

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/25/2015
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NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818
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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: 08/24/15 and 08/25/15</p> <p>Facility Number: 000255 Provider Number: 155364 AIM Number: 100273280</p> <p>At this Life Safety Code survey, Byron Health Center 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 four story facility with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors and areas open to the corridors. Battery operated smoke detectors have been installed in all resident rooms. The facility has a capacity of 191 and had a census of 94 at</p>	K 0000	<p>This Plan of Correction is Byron Health Center's credible allegation of compliance. It is the intention of Byron Health Center to be in complete compliance with all Federal and State guidelines. 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 state deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.</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 0021 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. Areas providing facility services were sprinklered.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>1. Based on observation an interview, The facility failed to ensure 3 of 3 single doors and 1 of 1 double set of doors entering the kitchen open to the corridor would automatically latch into the door frame. This deficient practice could affect 55 residents using the facility's dining room and staff in the kitchen.</p> <p>Findings include:</p> <p>Based on observations during the tour of the facility with the Director of Plant</p>	K 0021	<p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b></p> <p>1.All doors to the kitchen will be equipped with self-latchingdevices.</p> <p>2.All rubber stoppers have been removed.</p> <p><b>How other residentshaving the potential to be affect by the same deficient practice will beidentified and what corrective action(s) will be taken.</b></p> <p>1.All residents utilizing the area have thepotential to be affected</p>	09/24/2015
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	<p>Operations on 08/24/15 between 1:35 p.m. to 1:40 p.m. the following was noted:</p> <p>a.) there were three single doors entering the kitchen from the dining room corridor that were equipped only with a manual slide bolt causing the doors not to automatically latch into the frame.</p> <p>b.) there was one set of double doors entering the kitchen from the dining corridor that did not automatically latch into the frame or was equipped with a positive latching device. The first of the double doors was equipped with a manual slide latch that latched into the frame. The second door latched into the first door with a manual dead bolt. Based on interview at the time of observation, the Director of Plant Operations acknowledged that all doors did not automatically latch into the frame.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 3 single self closing kitchen doors was provided with a hold open device that would release with the fire alarm and cause the door to automatically close and latch into the door frame. This deficient practice could affect 55 resident using the dining room and staff in the kitchen.</p>		<p>by this practice.</p> <p>2.All residents utilizing the area have thepotential to be affected by this practice.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</b></p> <p>1.All doors to the kitchen with be equipped withself-latching devices.</p> <p>2.All kitchen staff will be in-serviced on notusing rubber stoppers by September 24, 2015 by the Director of Dietary Services.</p> <p><b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur.i.e., what quality assurance program will be put into place.</b></p> <p>The Director of Dietary Services, or his/her designee, willmonitor monthly the correct usage of all doors in the dietary department. The Director of Environmental Service, or his/her designee will monitor monthly the self-latching devices for proper closure The results of the monitoring will bereviewed in the QAPI meeting to ensure compliance.</p>	

