

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/24/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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K010000	<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: 06/24/14</p> <p>Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310</p> <p>Surveyor: Phillip Komsiski, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Golden Living Center-Fountainview 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 partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in</p>	K010000		

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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K010018 SS=E	<p>all resident sleeping rooms. The facility has a capacity of 130 and had a census of 95 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except for the maintenance shed used for storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/10/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS</p>			

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	<p>regulations in all health care facilities.</p> <p>Based on observation and interview, the facility failed to ensure 3 of 3 sets of double leaf corridor doors could latch independently into their door frames. This deficient practice could affect 18 residents on B wing east, 20 residents on Rehabilitation Hall south and 2 residents on Service hall adjacent to the Candlelight dining room as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observations on 06/24/14 during the tour between 1:00 p.m. and 4:00 p.m. with the Maintenance Supervisor, the following sets of double leaf corridor doors required one door to be latched manually into the door frame before the second door would latch into the first door and secure them both tightly into the door frame:</p> <ol style="list-style-type: none"> Double door set leading into the Restorative room on B wing east, Double door set leading into the dining room on Rehabilitation hall south, Double door set leading into the Laundry on Service hall. <p>Based on interview on 06/24/14 concurrent with the observations it was acknowledged by the Maintenance Supervisor, the aforementioned sets of corridor doors would not latch</p>	K010018	<p>K018</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>It is the practice of this facility to ensure that all double leaf corridor doors latch independently into thier door frames. Consistent with this practice, the following actions have been taken:</p> <ol style="list-style-type: none"> The doors identified in the above deficient practice were re-assessed by the Director of Maintenance and the determination was made to contract an outside vendor to make the repairs necessary for compliance with Life Safety Code Standard (LSCS) K018. All other doors were re-assessed by the Director of Maintenance and those identified to be affected by the deficient practice will also be repaired to ensure that the doors lock independently into their door frames. No other residents or visitors were affected. 	07/24/2014

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K010051 SS=C	independently into their door frame. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, 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 in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of		III. Re-education was provided to the Director of Maintenance and Maintenance Assistant on 07.21.14 regarding LSCS K-018. An audit tool was developed to monitor ongoing compliance with LSCS K-018 which the Director of Maintenance or designee will complete utilizing the facility's work order program program. Compliance with the facility's work order program specific to LSCS- K018 will be reviewed by the Executive Director (ED) weekly for 4 weeks and monthly thereafter until a threshold of 100% compliance is met. IV. The Director of Maintenance will review the results of these audits with the QAPI team monthly for further review for 6 months or until a threshold of 100% compliance is maintained. Date of Compliance: 07.24.14		

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	<p>tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6</p> <p>Based on observation and interview, the facility failed to install 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999 Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/24/14 at 1:56 p.m. with the Maintenance Supervisor, the fire alarm system circuit breaker located in the Boiler room on Service hall lacked full identification. Inside the panel cover to the circuit breakers the number 17 corresponding to the fire alarm breaker was labeled "fire" in black. Based on interview on 06/24/14 at 1:57 p.m. with the Maintenance Supervisor, it was acknowledged the circuit breaker was not labeled with red marking to say Fire Alarm Circuit Control.</p>	K010051	<p>K-051</p> <p>I. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>It is the practice of this facility to ensure that all fire alarm systems are functioning in accordance with NFPA 72, 1-5.2.5.2, including the red marking to identify the fire alarm circuit disconnecting. Consistent with this practice, the following actions have been taken:</p> <p>I. The circuit breaker that was identified in the above deficient practice was labeled to include the red marking of "Fire Alarm Circuit Control".</p> <p>II. All affected breakers were assessed and corrective actions were taken as necessary. No</p>	07/24/2014

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K010056 SS=F	3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate		other residents or visitors were affected. III. Re-education was provided to the Director of Maintenance and Maintenance Assistant on 07.21.14 regarding LSCS K-051. An audit tool was developed to monitor ongoing compliance with LSCS K-051 which the Director of Maintenance or designee will complete utilizing the facility's work order program. Compliance with the facility's work order program specific to LSCS- K051 will be reviewed by the Executive Director (ED) weekly for 4 weeks and monthly thereafter until a threshold of 100% compliance is met. IV. The Director of Maintenance will review the results of these audits with the QAPI team monthly for further review for 6 months or until a threshold of 100% compliance is maintained. Date of Compliance: 07.24.14		

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	<p>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 1 of 1 steel armover sprinkler pipes observed was installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, Section 6-2.3.4 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect all residents in the building if the sprinkler system required repair as well as staff or visitors.</p> <p>Findings include:</p> <p>Based on observation on 06/24/14 at 3:15 p.m. with the Maintenance Supervisor, in the partial basement under the rehabilitation pool in therapy there was an armover which measured thirty six inches in length and was unsupported. Based on interview on 06/24/14 concurrent with the observation with the Maintenance Supervisor, it was acknowledged the aforementioned steel sprinkler pipe armover exceeded twenty four inches in length and was</p>	K010056	<p>K-056</p> <p>I. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to ensure that all fire alarm systems are functioning in accordance with NFPA 13, 6-2.3.4. Consistent with this practice, the following actions have been taken:</p> <p>I. The armover that was identified to be unsupported and in excess of 24 inches was re-assessed by the Director of Maintenance. A vendor was contracted to complete the installation of a hanger to support as required for compliance with K-056.</p> <p>II. All armovers were assessed and corrective actions were taken as necessary. No other residents or visitors were affected.</p>	07/24/2014

