

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155292	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
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NAME OF PROVIDER OR SUPPLIER  AMERICAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2026 E 54TH ST INDIANAPOLIS, IN 46220
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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: 01/28/16</p> <p>Facility Number: 000189 Provider Number: 155292 AIM Number: 100267330</p> <p>At this Life Safety Code survey, American Village 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>American Village consists of two wings, Harrison Hall which is one story and Washington Manor which is two stories. This facility was determined to be of Type III (211) construction and was fully sprinklered except for the closet in the restroom in the Moving Forward Lounge. The east wing of the second floor of Washington Manor houses the Moving</p>	K 0000	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Sprinkler added to closet in the restroom on Moving Forward Lounge where residents have customary access. <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> All residents have the potential to be affected by the alleged deficient practice. It will be the practice of the provider to ensure that all areas that residents have customary access have a sprinkler in place. <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> Environmental Service Supervisor, Administrator to ensure and monitor that all areas that residents have customary access have sprinkler. <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> The Environmental Service Supervisor or designee will monitor through the Preventive Maintenance Program.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 0011 SS=E Bldg. 01	<p>Forward rehab wing. The facility has a fire alarm system with smoke detection on all levels in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in 59 of 82 resident sleeping rooms. The facility has smoke detectors hard wired to the facility's electrical system in 23 of 82 resident sleeping rooms. The facility has a capacity of 150 and had a census of 138 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered except for the closet in the restroom in the Moving Forward Lounge. All areas providing facility services were sprinklered except for a detached storage and repair shed.</p> <p>Quality Review on 02/04/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 doors on the second floor in the fire barrier wall separating health care from the assisted living occupancy provided the protection</p>	K 0011	<p>ComplianceDate: February 5, 2016</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A Latching Plate/ Striking Plate has been affixed to the door frame to ensure the door</b></p>	02/05/2016

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	<p>needed for a two hour fire barrier. LSC 19.1.1.4.2 refers to LSC 8.2. 8.2.3.2.3.1 requires openings in a 2 hour fire barrier be provided with doors having at least a 1 1/2 hour fire protection rating. LSC 8.2.4.3.5 states doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 23 residents, staff and visitors in Moving Forward.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/28/16, the second floor corridor door in the Moving Forward health care portion of the facility near Room 701 did not have a latching plate affixed to the door frame to ensure the door would self close and latch into the door frame. Based on interview at the time of observation, the Maintenance Director stated the door was equipped with a magnetic device designed to release with fire alarm system activation but acknowledged the aforementioned corridor door in the fire barrier wall separating health care from the assisted living occupancy was not equipped with a latching plate to ensure the door would self close and latch into the door frame.</p>		<p>(Room 701) self closes and latches into the door frame. <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> All residents have the potential to be affected by the alleged deficient practice. It will be the practice of the provider to ensure that all doors have a self closing or automatic closing in accordance with 7.2.1.8. <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> Environmental Services Supervisor, Maintenance Supervisor, and Administrator to during daily rounds monitor the doors to ensure they are properly self closing and latch plates in place. Any deficient practice will be brought to Maintenance Director. <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> The Environmental Service Supervisor or designee will monitor through the Preventive Maintenance Program. Compliance Date: February 5, 2016 <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b></p>	

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	<p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 fire barriers to a nonconforming building were protected by a two hour fire wall. This deficient practice could affect 23 residents, staff and visitors in Moving Forward.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/28/16, a twelve inch by eight inch hole was noted above the ceiling in the second floor firewall which separates the Moving Forward health care portion of the facility from Assisted Living area near Room 701. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned opening in the tenant separation firewall on the second floor was not firestopped.</p> <p>3.1-19(b)</p>		<p><b>practice?</b></p> <p>The 12x8" Hole identified above the ceiling in the second floor firewall which separates Moving Forward Rehabilitation Unit from Assisted Living near room 701 has been repaired and sealed.</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 the alleged deficient practice. It will be the practice of the provider to ensure that all nonconforming building is protected by a 2 hour fire wall.</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>Environmental Services Supervisor, Maintenance Supervisor, and Administrator to monitor for openings in tenant separation firewall and ensure firestopped throughout facility.</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 Environmental Service Supervisor or designee will monitor through the Preventive Maintenance Program.</p> <p>Compliance Date: February 5, 2015</p>		

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K 0029 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied 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 1 of 15 hazardous areas such as fuel fired heater rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents, staff and visitors in the vicinity of the 200 Hall Mechanical Room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/28/16, the 200 Hall Mechanical Room contained three natural gas fired water heaters. The suspended ceiling for the room contained three plastic ceiling tiles with grated openings which exposed the space between the suspended ceiling and the drywall ceiling for the room. The six inch annular space surrounding an eight</p>	K 0029	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Hazardous area in 200 Hall corridor identified, fire damper removed and hole closed with smoke resisting partition separating the hazardous area from other spaces. 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? All residents have the potential to be affected by the alleged deficient practice. It will be the practice of the provider to ensure that hazardous areas are separated from other spaces with smoke resistant partitions. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not</b></p>	02/02/2016			

