

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  07/07/2015
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NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/07/15</p> <p>Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000</p> <p>At this Life Safety Code survey, Crown Point Christian Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was located on the west side of the first floor and the entire lower level of a two story building. The facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in spaces open to the corridors and in resident rooms. The facility has a</p>	K 0000	<p>K 000</p> <p>This Plan ofCorrection is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constituteadmission or agreement by the provider of thetruth of the facts alleged or conclusions set forth in the statement ofdeficiencies. The plan of correction is prepared and/or executedsolely because it is required by the revision of federal and state law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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

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K 0018 SS=D Bldg. 01	<p>capacity of 146 and had a census of 119 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The detached waste water treatment plant, fire system pump house and equipment storage garages were unsprinklered.</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 regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 3 of 138 resident room corridor doors closed and latched into the door frame. This deficient practice could affect 4 residents.</p> <p>Findings include:</p>	K 0018	<p>REQUEST DESK COMPLIANCE</p> <p>K 018</p> <p>1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice.</p> <p>a. Door in rooms 101, 116,</p>	07/21/2015

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	<p>Based on observation and interview on 07/07/15 between 11:06 am and 3:51 p.m., the Maintenance Supervisor and Administrator in Training acknowledged the corridor door to resident rooms 101, 116, and 278 were not latching into the door frame after multiple attempts from the Maintenance Supervisor.</p> <p>3.1-19(b)</p>		<p>and 278 which failed to latch in the door frame have been repaired as the survey progressed.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>1. Residents, staff and visitors have the potential to be affected.</p> <p>2. The corrections being made protect residents, staff and visitors.</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:</p> <p>1. Maintenance department personnel shall inspect doors for code compliance quarterly, checking at a minimum 29 doors per month and corrections will be completed immediately.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>1. The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>2. To ensure that this practice does not recur the facility will</p>	

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K 0029 SS=D Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Trash collection rooms in D Hall, a hazardous area, were provided with a self closer. This deficient practice could affect 24 residents in the D Hall.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator in Training on 07/08/15 at 12:30 p.m., there was no self closer on the trash collection room door located in D Hall. Based on interview at the time of</p>	K 0029	<p>check all doors inthe facility on a revolving quarterly basis with results of audit forwarded tothe Quality Improvement Committee for a total of six months. (Attachment #1) 3.Thechange will be in place by July 21, 2015.</p> <p>REQUEST DESK COMPLIANCE K 029 1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice. a. Thefacility has placed a self-closer on the trash collection room door location inD Hall. (Seeattachment #2) 2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken: 1.Residents, staff and visitors have the potentialto be affected.</p>	07/21/2015

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K 0046 SS=E Bldg. 01	<p>observation, the Maintenance Supervisor and Administrator in Training acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1. Based on observation and interview, the facility failed to ensure 3 of 3 battery operated emergency light fixtures were</p>	K 0046	<p>2.The corrections being made protect residents,staff and visitors.</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:</p> <p>1.Maintenance department personnel shall inspect all doors for code compliance quarterly.</p> <p>4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>1.The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>2.To ensure that this practice does not recur the maintenance staff will check all doors requiring self-closers in the facility are functioning within code compliance for six months. Results of audit forwarded to the Quality Improvement Committee. (See attachment #1)</p> <p>3.The change will be in place by July 21, 2015.</p> <p>REQUEST DESK COMPLIANCE K 046 1.What corrective action (s) will be accomplished for those</p>	07/21/2015

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	<p>tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. In addition, NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Supervisor and Administrator in Training on 07/08/15 at 10:24 a.m., three battery operated emergency task lights were noted as being checked. Based on an interview with the Maintenance Supervisor and Administrator in Training during record review, the Maintenance described the</p>		<p>residents found to have been affected by the deficient practice.</p> <p>a. The facility administrator and maintenance Director have reviewed current emergency lighting procedure, cross referencing with stateguidelines.</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:</p> <p>1.Residents, staff and visitors have the potentialto be affected.</p> <p>2.The corrections being made protect residents,staff and visitors.</p> <p>3.What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur:</p> <p>1.Administrator and Maintenance director willensure that testing is done at 30 seconds monthly and 90 minutes annually.</p> <p>4.How the corrective action(s) will bemonitored to ensure the deficient practice will not recur: i.e., what quality assurance program will beput into place.</p> <p>1.The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>2.To ensure that this practice does not recur the maintenance director will performa 30 second test and a 90 minute test with Administrator</p>	

