

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155049	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 11/14/2011
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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1630 S COUNTY FARM RD WARSAW, IN46580
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 11/14/11</p> <p>Facility Number: 000017 Provider Number: 155049 AIM Number: 100273830</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Miller's Merry Manor 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 (000) construction</p>	K0000		

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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K0029 SS=E	<p>and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and single station battery operated smoke detectors in the resident rooms. The facility has a capacity of 137 and had a census of 98 at the time of this survey.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/22/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 kitchen storage</p>	K0029	We installed a fire rated door with a lock & self closing device at the kitchen storage area located at the end of the Country Manor hall & this was completed on 12/2/11.	12/14/2011	

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	<p>areas and 1 of 1 laundry rooms were separated from other spaces by smoke resisting partitions and a self closing door. This deficient practice could affect any of the 9 residents in the Country Manor hall and any resident near the laundry room.</p> <p>Findings include:</p> <p>a. Based on observation with the Maintenance Director and the Maintenance Assistant on 11/14/11 at 1:47 p.m., kitchen supplies such as cardboard boxes, plastic items and two Sterno cans were stored in an area at the end of the Country Manor hall lacking a separating wall with a self closing door. This was acknowledged by the Maintenance Director and the Maintenance Assistant at the time of observation.</p> <p>b. Based on observation with the Maintenance Director and the Maintenance Assistant on 11/14/11 at 12:50 p.m., the door entering the laundry room had two unsealed pencil size holes. Based on an interview with the Maintenance Director at the time</p>		<p>The two unsealed pencil size holes located on the Laundry Room door were filled in on 11/14/11. A self closing device was installed on the Country Manor room 6 door on 11/15/11. In addition, self closing latching hardware was installed on the Windsor 1 Shower Room on 11/15/11 to allow for this door to close automatically. No residents were adversely affected by these findings. All facility residents could have been potentially affected by these findings. A checklist (Attachment A) has been devised to check all facility doors to ensure that they are in proper working order with self closing devices & with no holes present. This checklist will be completed weekly for 4 weeks, then monthly thereafter, by the Maintenance Department as part of the facility Quality Assurance Program. The Maintenance Director, or designee, will be responsible to ensure future compliance with this checklist ongoing.</p>				

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	<p>of observation, a door handle with a keypad had recently been removed and replaced with a knob.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 resident rooms used as a storage room with combustibles, measuring over 50 square feet in size, was provided with a self closing device. This deficient practice could affect any of the 9 residents in the Country Manor hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and Maintenance Assistant on 11/41/11 at 1:45 p.m., the corridor door to resident room 6 on Country Manor hall lacked a self closing device. The room measured over 50 square feet in size and contained twenty cardboard boxes full of plastic floral arrangements and had a blanket in place of curtains in the</p>				

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	<p>window. This was acknowledged by the Maintenance Director and Maintenance Assistant at the time of observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 3 shower rooms used for storage of soiled linen, therefore creating a hazardous area, was provided with a door that would self close and latch into the frame. This deficient practice could affect any of the 26 residents on the Windsor 1 hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Maintenance Assistant on 11/14/11 at 12:27 p.m., soiled linen barrels were stored in the Windsor 1 shower room. This shower room lacked latching hardware and did not latch into the door frame. Based on an interview with the Maintenance Director at the time of observation, soiled linens are</p>				

