in accordance with Section 8-3. NFPA 8-3.1 requires hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. This deficient practice could affect five staff and visitors in the kitchen.</p> <p>Findings include:</p> <p>Based on review of Richard's Hood &amp; Duct Cleaning Service's "Exhaust Removal System's Report" documentation dated 04/20/15 with the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 11/23/15, documentation of semiannual kitchen exhaust systems inspection six months after 04/20/15 was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:20</p>			

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	<p>p.m. on 11/23/15, a sticker was affixed to the kitchen range hood indicating the most recent hood inspection was performed by Richard's Hood &amp; Duct in April 2015. No other kitchen exhaust systems inspection documentation after 04/20/15 was available for review. Based on interview at the time of record review and of the observation, the Maintenance Supervisor acknowledged documentation of semiannual kitchen exhaust systems inspection six months after April 2015 was not available for review.</p> <p>3.1-19(b)</p>						
K 0130 SS=C Bldg. 01	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on record review, observation and interview; the facility failed to maintain a preventive maintenance program for battery operated smoke detectors installed in 59 of 61 resident sleeping rooms. LSC 4.6.12.2 requires existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p>	K 0130	<p>I. Please note no residents were affected by the lack of documentation of annual cleaning of battery operated smoke detectors. The smoke detectors had been cleaned within the last 12 months, during routine weekly checks of the smoke detectors, but the cleaning was not documented. Maintenance staff have now cleaned each battery operated smoke detector again on 12/9/15, and documented</p>	12/09/2015			

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	<p>Findings include:</p> <p>Based on review of "Ben Hur Weekly Testing Battery Operated Smoke Alarms" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 11/23/15, documentation of an itemized list by location of battery operated smoke detector cleaning during the most recent twelve month period was not available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the aforementioned weekly battery operated smoke detector testing documentation only includes functional testing of the detectors and acknowledged documentation of an itemized list by location of battery operated smoke detector cleaning during the most recent twelve month period was not available for review. Based on observation with the Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:20 p.m. on 11/23/15, a Kidde Ionization Smoke Alarm Model i9040 battery operated smoke detector was installed in Room 85 in Wing 10. Manufacturer's instructions affixed to the back of the battery operated smoke detector stated to "gently vacuum or use clean compressed air annually" to clean the smoke detector. Based on</p>		<p>such on the appropriate record – please see attached report (Attachment #6) II. As all residents have the potential to be affected, maintenance staff have been inserviced on ensuring proper documentation of annual cleaning of all smoke detectors. III. Records of smoke detector cleaning and testing will be provided to the Executive Director for review to ensure all requirements are met. IV. Any failure of maintenance staff to ensure appropriate cleaning of smoke detectors at least annually will be reported by the Executive Director to the Quality Assurance Committee during routine meetings. V. Due to evidence submitted, facility requests desk review and paper compliance of K130.</p>	

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K 0144 SS=F Bldg. 01	<p>interview at the time of observation, the Maintenance Supervisor stated the facility has the same model battery operated smoke detector installed in each of 59 resident sleeping rooms in the facility and acknowledged an itemized list by location of annual battery operated smoke detector cleaning documentation for the most recent twelve month period was not available for review.</p> <p>3.1-19(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>Based on record review and interview, the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 3 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and</p>	K 0144	<p>I. Please note no residents were affected by the transfer time of the generator exceeding 10 seconds. The emergency generator has been adjusted by a contractor to ensure that the transfer time does not exceed 10 seconds when tested under load. See report attached – Attachment #7. II. As all residents have the potential to be affected, maintenance staff have been instructed to make appropriate adjustments or contact a contractor for repair if it is noted during routine testing that the emergency generator does not</p>	12/11/2015

