STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155751	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 12/12/2014
NAME OF PROVIDER OR SUPPLIER MEADOW LAKES		STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K010000	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). Survey Date: 12/12/14 Facility Number: 004831 Provider Number: 155751 AIM Number: 200809750 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Meadow Lakes 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 18, New Health Care Occupancies and 410 IAC 16.2. This one 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 and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm	K010000	Meadow Lakes is respectfully requesting apaper compliance review for the federal and state citings for the survey whichended December 12, 2014. Please review the plan of correction submitted, withsupporting documentation, to establish substantial compliance has been met andmaintained as of January 6, 2015. As a part of the plan of correction we arerequesting a paper IDR of the second portion of tag K-0062, we respectfullyrequest that this portion be deleted from the survey findings. Thank you, in advance, for your attention to this very serious matter.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	system in all resident sleeping rooms. The facility has a capacity of 137 and had a census of 123 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review by Dennis Austill, Life Safety Code Specialist on 12/22/14. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K010025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-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 in approved 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. 18.3.7.3, 18.3.7.5, 18.1.6.3 Based on observation and interview, the facility failed to ensure openings in 2 of 13 smoke barriers were protected to	K010025	**K-025** **SS=E** ***It is the intention ofMeadow Lakes***	12/30/2014

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	maintain the one hour fire resistance rating of the smoke barrier. This deficient practice could affect 30 residents, staff or visitors in the vicinity of the 200 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:20 p.m. on 12/12/14, the attic smoke barrier wall above the ceiling at the corridor door set by Room 201 had a four inch in diameter hole for the passage of sprinkler pipe and cables which was not firestopped. In addition, a two inch in diameter hole for the passage of eleven cables and two one inch in diameter open ended conduits for the passage of cables were not firestopped in the attic smoke barrier wall above the corridor set by Room 216. Based on interview at the time of the observations, the Maintenance Director acknowledged the aforementioned attic smoke barrier openings were not firestopped to maintain a one hour fire resistance rating of each smoke barrier. 3.1-19(b)		***to promote care for residents in an environment that in accordanceto the life safety code standard, contain smoke barriers that provide at leastone hour of fire resistance in accordance with 8.3.*** **What corrective action(s) will beaccomplished for those residents found to be affected by the deficientpractice-** No Residentsstaff or guests were harmed by the openings found in 2 of the 13 fire barriers.Fire Barrier Caulk was ordered and installed in the openings in the firebarrier to prevent the spread of fire. According to the manufacturer the Caulk meets specifications ASTM E-814,UL 1479, UBC 7-5. Following the repair there was found to be no further breaksin the fire barrier and no threat of harm to any residents, visitors or staff. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken-** No residentswere affected by the openings found in 2 of 13 fire barriers. No furtherresidents, staff, or guests have potential to be affected due to 13 of 13 firebarriers being intact after the fire caulk was installed. Attic was inspected by the Maintenance Directorto ensure no further openings were present. No residents, guests or staff werefound to be affected by the break in 2 of the 13 fire barriers.	

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			What measures will be put into placeor what systemic changes will be made to ensure the deficient practice does notrecur- 13 of 13Fire barriers are found to be sealed and intact. 13 of 13 In addition to PMchecks of fire barriers, fire barriers will be checked within 24 hoursfollowing any vendor service that involves working in the attic area. Any timethere is new cable or wiring installed the Maintenance Director will checkbarrier walls for holes in the fire barrier. As a part of PM Fire barriers willbe checked weekly for 4 weeks, monthly for 3 Months. The tool will continueweekly until substantial compliance is met. CQI tool will be reviewed forcompliance monthly by the Maintenance supervisor or designee and Quarterly bythe Executive Director. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, IE, what qualityassurance program will be put into place-** The facilitywill complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Life Safety; Fire Barriers,weekly for 4 weeks, then monthly for 3 months. The tool will continue weekly to ensuring substantial compliance is metand maintained. Substantial complianceis defined as a score at or above 95% **By what date the systemic changeswill be completed-**	