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K0038 SS=E	<p>stored in these barrels until they are taken by the laundry staff to the laundry room.</p> <p>3.1-19(b)</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 7 exit access corridors was readily accessible and unobstructed at all times. This deficient practice could affect any of the 26 residents on Windsor 1 hall.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Director and the Maintenance Assistant on 11/14/11 at 12:45 p.m., a resident bed was stored in the Windsor 1 corridor. Based on an interview with the Maintenance Director and the Maintenance Assistant at the time of observation, neither knew why the bed was stored in the corridor. They were able to ascertain that the bed had been stored in the corridor since yesterday.</p>	K0038	<p>The bed which was found to be in front of the fire extinguisher on the Windsor 1 hall, was removed on 11/14/11. In addition, the code for exiting the facility has been posted at all door exit locations as of 11/15/11. No residents were adversely affected by these findings. All facility residents had the potential to be affected by these findings. An all staff inservice will be held on 12/7/11 to remind staff about the need to not allow equipment, etc. to block fire extinguishers. A checklist (Attachment B) will be used to check to ensure that all facility fire extinguishers are not obstructed by any item(s), as well as codes remain in place for all exit doors, weekly for 4 weeks, then monthly thereafter, by the Maintenance Department as part of the facility Quality Assurance Program. The Maintenance Director, or designee, will be responsible to ensure future compliance with this checklist ongoing.</p>	12/14/2011	

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	<p>Additionally, the bed was obstructing a fire extinguisher.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure the means of egress through 7 of 10 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect any resident without a medical diagnoses requiring security measures exiting through all exits except the Heritage Nurses' station exit, the Country</p>				

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K0044 SS=E	<p>Manor exit and the front entrance.</p> <p>Findings include:</p> <p>Based on observation on with the Maintenance Director and the Maintenance Assistant on 11/14/11 from 11:50 a.m. to 2:55 p.m., with the exception of the Heritage nurses' station exit, the Country Manor exit and the front entrance, all other exit doors were magnetically locked and could be opened by entering a code, but the code was not posted. Based on interview with the Maintenance Director and the Maintenance Assistant at 11:50 a.m., only staff and visitors know the code to exit the building, residents do not have the code.</p> <p>3.1-19(b)</p> <p>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 2 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</p>	K0044	The fire door located at the end of the Rehabilitation hall was adjusted/repared so that it would latch on 11/14/11. No residents were adversely affected by this finding. All residents on the Rehabilitation hall had the potential to be adversely affected by this finding. All facility fire	12/14/2011	

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K0048 SS=C	<p>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 the door to close and latch each time it is opened. This deficient practice could affect any of the 15 residents on the Rehabilitation hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 11/14/11 at 11:52 a.m., the fire door at the end of the Rehabilitation hall failed to latch into the frame. The Maintenance Director confirmed these were fire doors at the time of observation.</p> <p>3.1-19(b)</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written fire plan in a timely manner which included the use of kitchen fire extinguishers for the protection of 98 of 98</p>	K0048	<p>doors will be checked weekly for 4 weeks, then monthly thereafter (Attachment A), by the Maintenance Department as part of facility Quality Assurance Program. The Maintenance Supervisor, or designee, will be responsible to monitor all facility fire doors to ensure future compliance with this checklist ongoing.</p> <p>An updated copy of "Types of Fire Extinguishers" (Attachment C) was added to all facility Disaster Manuals on 11/18/11. No residents were adversely affected by this finding. All facility resident had the potential to be affected by this finding. A checklist</p>	12/14/2011	

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	<p>residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the facilities "Disaster Manual" with the Maintenance Director and the Maintenance Assistant on 11/14/11 at 11:15 a.m., the manual did not include the proper procedures for the use of a fire extinguishers, the types of fire extinguishers in the facility and what specific fire they are designed to extinguish. This was acknowledged by the Maintenance</p>		(Attachment D) will be utilized by the Maintenance Department on a quarterly basis to ensure that a current copy of the "Types of Fire Extinguishers" is located in all facility Disaster Manuals. The Maintenance Supervisor, or designee, will be responsible to ensure future compliance with this checklist ongoing.				