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	<p>inch in diameter water heater flue which penetrated the ceiling exposed the attic above. In addition, the one inch annular space surrounding two three inch in diameter pipes and a one inch gap surrounding an eighteen inch long by six inch wide fresh air intake for the room also exposed the attic above. A twelve inch square fire damper in the fully open position was noted in the corridor wall above the corridor door above the suspended ceiling. The open fire damper exposed the area above the suspended ceiling in the 200 Hall corridor. Each of the aforementioned openings were not filled with an approved material to separate this hazardous area from other spaces with smoke resistant partitions. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned openings in the 200 Hall Mechanical Room were not filled with an approved material to separate this hazardous area from other spaces with smoke resistant partitions.</p> <p>3.1-19(b)</p>		<p><b>recur? Environmental Services Supervisor, Maintenance Supervisor, and Administrator to monitor for openings in hazardous areas that prevent separation from other spaces. Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place?</b> The Environmental ServiceSupervisor or designee will monitor through the Preventive Maintenance Program. ComplianceDate: February 2, 2016</p>		

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K 0034 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof towers used as exits are in accordance with 7.2. 19.2.2.3, 19.2.2.4</p> <p>Based on observation and interview, the facility failed to ensure items stored in 1 of 3 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3 requires usable space within an exit enclosure, including under stairs, or any open space within the enclosure shall not be used for any other purpose which could interfere with egress. This deficient practice could affect 23 residents, staff and visitors using the exit stairwell by Room 706 in Moving Forward.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/28/16, the exit stairwell on the second floor in Moving Forward was marked as a facility exit. A resident bed and three mattresses were being stored in the exit stairwell on the first floor underneath the stairs. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned</p>	K 0034	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Items removed from interior fireescape stairway by Room 706 on Moving Forward Rehabilitation Unit. <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> All residents have the potential to be affected by the alleged deficient practice. It will be the practice of the provider to ensure that hazardous areas are separated from other spaces with smoke resistant partitions. <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> Environmental Services Supervisor, Maintenance Supervisor, and Administrator to monitor interior stairways daily to ensure that they are not used as storage to interfere with egress. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>	02/02/2016

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K 0038 SS=E Bldg. 01	<p>stairwell on the first floor was used for storage which could interfere with egress.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to provide 1 of over 100 corridor room doors with not more than one releasing operation. LSC Section 7.2.1.5.4 states a latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and readily operated under all lighting conditions. The releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches above the finished floor. Doors shall be operable with not more than one releasing operation. Section A.7.2.1.5.4 states examples of devices that might be arranged to release latches include knobs, levers, and panic bars. This deficient practice could affect 30 residents, staff and visitors in the vicinity of the Activities Office in the 200 Hall.</p>	K 0038	<p><b>i.e., what quality assurance program will be put into place?</b> The Environmental Service Supervisor or designee will monitor through the Preventive Maintenance Program. ComplianceDate: February 2, 2016</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> The corridor door to the activities office in the 200 Hall area only has one lock on the door, with notmore than one releasing option. <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> All residents have the potential to be affected by the alleged deficient practice. It will be the practice ofthe provider to ensure that all doors shall be operable with not more than onereleasing operation. <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>	01/29/2016

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K 0048 SS=C Bldg. 01	<p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/28/16, the corridor door to the Activities Office in the 200 Hall has two locks on the door and a key was needed to unlock the deadbolt on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door required more than one releasing operation to open the door.</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 plan for 1 of 1 plans which incorporated all items listed in NFPA 101, Section 19.7.2.2.</p>	K 0048	<p>Environmental Services Supervisor, Maintenance Supervisor, and Administrator to monitor doors to ensure all are operable with no more than one releasing operation to open the door. <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> The Environmental Service Supervisor or designee will monitor during rounds to ensure no more than one releasing operation. Compliance Date: January 29, 2016</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> All maps have been updated to show location of all fire doors and exits in the fire safety</p>	02/16/2016

