

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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(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
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: 12/01/15</p> <p>Facility Number: 000253 Provider Number: 155362 AIM Number: 100266660</p> <p>At this Life Safety Code survey, Golden Living Center - Merrillville 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 was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are provided with battery powered smoked detectors. The facility has the capacity for 164 and had a census of 145 at the</p>	K 0000		

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 0017 SS=E Bldg. 01	<p>time of this survey.</p> <p>Quality Review completed 12/03/15 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 former resident rooms was separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building, or met an Exception. LSC 19-3.6.1, Exception # 6, Spaces other than patient sleeping rooms, treatment rooms, and hazardous areas may be open to the corridor and unlimited in area provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system, and</p>	K 0017	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Letter of intent from VFP to complete hard-wiring of smoke detector in dining room with anticipated start date of January 15 with estimated date of completion February 14, 2016. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No other rooms were identified 3. What measures will be put into place or what systemic changes will be made to ensrue that the deficient</p>	12/31/2015
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K 0025 SS=E Bldg. 01	<p>(b) Each space is protected by an automatic sprinklers, and (c) The space is arranged not to obstruct access to required exits. This deficient practice could affect staff and at least 10 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor and Executive Director on 12/1/15 at 12:14 p.m., resident room 305 had no door on the door frame. The room was used as a dining room and was not viewable from the nurse's station. Furthermore, Exception # 6, requirement (a) of the LSC Section 19-3.6.1 was not met in that room 305 was not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of observation, the Maintenance Supervisor and Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are</p>		<p>practice does not recur: Maintenance Director will inform ED and Facility Engineer Consultant of any physical plant changes to ensure compliance with State and Federal guidelines. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Physical plant restructure changes will be reported to QAPI for review and recommendations to ensure compliance for 6 months. 5. Date of Compliance: December 31, 2015.</p>		

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	<p>protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>1. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 10 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect staff and at least 85 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Executive Director on 12/1/15 at 2:38 p.m. then again at 2:47 p.m., the smoke barrier wall</p>	K 0025	<p>1. What corrective action will bge accomplished fo rthose residents found to have been affected byv the deificient practice: Smoke barrier wall near res room 324 and room 7 were sealed with approved fire caulk on December 14, 2015. Hole in wall across from Maintenance shop patched on December 14, 2015. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No other smoke barrier walls were identified 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director to inspect all smoke barrier walls quarterly for 6 months. Audit will be completed and submitted to ED quarterly to ensure compliance. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Audits will be sumbitted to QAPI monthly with compliance percentages to ensure quality improvement. 5. Date of Completion: December 31, 2015</p>	12/31/2015

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	<p>near resident room 324 had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was a half an inch gap around a cable. Then again the smoke barrier wall near resident room 7 had an unsealed penetration. Above the ceiling tile was the unsealed penetration which was three eighths inch. Based on interview at the time of each observation, the Maintenance Supervisor and Executive Director acknowledge each aforementioned condition and provided the measurements.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 corridor smoke barrier was protected to maintain the smoke resistance of the smoke barrier. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Executive Director on 12/1/15 at 1:14 p.m., there was a one inch penetration in the service corridor wall across from the Maintenance office door. Based on interview at the time of observation, the Maintenance Supervisor and Executive Director acknowledged the</p>			

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K 0029 SS=D Bldg. 01	<p>aforementioned condition.</p> <p>3.1-19(b)</p> <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 the corridor door to 1 of 1 kitchen, a hazardous area, was provided with self closer and would latch into the frame. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation and interview on 12/1/15 at 1:08 p.m., the Maintenance Supervisor and Executive Director confirmed the service corridor door entering the kitchen failed to latch when tested.</p>	K 0029	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Kitchen door latch was fixed on December 2, 2015. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No other doors were identified 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director will audit facility door latches monthly for 6 months and submit to ED. Maintenance Director has</p>	12/31/2015