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K0061 SS=F	<p>Director at the time of record review.</p> <p>3.1-19(b)</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 post indicator valves (PIV) was electrically supervised. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Maintenance Assistant on 11/14/11 at 1:55 p.m., the PIV was padlocked in the open position. No electronic tamper device was observed on the PIV. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3.1-19(b)</p>	K0061	<p>We have a quote dated 11/29/11 (Attachment E) from a contractor to update the facility generator PIV to ensure that it is electronically supervised in the future. Due to the scope & nature of this finding, and the need for reliance upon an outside contractor to help alleviate this finding, this facility will request a temporary waiver (Attachment F) for an extension of time through 1/14/12 to remedy this finding. No residents were adversely affected by this finding. All facility residents had the potential to be affected by this finding. Once this update has been completed, this finding will be resolved in it's entirety & will not require further monitoring as it will then be electronically supervised ongoing.</p>	01/14/2012	

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K0062 SS=C	<p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to document and conduct weekly tests of the fire pump in accordance with LSC Section 9.7.5 and 19.3.5.1 and NFPA 25. NFPA 25, Table 5-1.1 and then 5-2 through 5-3.2.4.4 requires the following weekly inspections: the pump house conditions-heat is at least 40 degrees F, heating ventilating louvers are free to operate, fire pump system conditions with valves fully open, piping free of leaks, suction line pressure gauge reading is normal, and suction reservoir is full. Additionally, 5-3.2.1 requires a no flow, ten minute pump test shall be performed weekly. This deficient practice affects all occupants.</p> <p>Finding include:</p> <p>Based on record review with the Maintenance Director on 11/14/11 at 11:10 a.m., the facility was unable to provide</p>	K0062	An update was made to our facility Preventative Maintenance Program to provide for recording the weekly inspection & testing of the fire pump. No residents were adversely affected by this finding. All facility residents had the potential to be affected by this finding. This checklist (Attachment G) will be completed weekly by the Maintenance Department ongoing. The Maintenance Supervisor, or designee, will be responsible to monitor this checklist to ensure future compliance with this finding.	12/14/2011	

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K0069 SS=E	<p>documentation of a weekly inspection and test of the fire pump. This was acknowledged by the Maintenance Director at the time of record review.</p> <p>3.1-19(b)</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>Based on observation and interview, the facility failed to maintain 1 of 1 K Class portable fire extinguishers in the kitchen cooking area in accordance with the requirements of NFPA 10, Standard for Portable Fire Extinguishers, 1998 Edition. NFPA 10, 2- 3.2 requires fire extinguishers provided for the protection of cooking appliances using combustible cooking media (vegetable or animal oils and fats) shall be listed and labeled for Class K fires. NFPA 10, 2-3.2.1 requires a placard shall be conspicuously placed near the extinguisher which states the fire protection system shall be activated prior to using the fire extinguisher. Since the fixed fire extinguishing system will</p>	K0069	<p>A K Class fire extinguisher placard was placed near the fire extinguisher located in the kitchen on 11/28/11 (Attachment H). No residents were adversely affected by this finding. All residents had the potential to be affected by this finding. The Maintenance Supervisor will conduct a monthly review (Attachment I) to ensure that this placard remains in place as part of facility Quality Assurance Program. The Maintenance Supervisor, or designee, will be responsible to ensure future compliance ongoing.</p>	12/14/2011	

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	<p>automatically shut off the fuel source to the cooking appliance, the fixed system should be activated before using a portable fire extinguisher. In this instance, the portable fire extinguisher is supplemental protection. This deficient practice could affect any residents using the main dining room, located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Maintenance Assistant on 11/14/11 at 1:10 p.m., the kitchen K Class fire extinguisher lacked a placard. Based on an interview with the Maintenance Director at the time of observation, the kitchen K Class fire extinguisher lacked a placard identifying its use as secondary backup to the kitchen automatic fire suppression system.</p> <p>3.1-19(b)</p>				

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K0074 SS=B	<p>Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 55 of 68 resident rooms were flame retardant. This deficient practice could affect all residents with the exception of the 15 residents on the Rehabilitation hall.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Maintenance Assistant on 11/14/11 from 11:50 a.m. to 2:05 p.m., the window curtains in all of the resident rooms with the exception of the Rehabilitation hall lacked attached documentation</p>	K0074	The window curtains in question were purchased for this facility in 2004 & we have located the documentation (Attachment J) to prove that they were inherently flame retardant. No residents were affected by this finding. All facility residents located on the Windsor & Heritage halls had the potential to have been affected by this finding. We will keep this documentation on file in the Maintenance Office ongoing & the Maintenance Supervisor will be responsible to ensure that this documentation is in place & available upon request in the future.	12/14/2011			