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	<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 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 Action Plan" documentation with the Maintenance Director during record review from 9:00 a.m. to 11:00 a.m. on 01/28/16, 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 C Evacuation Procedures" states "Residents, staff and visitors in the wing where the disaster is located must be immediately moved beyond the nearest smoke/fire barrier doors" and "A second option, the decision must be made as to the feasibility of evacuating the residents horizontally into another area on the</p>		<p>plan forevacuation purposes. <b>Howother residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</b> All residents have the potential to be affected by the alleged deficient practice. It will be the practice ofthe provider to ensure that all maps in the fire safety plan identify smoke barrier doors and fire doors in the facility for the evacuation of smoke compartments. <b>Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does not recur?</b> Environmental Services Supervisor, Maintenance Supervisor, and Administrator to review all maps andfire plans to ensure fire doors and exits for evacuation purposes areidentified and updated in facility. <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> The Environmental Service Supervisor or designee will audit and ensure that all Fire plans have an updated map indicating fire doors and smoke barrier doors for evacuation purposes. ComplianceDate: February 16, 2016</p>				

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K 0056 SS=E Bldg. 01	<p>nursing unit behind fire doors or into another fire zone free area free from smoke and fire. (SEE DIAGRAM FOR EVACUATION PROCEDURES IN SECTION A)." In addition, "Section E General Action Fire Plan" states during an evacuation to "Continue moving in sequence all persons in the area until all are past the fire doors. Do not go back through fire doors." No diagram for evacuation procedures was noted in Section A. Based on interview at the time of record review, the Maintenance Director 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 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</p>			

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	<p>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</p> <p>Based on observation and interview, the facility failed to ensure a sprinkler head was installed in 1 of over 50 restrooms to provide coverage for all portions of the building. This deficient practice could affect 15 residents, staff and visitors in the vicinity of the Moving Forward Lounge restroom.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/28/16, the closet in the restroom in the Moving Forward Lounge was not sprinklered. Based on interview at the time of observation, the Maintenance Director acknowledged the closet in the restroom in the Moving Forward Lounge was not sprinklered.</p> <p>3.1-19(b) 3.1-19(ff)</p>	K 0056	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Sprinkler added to closet inside restroom to provide coverage to all portions of the building. <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> All residents have the potential to be affected by the alleged deficient practice. It will be the practice of the provider to ensure that all areas are covered by sprinkler system.</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> Environmental Service Supervisor, Administrator to ensure and monitor that all areas are covered by sprinkler system.</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>	02/05/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155292	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED  01/28/2016
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NAME OF PROVIDER OR SUPPLIER  AMERICAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2026 E 54TH ST INDIANAPOLIS, IN 46220
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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>Based on observation and interview, the facility failed to replace 1 of over 100 sprinklers which had become corroded, had paint, lint or other foreign materials on them. 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 could affect two staff and visitors in the vicinity of the Laundry.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director during a tour of the facility from 11:00 a.m. to 2:10 p.m. on 01/28/16, the pendant sprinkler installed</p>	K 0062	<p>The Environmental Service Supervisor or designee will monitor through the Preventive Maintenance Program. Compliance Date: February 5, 2016</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> The pendant sprinkler installed in the laundry behind the washing machines has been replaced. <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> All residents have the potential to be affected by the alleged deficient practice. It will be the practice of the provider to ensure that all sprinkler heads corroded, painted, damaged, loaded or in the improper orientation be replaced. <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> Environmental Service Supervisor, Administrator to ensure and monitor that sprinkler</p>	02/05/2016

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NAME OF PROVIDER OR SUPPLIER  AMERICAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2026 E 54TH ST INDIANAPOLIS, IN 46220
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K 0147 SS=E Bldg. 01	<p>in the Laundry behind the washing machines was green with corrosion. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned sprinkler location had become green with corrosion and should be replaced.</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 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. This deficient practice could affect 32 residents, staff and visitors in the 200 Hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director during a tour of the</p>	K 0147	<p>components needing replaced is identified. <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> The Environmental Service Supervisor or designee will monitor through the Preventive Maintenance Program. Compliance Date: February 5, 2016</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Power surge cord used in the Activities and Social Service Office on 200 Hall has been removed. <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> All residents have the potential to be affected by the alleged deficient practice. It will be the practice of the provider to ensure that items are plugged into Fixed outlets and surge protectors not</p>	02/01/2016

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	<p>facility from 11:00 a.m. to 2:10 p.m. on 01/28/16, the following was noted:</p> <p>a. a coffee pot and a refrigerator were plugged into a power strip in the Activities Office in the 200 Hall.</p> <p>b. a microwave oven and a coffee pot were plugged into a power strip in the Social Services Office in the 200 Hall. Based on interview at the time of the observations, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned two locations.</p> <p>3.1-19(b)</p>		<p>as a substitute.</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>Environmental Service Supervisor, Administrator to ensure and monitor that no Power strips are used to substitute fixed power outlets throughout facility.</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 Environmental Service Supervisor or designee will monitor through the Preventive Maintenance Program.</p> <p>Compliance Date: February 1, 2016</p>	