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K010062 SS=F	<p>unsupported.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on observation and interview, the facility failed to provide a complete supply of spare sprinklers in 1 of 1 riser rooms in accordance with NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems,</p>	K010062	<p>III. Re-education was provided to the Director of Maintenance and Maintenance Assistant on 07.21.14 regarding LSCS K-056. An audit tool was developed to monitor ongoing compliance with LSCS K-056 which the Director of Maintenance or designee will complete utilizing the facility's work order program. Compliance with the facility's work order program specific to LSCS- K056 will be reviewed by the Executive Director (ED) weekly for 4 weeks and monthly thereafter until a threshold of 100% compliance is met.</p> <p>IV. The Director of Maintenance will review the results of these audits with the QAPI team monthly for further review for 6 months or until a threshold of 100% compliance is maintained. Date of Compliance: 07.24.14</p> <p>I. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The</p>	07/24/2014			

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	<p>Section 2-4.1.4 which requires a supply of at least six spare sprinklers shall be stored in a cabinet on the premises for replacement purposes. The stock of spare sprinklers shall be proportionally representative of the types and temperature ratings of the system sprinklers. A minimum of two sprinklers of each type and temperature rating installed shall be provided. This deficient practice could affect all residents throughout the facility as well as staff and visitors if the sprinkler system had to be shut down because a proper sprinkler head wasn't available as a replacement.</p> <p>Findings include:</p> <p>Based on observation on 06/24/14 at 1:55 p.m. with the Maintenance Supervisor, the riser room on Service hall which contained the sprinkler box with extra sprinkler heads was equipped with only five sprinkler heads. In addition, there were not two of every type of sprinkler head since only one sidemount sprinkler head was available in the box. Based on interview on 06/24/14 at 1:56 p.m. with the Maintenance Supervisor, it was acknowledged the spare sprinkler cabinet located in the Riser room did not have a minimum of six sprinkler heads and did not have two of each type of sprinkler</p>		<p>plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>It is the practice of this facility to ensure that automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically in accordance with NFPA 25, 9.7.5. Consistent with this practice, the following actions have been taken:</p> <p>I. The facility's stock of spare sprinklers was re-assessed by the Director of Maintenance. An order was placed with the facility's vendor, SafeCare for items necessary for compliance with K-062. The spare sprinklers necessary to meet the requirement were provided on 07.21.14.</p> <p>II. No other residents or visitors were affected.</p> <p>III. Re-education was provided to the Director of Maintenance and Maintenance Assistant on 07.21.14 regarding LSCS K-062. An audit tool was developed to monitor ongoing compliance with LSCS K-062 which the Director of Maintenance or designee will complete utilizing the facility's work order & preventative</p>				

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K010144 SS=F	<p>head in the sprinkler box.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator which would indicate generator functions. 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: (a) Individual visual signals shall</p>	K010144	<p>maintenance programs. Compliance with the facility's work order & preventative maintenance programs specific to LSCS- K062 will be reviewed by the Executive Director (ED) weekly for 4 weeks and monthly thereafter until a threshold of 100% compliance is met.</p> <p>IV. The Director of Maintenance will review the results of these audits with the QAPI team monthly for further review for 6 months or until a threshold of 100% compliance is maintained. Date of Compliance: 07.24.14</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to ensure that the generator is inspected weekly and tested under</p>	07/24/2014	

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	<p>indicate:</p> <ol style="list-style-type: none"> When the emergency or auxiliary power source is operating to supply power to load. 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"> Low lubricating oil pressure. Low water temperature. Excessive water temperature. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. Overcrank (failed to start). Overspeed. <p>Where a regular work station will 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 the residents as well as visitors and staff.</p> <p>Findings include:</p> <p>Based on observation on 06/24/14 at 2:55 p.m. with the Maintenance Supervisor,</p>		<p>load in compliance with K-144. Consistent with this practice, the following actions have been taken:</p> <p>I. a) The generator was re-assessed by the Director of Maintenance and the determination was made to contract an outside vendor to made the repairs necessary for compliance with Life Safety Code Standard (LSCS) K144. The alarm enunciator was installed on 07.02.14.</p> <p>I. b) The generator was re-assessed by the Director of Maintenance and the determination was made to contract an outside vendor to made the repairs necessary for compliance with Life Safety Code Standard (LSCS) K144. The remote manual shut off was installed on 07.02.14.</p> <p>I. c) The generator identified was tested for 30 minutes as required. The Director of Maintenance verified that the generator is capable of running on a load for a minimum of 30 minutes on 07.02.14.</p> <p>II. a) No other residents or visitors were affected.</p> <p>II. b) No other residents or visitors were affected.</p> <p>II. c) No other residents or visitors were affected.</p> <p>III. A load test will be conducted</p>				