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			12/30/2014	
K010051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 Based on observation and interview, the facility failed to ensure 1 of 8 exit door electromagnetic locks connected to the fire alarm system remained unlocked while the fire alarm was activated. LSC 9.6.1.3 says the provisions of 9.6 cover the basic functions of a complete fire alarm system. Section 9.6.1.4 requires fire alarm systems comply with NFPA 72, National Fire Alarm Code. NFPA 72, 3-9.7.1 states any device or system intended to actuate the locking or unlocking of exits shall be connected to the fire alarm system serving the protected premises. NFPA 72, 3-9.7.2 states all exits connected in accordance	K010051	**K- 051** **SS=E** ***It is the intention ofMeadow Lakes to ensure that the facility has a fire alarm system that hasapproved components devices or equipment installed according to NFPA 72.*** **What corrective action(s) will beaccomplished for those residents found to be affected by the deficientpractice-** No residentswere affected by the failure of 1 of 8 electromagnetic locks failed todisconnect during the testing of the fire suppression system on 12/12/2014. VanGuard,the company responsible for servicing the fire suppression system, was calledand arrived within	12/12/2014

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	with 3-9.7.1 shall unlock upon receipt of any fire alarm signal by means of the fire alarm system serving the protected premises. Exception: Where otherwise required or permitted by the authority having jurisdiction. This deficient practice could affect 28 residents, staff and visitors if needing to exit Memory Care by using the exit by the Memory Care Facilitator's Office. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:20 p.m. on 12/12/14, the electromagnetic lock on the exit door by the Memory Care Facilitator's Office did not release and remain unlocked when the fire alarm was activated at 2:45 p.m. Based on interview at the time of observation, the Maintenance Director acknowledged the electromagnetic lock on the exit door by the Memory Care Facilitator's Office did not release when the fire alarm system was activated. 3.1-19(b)		12 hours of discovery of the lock failure and ensured thatthe electromagnetic lock near the Memory Care Facilitators Office released whenthe fire suppression system is activated per policy on 12/12/2014. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken-** No other residentswere affected by the electromagnetic lock on 1 of 8 doors failing to releasewith the activation of the fire system. VanGuard, the company responsible forservicing the fire suppression system, was called and arrived within 12 hoursof discovery of the lock failure and ensured that the electromagnetic lockreleased when the fire suppression system is activated per policy on12/12/2014. 8 of 8 electromagnetic locks are found to release by the MaintenanceDirector at the time of activation of the fire system. All electromagneticlocks are found to be intact and in working order by the Maintenance Director.No guests, staff or residents were found to be affected by the locks' failureto release. **What measures will be put into placeor what systemic changes will be made to ensure the deficient practice does notrecur-** 8 of 8electromagnetic locks are found to release by the	

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			Maintenance Director at thetime of activation of the fire system. All electromagnetic locks are found tobe intact and in working order by the Maintenance Director. In addition tomonthly PM checks of electromagnetic locks, electromagnetic locks will bechecked weekly for 12 weeks then monthly. The tool will continue weekly untilsubstantial compliance is met. CQI tool will be reviewed for compliance monthlyby the Maintenance supervisor or designee and Quarterly by the ExecutiveDirector. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, IE, what qualityassurance program will be put into place-** The facilitywill complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Life Safety;Electromagnetic Lock Release, weekly for 12 weeks, then monthly thereafter. The tool will continue weekly to ensuringsubstantial compliance is met and maintained. Substantial compliance is defined as a score at or above 95% **By what date the systemic changeswill be completed-** 12/12/2014	
K010062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating			

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	condition and are inspected and tested periodically. 18.7.6, 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 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. Findings include: Based on review of P.I.P.E. "Report of Inspection" documentation dated 08/28/14 with the Maintenance Director during record review from 9:30 a.m. to 11:30 a.m. on 12/12/14, it has been more than three months since the most recent documented quarterly sprinkler system	K010062	**K- 0062 We respectfully request a paper IDR of the second portion of K-0062. At the time of inspection all gauges were labeled by the installer PIPE Inc. Please see the attached photos and invoice of the date of installation and calibration of the gauges. The Maintenance Director spoke to PIPE Inc. after the surveyor left and was informed that all gaugeswere installed on the same date, as seen on the invoice, and that they should all be labeled on the back. The Maintenance Director found 10 of 10 gauges were labeled as stated by PIPE Inc. Therefore we ask that you please delete the second portion of tag K-0062 K- 0062 SS=F** ***It is the intention ofMeadow Lakes to ensure that the automatic sprinkler systems are continuouslymaintained in reliable operating condition and are inspected and testedperiodically. 18.7.6, 4.6.12, NFPA 25, 9.7.5*** **What corrective action(s) will beaccomplished for those residents found to be affected by the deficientpractice-** 1. Noresidents, staff or visitors were found to be affected by the fire suppressionsystem inspection	12/15/2014