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K 0147 SS=E Bldg. 01	<p>repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on review of "Emergency Generator - Weekly Exercise/Monthly Generator Test" and "Emergency Generator - Monthly Test Log" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 11/23/15, monthly load test documentation for 06/10/15, 09/30/15 and 10/28/15 lists the transfer time as, respectively, 11 seconds, 12 seconds and 11 seconds. Based on interview at the time of record review, the Maintenance Supervisor stated emergency power is not consistently transferred to the emergency generator in ten seconds or less and acknowledged it took greater than ten seconds to transfer power to the emergency generator for the aforementioned three monthly load tests.</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</p>		<p>transfer power in 10 seconds or less during load. III. Records of emergency generator testing will be provided to the Executive Director for review to ensure all requirements for transfer of power are met during routine testing. IV. Any failure of the emergency generator to transfer power appropriately during testing will be reported by the Executive Director to the Quality Assurance Committee during routine meetings. V. Due to evidence submitted, facility requests desk review and paper compliance of K144.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155401	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  11/23/2015
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	<p>Electrical Code. 9.1.2</p> <p>1. Based on record review, observation and interview; the facility failed to ensure 5 of 5 extension cords including power strips were not used as a substitute for fixed wiring. 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. LSC Section 4.5.6 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 1999 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 7-5.2.2.1 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could</p>	K 0147	<p>#1 I. Please note no residents were affected by the use of the extension cords/power strips noted. All of the cords noted in this citation have been resolved by rearranging equipment and resident areas so that it is no longer necessary to utilize a substitute for fixed wiring. II. As all residents have the potential to be affected, the Environmental Services Supervisor has been instructed to evaluate use of all equipment and appliances during routine building rounds, and resolve issues appropriately when encountered. III. The Environmental Services Supervisor will report to the Executive Director any issues related to appropriate use of power strips, and alternatives will be arranged to accommodate the resident's needs. IV. Any inappropriate use of electrical extension cords and the resolve of the issue will be reported by the Executive Director to the Quality Assurance Committee during routine monthly meetings. V. Based on evidence submitted, facility requests desk review and paper compliance of K147. #2 I. Please note no residents were affected by the opening in the Wing 10 ceiling smoke barrier. The light fixture which had been removed pending renovations of this area has been reinstalled to correct this and ensure the appropriate one half hour fire</p>	12/09/2015	

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	<p>affect 9 residents, staff and visitors in Wing 2.</p> <p>Findings include:</p> <p>Based on review of "Disaster Preparedness Plan" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to 12:30 p.m. on 11/23/15, it is stated on page 49 of the aforementioned plan "The use of extension cords in lieu of permanent wiring is prohibited". Based on interview at the time of record review, the Maintenance Supervisor acknowledged extension cords are not to be used in the facility. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:20 p.m. on 11/23/15, the following was noted:</p> <p>a. a refrigerator was plugged into a power strip in the Marketing and Admissions Office. In addition, a computer backup device was plugged into an extension cord under the desk in the office.</p> <p>b. an oxygen concentrator and a Synergy Air Elite Dynamic Low Air Less Alternating System device attached to the foot of the bed was plugged into a power strip under the resident bed in Room 17.</p> <p>c. the resident bed and a phone charger were plugged into a power strip which was hung from a wall hook one foot above the bed in Room 19.</p>		<p>resistance rating for the ceiling smoke barrier is in place. II. As all residents have the potential to be affected, the Environmental Services Supervisor inspected all other areas to ensure there are no other ceiling smoke barrier issues. III. The Environmental Services Supervisor will check monthly during building preventative maintenance rounds to ensure there are no breaches in ceiling smoke barrier. If issues are identified, they will be repaired as expeditiously as possible. IV. Evidence of the form to be utilized for monitoring during monthly building rounds is provided – Attachment #2. Results of the monitoring by the Environmental Services Supervisor will be provided to the Executive Director, who will report to the Quality Assurance Committee during quarterly meetings any failure of fire resistance ratings of ceiling areas. V. Based on evidence submitted, facility requests desk review and paper compliance of K147.</p>				

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	<p>d. a lamp was plugged into a power strip which was under the resident bed in Room 20. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned locations.</p> <p>3.1-19(b)</p> <p>2. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed was maintained in a safe operating condition. LSC 19.5.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 1999 Edition. NFPA 70, 1999 Edition, Article 370-28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect 10 residents, staff and visitors in Wing 10.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor during a tour of the facility from 12:30 p.m. to 2:20 p.m. on 11/23/15, a 4 inch by 12 inch electrical junction box with numerous wire connections jutting out of the box without a cover was noted on the ceiling</p>			

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	<p>in the corridor near the Wing 10 storage room by the lounge. Based on interview at the time of observation the Maintenance Supervisor stated a light fixture was removed for an upcoming remodeling project which exposed the junction box and acknowledged the electrical junction box was without a cover was noted on the ceiling in the corridor near the Wing 10 storage room by the lounge.</p> <p>3.1-19(b)</p>				