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K 0062 SS=E Bldg. 01	<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>1. Based on record review and interview, the facility failed to ensure maintain 1 of 1 automatic sprinkler piping systems. NFPA 25 7-3.6.2 requires water supply piping shall be maintained free of internal obstructions. This deficient practice affects all occupants in the facility including staff, visitors and residents.</p> <p>Findings include:</p> <p>Based on review of sprinkler system "Report of Inspection" documentation with the Maintenance Supervisor and Executive Supervisor on 12/1/15 at 10:13 a.m., the internal inspection had been performed on 3/24/14 by SafeCare. In the report, SafeCare noted "Performed Internal Pipe inspection on both systems</p>	K 0062	<p>been educated on Life Safety guidelines regarding fire safety on December 14, 2015. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Audits will be submitted to QAPI monthly with percentage compliance for review and recommendations to ensure improvement. 5. Date of Completion: December 31, 2015</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Letter of intent from VFP to provide a 5 year internal pipe inspection and change of 10 corroded exterior sprinkler heads located by rm 216 and rm 317 with anticipated start date of January 15, 2016 and estimated completion date of February 14, 2016. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: None identified 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Any recommendations on repairs will be communicated</p>	12/31/2015

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	<p>found both systems had large amounts of rust build up recommend both systems be flushed." Based on interview at the time of record review, the Maintenance Supervisor acknowledged the facility had submitted a quote to have the sprinkler system flushed but was denied by the corporate office and no further action has occurred.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 8 of 8 corroded exterior sprinkler heads by resident room 216 and 2 of 6 corroded exterior sprinkler heads by resident room 317. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected 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 staff, visitors, and up to 26 residents.</p> <p>Findings include:</p> <p>Based on observation with the</p>		<p>with Executive Director and Facility Engineer Consultant by Maintenance Director. Maintenance Director will audit exterior sprinkler heads monthly for 6 months. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Recommendations on repairs and sprinkler head inspection audit will be submitted to QAPI monthly for review and recommendations to ensure improved compliance. 5. Date of Completions: December 31, 2015</p>	

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K 0066 SS=D Bldg. 01	<p>Maintenance Supervisor and Executive Director on 12/1/15 at 11:47 a.m. then again at 12:23 p.m., the exit discharge near resident room 216 had an overhang greater than 4 ft requiring sprinkler heads. Eight of eight sprinkler heads in the overhang were corroded. Then again the exit discharge near resident room 317 had an overhang greater than 4 ft requiring sprinkler heads. Two of six sprinkler heads in the overhang were corroded. Based on interview at the time of each observation, the Maintenance Supervisor and Executive Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and</p>			

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K 0075 SS=E Bldg. 01	<p>safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Executive Director on 12/1/15 at 12:51 p.m., there were at least 50 cigarette butts on the ground in the designated smoke area and near the generator. Based on interview at the time of observation, the Maintenance Supervisor and Executive Director acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles</p>	K 0066	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Cigarette butts removed from designated smoker's area and placed in bin on December 2, 2015. Smoker's Oasis purchased on December 9, 2015. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No other areas identified 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director/Designee will audit designated smoker's area for loose cigarette butts 5x/weekly for 3 months then 2x/weekly for 3 months. 4. How the corrective action will be monitored to ensure the deficient practice will not recur: Audit will be submitted to QAPI monthly with percentage compliance for review and recommendation to ensure improvement. 5. Date of Completion: December 31, 2015</p>	12/31/2015	

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	<p>do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5</p> <p>Based on observation and interview, the facility failed to ensure a capacity of 32 gallons for soiled linen or trash collection receptacles was not exceeded within any 64 square foot area which was not protected as a hazardous area for 1 of 1 Therapy and 1 of 1 Advance Alzheimer's Wing. This deficient practice could affect staff and up to 22 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Executive Director on 12/1/15 at 11:11 a.m. then again at 1:55 p.m., a 45 gallon soiled linen cart was stored in Therapy. The Therapy doors did not have self closers. Then again in the Advance Alzheimer's Wing two separate 45 gallon soiled linen and trash were stored in the Kitchen bathroom. The Kitchen bathroom nor the dining room had doors that self-closed. Based on an interview at the time of observation, the Maintenance Supervisor and Executive Director acknowledged the</p>	K 0075	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: 30 gallon bags purchased December 1, 2015. Linen cart was removed from Advanced Alzheimer's bathroom on December 1, 2015. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No other areas identified 3. What measures will be put into place or what systemic changes will be made to ensure practice will not recur: Maintenance Director will audit trash bag size in Therapy gymnasium weekly for 3 months then monthly for 3 months. Maintenance Director will audit Alzheimer's Unit dining room bathroom for unattended linen cart weekly for 3 months then monthly for 3 months.4. How the corrective action will be monitored to ensure the deficient practice will not recur: Audit will be submitted to QAPI monthly with percentage compliance for review and recommendations to ensure</p>	12/31/2015