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	inspection was performed. Based on interview at the time of record review, the Maintenance Director stated the facility has switched inspection contractors, the new contractor had not yet scheduled or performed a fourth quarter 2014 sprinkler system inspection and acknowledged it has been more than three months since the most recent documented quarterly sprinkler system inspection was performed. Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:20 p.m. on 12/12/14, calendar quarter sprinkler inspection tags affixed to sprinkler system riser indicated the most recent documented quarterly sprinkler system inspection was on 08/28/14. 3.1-19(b)		being completed more than 3 months following the previousinspection. The inspection was completed on 12/15/14, the report following theinspection showed the fire suppression system to have no deficiencies and inproper working order. 2. No residents,staff or visitors were affected by the air and water pressure gaugesmanufactured in 2008. All 10 of the gauges were installed and calibrated on07/29/2011. Date of installation and last calibration is written in marker onthe back of each gauge by PIPE Inc. Company that installed and calibrated allgauges, writes the date the gauge was installed or calibrated on the back ofeach gauge all gauges were found to have the same date written on the back ofthe gauge in marker. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken-** 1. Noresidents, staff or visitors were affected as the system was inspected byVanguard on 12/15/2014 with no issues found. No residents were affected bythis. 2. Noresidents, staff or visitors were found to be affected as the gauges were notfound to be in need of calibration or replacement due to a 07/29/2011installation date on the invoice provided by the installer	

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			PIPE Inc. MaintenanceDirector inspected all 10 of the gauges and found 10 of 10 were labeled and ensuredall had been calibrated within the last 5 years. **What measures will be put into placeor what systemic changes will be made to ensure the deficient practice does notrecur-** 1. FireSuppression system Inspections will be added to the PM log as a part of theQuarterly PM program. Maintenancesupervisor to contact Vanguard each month for 6 months and quarterly thereafterto ensure quarterly inspections are within 90 days of last inspection. The tool shall include date of contact, timeof contact and Vanguard Representatives name. The tool will continue monthly untilsubstantial compliance is met. CQI tool will be reviewed for compliance monthlyby the Maintenance supervisor or designee and Quarterly by the ExecutiveDirector. 2. Air andWater Pressure gauges will be replaced and or calibrated within 5 years of lastinstallation or calibration. Dates onall gauges will be recorded monthly for 3 months then annually in the PM log toensure timely calibration and replacement of gauges. The tool will continue monthlyuntil substantial compliance is met. CQI tool will be reviewed for compliancemonthly by the Maintenance supervisor or	

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			designee and Quarterly by theExecutive Director. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, IE, what qualityassurance program will be put into place-** 1. Thefacility will complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Life Safety; FireSuppression System Inspection, monthly for 6 months, then quarterly thereafter. The tool will continue monthly to ensuringsubstantial compliance is met and maintained. Substantial compliance is defined as a score at or above 95% 2. Thefacility will complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Life Safety; FireSuppression System Inspection, monthly for 3 months, then annually thereafter. The tool will continue monthly to ensuringsubstantial compliance is met and maintained. Substantial compliance is defined as a score at or above 95% **By what date the systemic changeswill be completed-** 1.12/15/2014 2.12/12/2014	
K010070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 18.7.8 Based on record review, observation and	K010070	**K- 070**	01/06/2015