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K 0052 SS=A Bldg. 01	<p>testing as just pushing the test button for a second or two. Maintenance Supervisor and Administrator in Training said they were unaware of the requirement for a written record of a monthly thirty second function test or an annual ninety minute test for the battery operated emergency task lights.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 1 of 7 smoke detectors had been sensitivity tested. LSC 9.6.2.10.1 refers to NFPA 72, the National Fire Alarm Code. NFPA 72, at 7-3.2.1 states Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be</p>	K 0052	<p>present and then continue monthly testing. Record of 90 minute annual test as well as 30 second monthly tests will be documented on an audit tool for six months. The Quality Improvement Committee will review audit sheet monthly. (See attachment #3)</p> <p>3. The change will be in place by July 21, 2015.</p> <p>No deficiency in this category</p>	07/21/2015			

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	<p>permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> <li>(1) Calibrated test method,</li> <li>(2) Manufacturer's calibrated sensitivity test instruments,</li> <li>(3) Listed control equipment arranged for the purpose,</li> <li>(4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside the listed sensitivity range,</li> <li>(5) Other calibrated sensitivity test methods approved by the authority having jurisdiction.</li> </ol> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated, or be replaced.</p> <p>NOTE: The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector.</p>			

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K 0062 SS=D Bldg. 01	<p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on record review and interview on 07/08/2015 at 9:39 a.m., the Maintenance Supervisor and Administrator in Training acknowledged the smoke detector in the resident room 204 was out of range. Sensitivity test report from SafeCare showed resident room 204 photoelectric smoke detector read 3.67%. The range for that device was listed as (1.5-3.59%).</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>1. Based on observation and interview, the facility failed to replace 1 of 1 sprinkler heads in the bathroom of resident room 274. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is</p>	K 0062	<p>REQUEST DESK COMPLIANCE</p> <p>K 062</p> <p>1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice.</p> <p>a. The sprinkler heads in Room 274 and the Game Room have been corrected.</p>	07/21/2015

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	<p>painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 1 resident.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator in Training on 07/07/15 at 2:06 p.m., one of one automatic sprinklers in the bathroom of resident room 274 was corroded with a green substance. Based on interview at the time of the observation, the Maintenance Supervisor and Administrator in Training acknowledged the condition of the sprinkler head.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 1 sprinkler heads in the Game Room. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and any</p>		<p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:</p> <p>1.Residents, staff and visitors have the potentialto be affected.</p> <p>2.The corrections being made protect residents,staff and visitors.</p> <p>3.What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur:</p> <p>4.</p> <p>a. The facility Maintenance Supervisor willperform quarterly sprinkler system checks to assurethat the sprinkler head is inspected, tested and maintained in accordance with NFPA 25.</p> <p>5.How the corrective action(s) will bemonitored to ensure the deficient practice will not recur: i.e., what quality assurance program will beput into place.</p> <p>1.The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>2.Toensure that this practice does not reoccur the maintenance director will performquarterly sprinkler system checks and track the</p>	

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K 0130 SS=E Bldg. 01	<p>resident in the game room.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor and Administrator in Training on 07/07/15 at 2:37 p.m., one of one automatic sprinklers in the Game room was painted. Based on interview at the time of the observation, the Maintenance Supervisor and Administrator in Training acknowledged the condition of the sprinkler head.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>1. Based on observation and interview, the facility failed to ensure the penetration in 1 of 2 fire barrier walls on the Lower Level 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</p>	K 0130	<p>Maintenance audit sheets for the next six months. The change will be in place by July 21, 2015.</p> <p>REQUEST DESK COMPLIANCE</p> <p>K 130</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>a. The fire barrier areas on C Hall that was penetrated has been repaired.</p> <p>b. The facility will install a fire barrier door with rating that meets LSC 101.8.2.3.2.3.1 Section 8.2.3.2.3.1</p>	07/21/2015