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K 0025 SS=E Bldg. 01	<p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Operations on 08/24/15 at 1:36 p.m., the kitchen door from the wash room to the dining room was equipped with a self closing device but was held open by a rubber stopper that did not automatically release with the fire alarm. Based on interview at the time of observation, the Director of Plant Operations acknowledged the device holding the door open did not release with the fire alarm and removed the stopper.</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 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 provide complete smoke barriers for 2 of 2 smoke barrier walls on the third floor. LSC Section</p>	K 0025	<p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b></p> <p>1.The improper foam was</p>	09/24/2015
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	<p>8.3.2 requires smoke barriers to be continuous through all concealed spaces, such as those found above a ceiling. This deficient practice affects 26 residents on the third floor.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Lead Maintenance Technician on 08/25/15 between 12:00 p.m. and 12:50 p.m., all smoke barriers providing separation for the third floor were incomplete. Each of the smoke barriers terminated one inch below the corrugated roof deck, and the gaps between the smoke barrier and the corrugated roof deck was filled with yellow expandable foam; an unapproved material. Based on interview at the time of observation, the Lead Maintenance Technician did not know if the yellow expandable foam was an approved material and did not have the documentation to show the foam met the requirements for use in through penetration fire stop systems.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 4 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating.</p>		<p>removed and the areas weresealed with ASTM E 84 and ASTM E814/ULI 1479 tested fire stop expanding foam.</p> <p>2.The ceiling tiles were replaced.</p> <p><b>How other residentshaving the potential to be affect by the same deficient practice will beidentified and what corrective action(s) will be taken.</b></p> <p>1.All residents living in the affected area havethe potential to be affected by this practice.</p> <p>2.No resident had the potential to be affected bythe broken ceiling tiles, as they were not in resident areas.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</b></p> <p>1.Any time any new wires or conduit is installed,it must sealed with fire rated foam.</p> <p>2.All staff will be in-serviced by the Director ofEnvironmental Services, or his designee, on reporting broken ceiling tiles tothe Environmental Services team.</p> <p><b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur.i.e., what quality assurance program will be put into place.</b></p> <p>1.The Director of Environmental Services, or hisdesignee, will monitor all work, once completed, to ensure fire rated foam wasused to reseal the area.</p>		

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K 0029 SS=E Bldg. 01	<p>LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 25 residents on the second floor.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Operations and the Lead Maintenance Technician on 08/24/15 between at 11:15 a.m. and 1:00 p.m., the following was noted:</p> <p>a.) in the ceiling of the second floor center storage room there was an uncovered hole measuring seven inches by twelve inches in size.</p> <p>b.) in the ceiling of the second floor pantry there was an uncovered hole measuring six inches by twelve inches in size.</p> <p>Based on interview at the time of observation, the Director of Plant Operations and the Lead Maintenance Technician acknowledged and provided the measurements of the uncovered holes.</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</p>		<p>Results of themonitoring will be discussed in the QAPI meeting to ensure compliance.</p> <p>2.The Director of Environmental Services, or hisdesignee, will monitor 25% of ceiling tiles weekly, to ensure there are nobroken ceiling tiles. Results of the monitoring will be discussed in the QAPImeeting to ensure compliance.</p>	

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	<p>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 doors to 1 of 1 Bio-Hazardous rooms on the south ramp service hall and 1 of 1 whirlpool rooms on the second floor, both hazardous areas, were provided with self closer's and would latch into their door frames. This deficient practice could affect 25 residents on the second floor and staff in the south ramp service corridor.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations and the Lead Maintenance Technician on 08/24/15 at 11:35 a.m. and on 08/25/15 at 11:20 a.m., the following was noted:</p> <p>a.) there was no self closer on the second floor whirlpool room door where two containers were stored totaling more than 32 gallons fill with trash and soiled linens.</p> <p>b.) the door to the Bio-Hazardous room</p>	K 0029	<p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b></p> <p>1.Containers not to exceed 32 gallons will beallowed in the whirlpool room at a time.</p> <p>2.The latch on the door to the Bio-Hazardous room hasbeen corrected and now self-closes.</p> <p><b>How other residentshaving the potential to be affect by the same deficient practice will beidentified and what corrective action(s) will be taken.</b></p> <p>1.All residents living in the affected area havethe potential to be affected by this practice.</p> <p>2.All residents living in the affected area havethe potential to be affected by this practice.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</b></p> <p>1.System for bio-hazard container identificationwill be re-implemented with all staff. All staff will be in-serviced on thecorrect bio-hazard container</p>	09/24/2015
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K 0038 SS=E Bldg. 01	<p>on the the south ramp service corridor did self close but failed to latch into the door frame. Based on an interview, this was acknowledged by the Director of Plant Operations and the Lead Maintenance Technician at the time of observations.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview the facility failed to ensure 2 of 18 corridors were maintained to provide adequate headroom. LSC 7.1.5 requires the means of egress shall be designed and maintained to provide adequate headroom as provided in other sections of this Code and shall not be less than 7 ft 6</p>	K 0038	<p>system by the Environmental Services team. 2.All staff will be in-serviced on reporting issueswith any self-closing doors to the Environmental Services team. <b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur.e., what quality assurance program will be put into place.</b> 1.The Director of Nursing, or her designee, willmonitor monthly the correct use of bio-hazard containers in the whirlpool room.Results of the monitoring will be discussed in the QAPI meeting to ensurecompliance. 2.The Director of Environmental Services, or hisdesignee, will monitor monthly the self-closing capability of 10 % of theself-closing doors in the facility. Results of the monitoring will be discussedin the QAPI meeting to ensure compliance.</p> <p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b> The cited corridors are not corridors residents are requiredto use and are not part of corridors for egress from the building. This facility has been granted a waiver formany years and</p>	09/24/2015

