STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 06/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

(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	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: 06/20/16 Facility Number: 000150 Provider Number: 155246 AIM Number: 100267000 At this Life Safety survey, Chesterton Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2 This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and areas open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 100 and had a census of 70 at the time of this survey.	K 0000	K 000 INITIAL COMMENTS K 000 A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health inaccordance with 42 CFR 483.70(a). Survey Date: 06/20/16 **The facility requests paper compliance for these citations.** The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.	

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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	Areas where residents have customary access were sprinklered except the smoke hut. All areas providing facility services were sprinklered. Quality Review completed on 06/22/16 - DA			
K 0017 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck 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 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, 19.3.6.4, 19.3.6.5 Based on observation, the facility failed to ensure 1 of 1 300 Hall corridors was capable of resisting smoke. This deficient practice could affect staff and up to 12 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at	K 0017	K 017 SS=E NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance Based on observation, the facility failed to ensure 1 of 1, 300 Hall corridors was capable of resisting smoke. This deficient practice could affect staff and up to 12 residents. Findings include: Based on observation with the Maintenance Supervisor on	07/01/2016

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	12:24 p.m., the corridor wall next to resident room door 307 was not smoke resistant due to a two inch by one inch penetration. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition and provided the measurements. 3.1-19(b)		06/20/16 at 12:24 p.m., the corridor wall next to resident room door 307 was not smoke resistant due to a two inch by one inch penetration. Based on interview at the time of observation, the Maintenance Supervisor has repaired the penetration acknowledged in the aforementioned condition and a 100% review of doorways on all halls that could have the potential condition was completed June 24, 2016. No other penetrations we identified. Monthly audits of all hallway doors will be conducted and recorded in the TELS electronic maintenance program. This will become part of monthly preventative maintenance tasks, and a record of findings will be reported in monthly QA meetings times six months. Random spot checks audits will be conducted weekly on one hall for six months by the Maintenance Director or his designee. A record of this will be maintained in the TELS program and reported at monthly QA meetings for six months. Should any concerns be identified an additional 30 days will be added to audits to be reported in QA meeting. C	
K 0018 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed			

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	of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 200 Hall Linen room corridor door latched into the door frame. This deficient practice could affect staff and up to 19 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 12:36 p.m., the 200 Hall Linen room door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)	K 0018	K 018 SS=E NFPA 101 LIFE SAFETY CODE STANDARD This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 1, 200 Hall Linen room corridor door latched into the door frame. This deficient practice could affect staff and up to 19 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 12:36 p.m., the 200 Hall Linen room door failed to latch into the frame when tested. Based on interview at the time of observation, the Maintenance Supervisor has repaired the Linen room door latch into the frame acknowledged in the aforementioned condition and a 100% review of doorways on all halls that could have the potential	07/01/2016

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 resident room 202 corridor door was smoke resistive. This deficient practice could affect staff and up to 19 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 12:31 p.m., a one eighth inch gap around the door hand in the resident room 202 corridor door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 Maintenance corridor door had no impediment to latching. This deficient practice could affect staff and up to 9 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 12:47 p.m., the Maintenance corridor door contained a rubber door stop. Based on interview at the time of observation,		condition was completed June 24, 2016. No other latches we identified. Monthly audits of all hallway doors will be conducted and recorded in the TELS electronic maintenance program, by the maintenance director , or his designee. This will become part of monthly preventative maintenance tasks, and a record of findings will be reported in monthly QA meetings times six months by the maintenance supervisor, or his designee. Random spot checks audits will be conducted weekly on one hall for six months. A record of this will be maintained in the TELS program and reported at monthly QA meetings for six months. Should any concerns be identified an additional 30 days will be added to audits to be reported in QA meeting. 2. Based on observation and interview, the facility failed to ensure 1 of 1, resident room 202 corridor door was smoke resistive. This deficient practice could affect staff and up to 19 residents. Based on interview at the time of observation, the Maintenance Supervisor has repaired the one eighth inch gap around the door handle in the resident room 202 corridor door. A 100% review of door handles on all halls that could have the potential condition was completed June 24, 2016. No other handles we identified. Monthly audits of all hallway door handles will be conducted and	