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K 0130 SS=E Bldg. 01	<p>aforementioned conditions.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation and interview, the facility failed to ensure the penetration in 3 of 3 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item</p>	K 0130	<p>improvement.5. Date of Compliance: December 31, 2015</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Fire barrier walls located on C wing, D wing 1 and D wing 2 were sealed on December 14, 2015 with approved intumescent fire caulk.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: No other fire barrier walls were identified.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director to inspect all fire barrier walls quarterly for 6 months. Audit will be completed and submitted to ED quarterly to ensure compliance.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: Audits will be submitted to QAPI monthly with compliance percentages to ensure quality improvement.</p> <p>5. Date of completion: December 31, 2015</p>	12/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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K 0147 SS=E Bldg. 01	<p>and the sleeve shall meet on of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>This deficient practice could affect at least 30 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor on 12/1/15 between 2:11 p.m. and 2:36 p.m., the following fire wall penetrations were discovered above the drop ceiling:</p> <p>a) a half inch penetration around cable in C Wing</p> <p>b) one inch penetration in D Wing #1</p> <p>c) a two inch penetration in D Wing #2</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor acknowledged each aforementioned condition and provided the measurements.</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>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155362	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING _____	X3) DATE SURVEY COMPLETED 12/01/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-MERRILLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 VIRGINIA PL MERRILLVILLE, IN 46410
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	<p>1. Based on observation and interview, the facility failed to ensure 12 of 12 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff and up to 16 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Executive Director on 07/20/15 between 10:46 a.m. to 12:41 p.m. the following was discovered:</p> <p>a) a surge protector was powering another surge protector powering computer components in the Reception office</p> <p>b) a surge protector was powering a coffee pot in the Reception office</p> <p>c) two different surge protectors were each powering another surge protector, both powering computer components in the C Wing Nurse's station</p> <p>d) a surge protector powering an oxygen concentrator in resident room 216.</p> <p>e) a multiplug extension cord was</p>	K 0147	<p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Surge protector removed from reception office, coffee pot unplugged from surge protector in office area, 2 surge protectors removed from C wing nurse's station, Rm 216 oxygen plugged into outlet, extension cord removed from ACU Director office, D wing nurse's station office surge protector removed on December 1, 2015. Outlet cover in mechanical room loft was replaced on December 14, 2015.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: Whole house audit for surge protectors compliance and outlet covers completed with no deficiencies noted.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure the deficient practice does not recur: Maintenance Director/Designee to audit resident rooms and facility office personnel for appropriate useage of surge protectors and mechanical room outlet covers weekly for 4 weeks then every other week for 4 weeks then monthly for 4 months.</p> <p>4. How the corrective action will be monitored to ensure the deficient practice will not recur: Audits will be submitted to QAPI monthly</p>	12/31/2015

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	<p>powering a refrigerator in the ACU Director's office</p> <p>f) a surge protector was powering two other surge protectors in D Wing Nurse's station office.</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor and Executive Director acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to maintain 1 of 4 electrical outlets in the Mechanical Room Loft. NFPA 70, National Electrical Code 70, 1999 edition, Article 410-3, Live Parts, requires receptacles to have no live parts normally exposed to contact. This deficient practice affects staff only.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor and Executive Director on 12/1/15 at 1:02 p.m., an electrical outlet was missing a cover in the Mechanical Room loft. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		with percentage compliance for review and recommendations to ensure improvement. 5. Date of Completions: Decemer 31, 2015	