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	interview; the facility failed to ensure 1 of 1 portable space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice affects two staff and visitors in the Director of Nursing Services Office by the 200 Hall nurses station. Findings include: Based on review of "Disaster Action Plan: Fire Prevention" documentation with the Maintenance Director during record review from 9:30 a.m. to 11:30 a.m. on 12/12/14, portable space heating devices are prohibited from being used in the facility. Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:20 p.m. on 12/12/14, one operable electric portable space heater was observed plugged into a wall outlet in the Director of Nursing Services Office by the 200 Hall nurses station. No documentation was affixed to the aforementioned portable space heater stating its operating temperature. Based on interview at the time of observation, the Maintenance Director stated documentation of the operating temperature was not available for review and acknowledged the aforementioned facility policy prohibits portable space heaters to be used		**SS=D** ***It is the intention ofMeadow Lakes to staff and visitors are kept safe by prohibiting space heatingdevices in health care occupancies except in non-sleeping staff and employee areaswhere the heating elements of the devices do not exceed 212 degrees F. 18.7.8*** **What corrective action(s) will beaccomplished for those residents found to be affected by the deficientpractice-** No staff,visitors or residents were found to be affected by the space heater located inthe DNS office across from the 200 Hall nurses station with a heating elementthat might exceed 212 degrees F. The heater removed from the office on12/12/2014. Following the removal of the space heater a permanent heat sourcewas installed in the office on 12/16/2014 that is controlled by a thermostatand does not exceed 212 degrees F. There were no affects noted or found byresidents, staff or visitors due to the potable space heating device found inthe DNS office. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken-** No otherstaff, visitors or residents were found to be affected as the space heater wasremoved on 12/12/2014 and a permanent heat source was installed on 12/16/2014.	

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	anywhere in the facility. 3.1-19(b)		MaintenanceDirector did an inspection of the building to ensure no other space heaterswere present. No staff, residents, or residents were affected by this. **What measures will be put into place orwhat systemic changes will be made to ensure the deficient practice does notrecur-** Space heaterwas removed by the Maintence Director on 12/12/2014. A permanent heat sourcecontrolled by a thermostat was installed in the DNS office on 12/16/2014. Allstaff were in-serviced to ensure they know that no space heater are allowed to bebrought into the building. In-service presented by Mike Miller, Director of Maintenance,to be completed by all staff on or before 01/06/2014. Office spaces will bechecked for unapproved heat sources weekly for 12 weeks, monthly for 3 monthsand then quarterly thereafter. The tool will continue monthly until substantialcompliance is met. CQI tool will be reviewed for compliance monthly by theMaintenance supervisor or designee and Quarterly by the Executive Director. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, IE, what qualityassurance program will be put into place-** The facilitywill complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Life Safety; UnapprovedPortable Heating Devices, weekly for 12	

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NAME OF PROVIDER OR SUPPLIER MEADOW LAKES		STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158	

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			weeks, monthly for 3 months, then quarterly thereafter. The tool will continue weekly to ensuringsubstantial compliance is met and maintained. Substantial compliance is defined as a score at or above 95% **By what date the systemic changeswill be completed-** 01/06/2014	
K010074 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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. 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. 18.7.5.1, 1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4, 18.7.5.3 Based on record review, observation and interview; the facility failed to ensure window curtains in 5 of 13 smoke compartments were flame resistant. This deficient practice could affect all residents, staff and visitors.	K010074	**K- 074** **SS=C** ***It is the intention ofMeadow Lakes to ensure that residents are safe from the spread of fire byensuring all draperies are in accordance with provisions 10.3.1 and NFPA 13.*** **What corrective action(s) will**	01/06/2015

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	Findings include: Based on record review with the Maintenance Director from 9:30 a.m. to 11:30 a.m. on 12/12/14, flame resistant documentation for window curtains was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:20 p.m. on 12/12/14, window curtains in the main entrance lobby, lobby conference room and dining areas in the 100 Hall, 200 Hall, 300 Hall and 600 Hall had no affixed documentation stating each curtain was inherently flame retardant. Based on interview at the time of the observations, the Maintenance Director stated the aforementioned window curtains are not treated with a flame retardant material and acknowledged flame resistant documentation for window curtains was not available for review. 3.1-19(b)		**beaccomplished for those residents found to be affected by the deficientpractice-** No staffresidents or visitors were affected by the lack of flame retardantdocumentation on the curtains in the Lobby, Lobby Conference room, 100 HallDining Room, 200 Hall Dining Room, 300 Hall Dining Room or the 600 Hall DiningRoom. The curtains were all sprayed by the Housekeeping Supervisor with firetect a fire retardant spray for fabric. Following the treatment all curtainswere found to be treated with fire retardant solution and labeled with the datetreated. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken-** No otherresidents, staff or visitors were found to be affected as all of the curtainswere treated by the Housekeeping Supervisor with flame retardant spray. MaintenanceDirector checked all curtains to ensure all have fire retardant material and documentationfor support. No residents, staff or visitors were found to be affected by theprevious lack of proof of curtains being treated with fire retardant spray orlabeling on curtains. **What measures will be put into placeor what systemic changes will be made to ensure the deficient**	