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	the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of 1 Staff Break room corridor door contained positive latching hardware. This deficient practice could affect staff and up to 9 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 1:00 p.m., the Staff Break room corridor door contained a manual slide bolt. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		recorded in the TELS electronic maintenance program by the maintenance director, or his designee. This will become part of monthly preventative maintenance tasks, and a record of findings will be reported in monthly QA meetings times six months. Random spot checks audits will be conducted weekly on one hall for six months. A record of this will be maintained in the TELS program and reported at monthly QA meetings for six months.Should any concerns be identified an additional 30 days will be added to audits to be reported in QA meeting. 3. Based on observation and interview, the facility failed to ensure 1 of 1 Maintenance corridor door had no impediment to latching. This deficient practice could affect staff and up to 9 residents. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. Based on interview at the time of observation, the Maintenance Supervisor has removed the aforementioned and corrected the condition and a 100% review of doorways that could have the potential condition was completed June 24, 2016. No other Door stops we identified. Monthly audits of all hallway doors will be conducted and recorded in the TELS electronic maintenance program by the maintenance director, or his designee. This will	

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			become part of monthly preventative maintenance tasks, and a record of findings will be reported in monthly QA meetings times six months. Random spot checks audits will be conducted weekly on one hall for six months. A record of this will be maintained in the TELS program and reported atmonthly QA meetings for six months. Should any concerns be identified an additional 30 days will be added to audits to be reported in QA meeting. 4. Based on observation and interview, the facility failed to ensure 1 of 1 Staff Break room corridor door contained positive latching hardware. This deficient practice could affect staff and up to 9 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 1:00 p.m., the Staff Break room corridor door contained a manual slide bolt. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. Based on interview at the time of observation, the Maintenance Supervisor has removed the aforementioned corrected the condition and a 100% review of doorways on all halls that could have the potential condition was completed June 24, 2016.	
K 0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

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Bldg. 01	One hour fire rated construction (with o 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			
	1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 Storage room 311 greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and at least 12 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 12:17 p.m., Storage room 311 contained six mattresses, thirty large cardboard boxes, a wooden storage area containing facility tools, and other storage. The corridor door did not have a self-closing device installed. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)	K 0029	K 029 SS=E NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ohour fire-rated doors) or an approved automatic fire extinguishing system inaccordance 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 1. Based onobservation and interview, the facility failed to ensure the corridor door to 1of 1 Storage room 311 greater than 50 square feet, a hazardous area, was provided with self-closer and would latch into the frame. This deficient practice could affect staff and at least 12 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 12:17	07/01/2016

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	2. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 Kitchen, a hazardous area, was provided with positive latching hardware. This deficient practice could affect staff and at least 9 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 12:49 p.m., one of the two corridor doors to the Kitchen contained a slide bolt towards the bottom of the door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		p.m., Storage room 311 contained six mattresses, thirty large cardboard boxes, a wooden storage area containing facility tools, and other storage. The corridor door did not have a self-closing device installed. Based on interview at the time of observation, the Maintenance Supervisor has purchased and installed adoor self-closer, correcting the aforementioned condition. Date of completion07/01/2016. 2. Based on observation and interview, the facility failed to ensure the corridor doors to1 of 1 Kitchen, a hazardous area, was provided with positive latching hardware.This deficient practice could affect staff and at least 9 residents. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at12:49 p.m., one of the two corridor doors to the Kitchen contained a slide bolt towards the bottom of the door. Based on interview at the time of observation, the Maintenance Supervisor has removed the aforementioned slide bolt from the kitchen correcting the condition. Date of completion 07/01/2016.	
K 0051 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire			

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	Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6			
	Based on observation and interview, the facility failed to ensure smoke detectors in were not installed where air flow would adversely affect the operation. NFPA 72, 2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and up to 35 residents. Findings include: Based on observation with Maintenance Supervisor on 06/20/16 between 11:23 a.m. to 1:03 p.m., the following was discovered:	K 0051	K 051 SS=E NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not	07/01/2016

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	a) a ceiling fan blade was directly under 1 of 1 smoke detector in the Beauty Shop b) one of eight smoke detector was eighteen inches away from an HVAC vent near the only Nurses' station c) two of two smoke detectors were eleven and a half inches and eighteen inches away from HVAC vents in the Restorative Dining room. d) one of one smoke detector was twenty six and a half inches away from an HVAC vent outside of the Staff Break room. Based on interview at the time of observation, the Maintenance Supervisor the aforementioned condition and provided the measurements. 3.1-19(b)		be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. Incritical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in Based on observation and interview, the facility failed to ensure smoke detectors in were not installed where air flow would adversely affect the operation. NFPA 72,2-3.5.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect staff and up to 35 residents. Findings include: Based on observation with Maintenance Supervisor on 06/20/16 between 11:23 a.m. to 1:03 p.m., the following was discovered: a) A ceiling fan blade was directly under 1 of 1 smoke detector in the Beauty Shop. The maintenance director moved the smoke detector, correcting the deficiency on 07/01/2016. b) One of eight smoke detector was eighteen inches away from an HVAC vent near the only Nurses' station. The maintenance director moved the smoke detector, correcting the deficiency on 07/01/2016. c) Two of two smoke detectors were eleven and a half inches and eighteen inches away from HVAC vents in the	