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K0144 SS=F	<p>confirming they were inherently flame retardant. Based on interview with the Maintenance Director and the Maintenance Assistant at 2:05 p.m., there was no documentation regarding flame retardancy for these window curtains available for review.</p> <p>3.1-19(b)</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA</p>	K0144	<p>We have a quote dated 11/29/11 (Attachment E) from a contractor to ensure that our emergency generator is equipped with a remote manual stop & an alarm will be installed to signal us when a problem arises with the battery charger or the level of fuel is too low. Due to the scope & nature of this finding, and the need for reliance upon an outside contractor to help alleviate this finding, this facility will request a temporary waiver (Attachment F) for an extension of time through 1/14/12 to remedy this finding. No residents were affected by this finding. All facility residents had the potential to be affected by this finding. Once these updates have been completed, this finding will be resolved in it's entirely & will not require further monitoring as it</p>	01/14/2012	

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	<p>37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director and the Maintenance Assistant on 11/14/11 during a tour of the facility from 11:50 a.m. to 2:55 p.m., the facility did not have a remote manual stop for the emergency generator. Based on an interview with the Maintenance Director at 1:22 p.m., the facility has a 300 kW generator.</p> <p>3-1.19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator that would signal an alarm for all of the</p>		will then be electronically supervised ongoing.		

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	<p>emergency conditions listed below. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows:</p> <p>(a) Individual visual signals shall indicate:</p> <ol style="list-style-type: none"> 1. When the emergency or auxiliary power source is operating to supply power to load. 2. When the battery charger is malfunctioning. <p>(b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. <p>Where a regular work station will</p>				

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	<p>be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on an observation with Maintenance Director and the Maintenance Assistant on 11/14/11 at 2:00 p.m., the emergency generator's annunciator panel located on the generator lacked an alarm to signal when the generator experienced a problem with the battery charger or low fuel in the main fuel storage tank. This was acknowledged by the Maintenance Director at the time of observation.</p> <p>3-1.19(b)</p>				

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K0147 SS=E	<p>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 7 of 7 flexible cords were not used as a substitute for fixed wiring to provide power for medical equipment. NFPA 70, National Electrical Code, 1999 Edition, 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 any residents in the Therapy room, 3 residents in the rooms listed below and the any number of staff in the ADON/Social Service office.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director and the Maintenance Assistant on 11/14/11 from 12:38 p.m. to 1:05 p.m., medical equipment was supplied with electricity by</p>	K0147	<p>All extension cords or power strips were removed upon discovery on 11/14/11. No residents were adversely affected by this finding. All facility residents had the potential to be affected by this finding. Additional electrical outlets were added for areas found to have inappropriate extension cords or power strips. An all staff inservice will be held on 12/7/11 to remind staff to watch for inappropriate extension cords or power strips to ensure future compliance. A weekly checklist (Attachment B) will be completed by the Maintenance Department for 4 weeks, then monthly thereafter, as part of the facility Quality Assurance Program to ensure that no inappropriate extension cords or power strips are located within the facility. The Maintenance Supevisor, or designee, will be responsible to monitor this system for future compliance ongoing.</p>	12/14/2011	

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	<p>extension cord power strips or regular light weight extension cords in use in the following locations:</p> <p>a) in the ADON/Social Service office, one extension cord was plugged in and supplying power to a toaster and another extension cord was supplying power in a coffee pot and a radio</p> <p>b) in resident room 25, an oxygen concentrator and a nebulizer were plugged into a power strip and the mattress air pump was plugged into another power strip</p> <p>c) in resident room 33, a power strip was plugged into another power strip which was providing power to a refrigerator, microwave, light and a telephone</p> <p>d) in the Therapy room, a Short Wave Diathermy was plugged into a power strip.</p> <p>These were acknowledged by the Maintenance Director and the Maintenance Assistant at the time of observations.</p> <p>3.1-19(b)</p>				