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	<p>the alarm annunciator panel for the new generator was not present in the facility. During an interview on 06/24/14 at 2:56 p.m. with the Maintenance Supervisor, it was acknowledged the generator had been installed two months ago and the new annunciator panel for the generator had not been installed.</p> <p>3.1-19(b)</p> <p>2. Based on observation, record review 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 II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 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 the shutting down the engine at the engine and from a remote location. This deficient practice</p>		<p>on the generator at a minimum of monthly for a minimum of 30 minutes. The results of this test will be recorded in accordance with LSCS- K144. Re-education was provided to the Director of Maintenance and Maintenance Assistant on 07.21.14 regarding LSCS K-144. An audit tool was developed to monitor ongoing compliance with LSCS K-144 which the Director of Maintenance or designee will complete utilizing the facility's preventative maintenance program. Compliance with the facility's preventative maintenance program specific to LSCS- K144 will be reviewed by the Executive Director (ED) weekly for 4 weeks and monthly thereafter until a threshold of 100% compliance is met.</p> <p>IV. The Director of Maintenance will review the results of these audits with the QAPI team monthly for further review for 6 months or until a threshold of 100% compliance is maintained. Date of Compliance: 07.24.14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED 06/24/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545			
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	<p>could affect all occupants.</p> <p>Findings include:</p> <p>Based on observation of generator equipment on 06/24/14 at 2:45 p.m. with the Maintenance Supervisor, a remote shut off device was not found for the generator. Based on review of Generator Maintenance records on 06/24/14 at 3:50 p.m. with the Maintenance Supervisor, the generator was installed in April 2014 and a remote means to shut the generator off was not provided. Based on interview on 06/24/14 at 2:48 p.m. with the Maintenance Supervisor, it was acknowledged the facility was aware a remote shut off for the generator was required, but it had not been installed.</p> <p>3. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading which maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with</p>						

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	<p>NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>a. Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating.</p> <p>b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.</p> <p>The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents as well as staff and visitors.</p> <p>Findings include:</p> <p>Based on review of Generator System Testing records and Maintenance logs on 06/24/14 at 3:38 p.m. with the Maintenance Supervisor, the amperage during load was not documented and it could not be verified to be 30 percent of the EPS nameplate rating for the past twelve months. Based on interview on 06/24/14 concurrent with record review with the Maintenance Supervisor, it was acknowledged the facility had been running the generator monthly, but was unaware it had to be documented to be at least 30 percent of the EPS nameplate</p>			

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K010147 SS=E	<p>rating. No other equivalent method was used to comply with percentage of load capacity for the past twelve months.</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 Based on observation and interview, the facility failed to ensure 2 of 24 surge protectors observed and 3 prong extension cords including extension cords, non-fused extension cords and multiplug adapters were not used as a substitute for fixed wiring. NFPA 70, National Electrical Code, 1999 Edition. 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 2 residents in resident room # 117 and 2 residents in room # 135, as well as visitors and staff.</p>	K010147	K-147 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. It is the practice of this facility to ensure that electrical wiring and equipment is maintained in accordance with NFPA 70, National Electrical Code 9.1.2. Consistent with this practice, the following actions have been taken: 1. The non-compliant	07/24/2014

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	<p>Findings include:</p> <p>Based on observations on 06/24/14 during the tour between 2:26 p.m. and 2:40 p.m., a surge protector was used to provide power to resident beds which are medical equipment for two residents in room #117 and two residents in room #135 instead of plugging the medical equipment directly into a wall outlet. In addition, a three prong extension cord in the laundry behind the three washers was used to power soap dispensing containers. Based on interview on 06/24/14 concurrent with the observations it was acknowledged by the Maintenance Supervisor, a surge protector was used for the aforementioned medical devices and a three prong extension cord was used in laundry.</p> <p>3.1-19(b)</p>		<p>cords were removed from the identified areas. Necessary items were plugged directly into the wall outlets. A vendor was contracted to install 2 hospital grade quads in rooms #117 & #135 on 07.22.14. Also the vendor will add a single outlet, each connecting to GFI for each of the 3 non-compliant cords that were identified in the laundry areas for the soap dispensers. II. All electrical outlets were audited to identify any other deficiencies. No residents or visitors were found to be affected by the deficient practice. III. Re-education was provided to the Director of Maintenance and Maintenance Assistant on 07.21.14 regarding LSCS K-147. An audit tool was developed to monitor ongoing compliance with LSCS K-147 which the Director of Maintenance or designee will complete utilizing the facility's work order & preventative maintenance program. Compliance with the facility's preventative maintenance program specific to LSCS- K147 will be reviewed by the Executive Director (ED) weekly for 4 weeks and monthly thereafter until a threshold of 100% compliance is met. IV. The Director of Maintenance will review the results of these audits with the QAPI team monthly for further review for 6 months or until a threshold of 100% compliance is maintained. Date of Compliance:</p>		

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

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