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			Restorative Dining room. The maintenance director moved the smoke detector, correcting the deficiency on 07/01/2016. d) One of one smoke detector was twenty six and a half inches away from an HVAC vent outside of the Staff Break room. The maintenance director moved the smoke detector, correcting the deficiency on 07/01/2016.	
K 0062 SS=F Bldg. 01	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 Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support nonsystem components. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Supervisor on 06/20/16 at 1:24 p.m., excess Ethernet cable was wrapped together then zip tied around a sprinkler pipe in the attic near the 400 Hall fire barrier. Based on interview at	K 0062	K 062 Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with NFPA 13, 1999 Standard for the Installation of Sprinkler Systems. NFPA 13, 6-1.1.5 requires sprinkler piping or hangers shall not be used to support non-systematic components. This deficient practice could affect all occupants. Findings include: Based on observations with the Maintenance Supervisor on 06/20/16 at 1:24 p.m., the excess Ethernet cable that was wrapped together with zip ties around sprinkler pipe in the attic near the 400 Hall fire barrier was removed from piping by Safe Care sprinkler contracting firm. Based on interview at the time of	07/01/2016

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	the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		observation, the Maintenance Supervisor directed Safe Care to complete a 100% review of the sprinkler piping to identify and remove additional zip ties that maybe wrapped around piping and make appropriate corrections as necessary. Monthly audits of sprinkler piping will be conducted by the maintenance director, or his designee and recorded in the TELS electronic maintenance program. This will become part of monthly preventative maintenance tasks, and a record of findings will be reported in monthly QA meetings times six months. Corrections were completed 6/27/2016.	
K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 4 of 58 single station smoke detectors would operate. This deficient practice could affect staff and up to 5 residents. Findings include: Based on record review with the Maintenance Supervisor on 06/20/16 at 10:25 a.m., the "Battery Check Smoke Detectors" failed to include information indicating a battery replacement program	K 0130	K 130 SS=E NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by Based on record review and interview, the facility failed to ensure a battery replacement program was provided to ensure 4 of 58 single station smoke detectors would operate. This deficient practice could affect staff and up to 5 residents. Findings include: Based on record review with the Maintenance Supervisor on 06/20/16 at 10:25 a.m., the "BatteryCheck Smoke Detectors" failed to include information indicating a battery	07/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED
	155246		06/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

(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
	for four single station smoke detectors in the Beauty Shop, Meeting Room, and two in Therapy. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition and confirmed no other documentation is available for review. 3.1-19(b)		replacementprogram for four single station smoke detectors in the Beauty Shop, Meeting Room, and two in Therapy. Maintenance personnel have been re-educated on the procedure to ensure a battery replacement program is provided. In addition to review and re-education, the maintenance department conducted a 100% audit to ensure all battery operated smoke detectors checks are recorded in the TELS electronic maintenance program. This will become part of monthly preventative maintenance tasks, and arecord of findings will be reported in monthly QA meetings times six months. Random spot checks audits will be conducted weekly on one hall for six months by the maintenance director, or his designee. A record of this will be maintained in the TELS program and reported at monthly QA meetings for six months. Should any concerns be identified an additional 30 days will be added to audits to be reported in QA meeting.	
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA 70, National	K 0147	K 147 SS=D NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be inaccordance with National Electrical Code. 9-1.2	07/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155246	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 06/20/2016
NAME OF PROVIDER OR SUPPLIER CHESTERTON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 110 BEVERLY DR CHESTERTON, IN 46304	

(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
	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 only. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 11:43 a.m., a battery back up surge protector was powering another surge protector powering telephone equipment in the Electric room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b)		(NFPA 99) 18.9.1, 19.9.1 NFPA70, National Electrical Code, 1999 Edition, Article 400-8. Findings include: Based on observation with the Maintenance Supervisor on 06/20/16 at 11:43 a.m., a battery backup surge protector was powering another surge protector powering telephone equipment in the Electric room. Based on interview at the time of observation, the Maintenance Supervisor removed the aforementioned battery backup surge protector and plugged the device directly into a fixed wiring power supply correcting the condition. Monthly audits will be conducted as part of preventative maintenance rounds and recorded in the TELS electronic maintenance program. This will become part of monthly preventative maintenance tasks, and a record of findings will be reported in monthly QA meetings times six months. Random spot checks audits will be conducted weekly on one hall for six months. A record of this will be maintained in the TELS program and reported at monthly QA meetings for six months. Should any concerns be identified an additional 30 days will be added to audits to be reported in QA meeting.	