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			practice does notrecur- Curtainswill be checked for tags weekly for 4 weeks, monthly for 3 months and thenquarterly thereafter. The tool will continue monthly until substantialcompliance is met. CQI tool will be reviewed for compliance monthly by theMaintenance supervisor or designee and Quarterly by the Executive Director. Allstaff were in-serviced to ensure they know that no curtains are to be hung by nonmaintenance staff members; All curtains must be approved as being made of afire retardant material and having proper documentation by the Maintenance Supervisorprior to being hung. In-service presented by Mike Miller, Director of Maintenance,to be completed by all staff on or before 01/06/2014. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, IE, what qualityassurance program will be put into place-** The facilitywill complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Life Safety; FireRetardant Tx of Curtains, weekly for 4 weeks, monthly for 3 months, then quarterly thereafter. The tool will continue weekly to ensuringsubstantial compliance is met and maintained. Substantial compliance is defined as a score at or above 95% **By what date the systemic changeswill be completed-**	

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			01/06/2014	
K010147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 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 four residents, staff and visitors in the vicinity of the Business Office. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 12:00 p.m. to 3:20 p.m. on 12/12/14, a coffee pot oven was plugged into a power strip in the Business Office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring in the Business Office. 3.1-19(b)	K010147	**K-0147** **SS=D** ***It is the intention ofMeadow Lakes to ensure that all electrical wiring and equipment are installedin accordance with NFPA 70, National Electrical Code. 9.1.2*** **What corrective action(s) will beaccomplished for those residents found to be affected by the deficientpractice-** Noresidents, staff or visitors were found to be affected by the presence of thecoffee pot plugged into a power strip and not directly into the wall socket.The coffee pot was removed from the business office on 12/12/2014 and the powerstrip was removed from the wall socket to ensure no further use. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action(s) will be taken-** No residentswere found to be affected by the coffee pot plugged into a power strip in thebusiness office as the coffee pot and power strip were removed on 12/12/2014.Maintenance supervisor removed the coffee pot within an hour of the discoveryof the power	01/06/2015

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			strip. Maintenance Supervisor completed an audit of the facilityto ensure no other non-electronic electrical equipment was plugged into a powerstrip. No guests, staff or residents were found to be affected by the coffeepot being plugged into a power strip and not directly into the wall socket. **What measures will be put into placeor what systemic changes will be made to ensure the deficient practice does notrecur-** Coffee potwas removed from the business office area. All staff were in-serviced to ensurethey know that no non-electronic devices are allowed to be plugged into a powerstrip. In-service presented by Mike Miller, Director of Maintenance, to be completedby all staff on or before 01/06/2014. Business office will be checked weeklyfor 4 weeks, monthly for three months and quarterly thereafter to ensure no powerstrip is being used in place of a power cord connecting directly into the wallsocket for a coffee pot electronic device. The tool will continue monthly untilsubstantial compliance is met. CQI tool will be reviewed for compliance monthlyby the Maintenance supervisor or designee and Quarterly by the ExecutiveDirector. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, IE, what qualityassurance program will**	

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			be put into place- The facilitywill complete a Continuous Quality Improvement Tool titled: 'Quality Indicator: Life Safety; ElectricalEquipment Installation, weekly for 4 weeks, monthly for 3 months, then quarterly thereafter. The tool will continue weekly to ensuringsubstantial compliance is met and maintained. Substantial compliance is defined as a score at or above 95% **By what date the systemic changeswill be completed-** 01/06/2014	