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	<p>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 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 62 residents the Lower Level, staff, and visitors.</p> <p>Findings include:</p> <p>Based on an observation with the Maintenance Supervisor and Administrator in Training on 07/07/15 at 3:33 p.m., the fire barrier wall in C Hall had an unsealed penetration above the</p>		<p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:</p> <p>1.Residents, staff and visitors have the potentialto be affected.</p> <p>2.The corrections being made protect residents,staff and visitors.</p> <p>3.What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur:</p> <p>a. The Maintenance director securing bids toreplace fire barrier door to meet LSC 101.8.2.3.2.31Section 8.2.3.2.3.1</p> <p>b. Any work done which penetrates fire barrierwill be checked upon completion of the work toassure the fire barrier is repaired.</p> <p>4.How the corrective action(s) will bemonitored to ensure the deficient practice will not recur: i.e., what quality assurance program will beput into place.</p> <p>1.Themaintenance supervisor/designee is responsible for ongoing compliance.</p> <p>2.Toensure that this practice does not reoccur the</p>	

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NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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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
	<p>drop ceiling measuring three inches by three inches between large piping. Based on interview at the time of observation, the Maintenance Supervisor and Administrator in Training acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on record review, interview, and observation, the facility failed to install a 1.5 hour door in accordance to LSC 101 8.2.3.2.3.1. Section 8.2.3.2.3.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. The fire protection rating for opening protectives (1) 2 hour fire barrier -- 1 1/2 hour fire protection rating. This deficient practice could affect 62 residents, staff, and visitors.</p> <p>Findings include:</p> <p>Based on interview and record review with the Maintenance Supervisor and Administrator in Training on 07/07/15 during record review between 9:50 a.m. and 11:06 a.m., site plans were reviewed and the Maintenance Supervisor pointed out the facility's fire and smoke barriers. A two hour fire barrier in C Hall was noted. Based on observation with the</p>		<p>maintenance director will:</p> <ol style="list-style-type: none"> <li>1. Ask all outside vendors to check in at reception and do exit conference with maintenance of area that they worked while in the facility so areas can be checked to assure no penetration of fire barrier. (See attachment #4)</li> <li>2. If workers complete repair, the maintenance supervisor will monitor the worker that no penetration of fire barrier has occurred.</li> <li>3. The change will be in place by July 21, 2015.</li> </ol>	

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K 0147 SS=D Bldg. 01	<p>Maintenance Supervisor at 3:40 p.m., the fire door rating in the C-Hall was rated for 60 minutes. The Maintenance Supervisor acknowledged the aforementioned condition.</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 6 of 6 flexible cords such as extension cords, extension cord power strips, and multiplug adapters were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment to comply with 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. These deficient practices could affect up to 2 residents in each resident room and staff. Findings include: Based on an observation with the</p>	K 0147	<p>REQUEST DESK COMPLIANCE K 147</p> <p>1.What corrective action (s) will be accomplishedfor those residents found to have been affected by the deficient practice.</p> <p>a. Themicrowave and refrigerator were moved where the appliances could be plugged directly into the wall according to LSC 9.1.2 NFPA 70.</p> <p>b. Theoxygen concentrator was removed from the surge protector and plugged into thewall accordingto LSC 9.1.2 NFPA 70. c. Multiplug adapter in room 269 removed.</p> <p>d. Extension cord removed from payroll office</p> <p>2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:</p> <p>1.Residents, staff and</p>	07/21/2015

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	<p>Maintenance Supervisor and Administrator in Training on 07/07/15 between 11:28 a.m. to 2:59 p.m. the following was discovered:</p> <p>a. A microwave and refrigerator were plugged into a surge protector, which was plugged into another surge protector in the Restorative Room.</p> <p>b. An oxygen concentrator was plugged into an extension cord, which was plugged into a surge protector in resident room 132.</p> <p>c. A lamp and radio were powered by a surge protector, which was plugged into a multiplug adapter in resident room 269.</p> <p>d. A fan was powered by an extension cord in Payroll</p> <p>Based on interview at the time of each observation, the Maintenance Supervisor and Administrator in training acknowledged the aforementioned conditions.</p> <p>3.1-19(b)</p>		<p>visitors have the potential to be affected.</p> <p>2. The corrections being made protect residents, staff and visitors.</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: a. Staff, residents as well as families of residents will be educated regarding not allowing any of the following in resident rooms, resident areas, and other areas in the facility: 1. No power strips plugged into power strips 2. No extension cords 3. No multiplug devices 4. High amp. draw items must be plugged directly into designated outlets.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: i.e., what quality assurance program will be put into place.</p> <p>1. The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>2. To ensure that this practice does not reoccur the housekeeping department will conduct weekly audits for power strips plugged into power strips, extension cords and multiplug devices for six months. All audits will be submitted to the Quality Assurance committee for compliance. (See attachment #5) The change will be in place by July 21, 2015.</p>	

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

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