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	<p>in. with projections from the ceiling not less than 6 ft. 8 inches nominal height above the finished floor. The minimum ceiling height shall be maintained for not less than two thirds of the ceiling area of any room or space, provided the ceiling height of remaining ceiling area is not less than 6 ft. 8 in. This deficient practice could affect any residents, staff and visitors in the facility that would use these basement corridors.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations on 08/25/14 from 10:15 p.m. to 12:00 p.m. the following areas in the basement failed to provide adequate headroom:</p> <p>a.) The basement ceiling height in the east-west corridor measured six feet two and one half inches. Additionally, there was a pipe protruding below the ceiling along the 70 foot corridor that measured five feet seven inches from the floor.</p> <p>b.) The ceiling height at the south basement corridor smoke barrier wall measured five feet nine inches. Additionally, there was a pipe protruding below the ceiling which ran along the center basement corridor that measured six feet from the floor and the north-south corridor intersection had</p>		<p>we will once again request the waiver.</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>The ceiling heights have been this way for decades and no resident has been adversely affected.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>The ceiling area cited is in the basement area was built in the 1920's There is no economically feasible way to raise the ceiling height. The useful life of the building is only 2 years.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur. e., what quality assurance program will be put into place.</b></p> <p>We will be requesting a waiver. Please see attachment</p>	

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K 0062 SS=E Bldg. 01	<p>pipes protruding below the ceiling which ran along the corridor that measure five feet nine inches from the floor. Based on interview, this was acknowledged by the Director of Plant Operations at the time of observations.</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 ensure 5 of 5 sprinklers in the third floor day room were properly maintained. 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. This deficient practice can affect 26 residents on the third floor.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Plant Operations on 08/24/15 at 11:45 a.m., all five sprinkler heads in the third floor day</p>	K 0062	<p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b></p> <p>1.All escutcheons have been replaced. 2.The affected sprinkler head has been replaced.</p> <p><b>How other residentshaving the potential to be affect by the same deficient practice will beidentified and what corrective action(s) will be taken.</b></p> <p>1.Any resident in the day room has the potentialto be affected by the missing escutcheon. 2.Noresident had the potential to be affected by the defective sprinkler headbecause it was not in a resident area.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that</b></p>	09/24/2015

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	<p>room were missing the escutcheons. Based on interview at the time of observation, this was acknowledge by the Director of Plant Operations.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to replace 1 of 2 automatic sprinklers in the south ramp storage room which was corroded. 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 was not in a resident care area but could affect staff in the south ramp service hall.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Lead Maintenance Technician on 08/25/14 at 11:18 a.m., in the south ramp storage room there was one automatic sprinkler head pitted and corroded with a white substance. Based on interview at the time of the</p>		<p><b>thedeficient practice does not recur.</b></p> <p>1.10% of the sprinklers will be monitored monthlyto ensure no missing escutcheons.</p> <p>2.10% of the sprinklers will be monitored monthly tovisually check the condition of the sprinkler heads.</p> <p><b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur.i.e., what quality assurance program will be put into place.</b></p> <p>1.The Director of Environmental Services, or hisdesignee, will do monthly checks on 10% of the sprinkler heads to ensure no missingescutcheons.</p> <p>2.The Director of Environmental Services, or hisdesignee, will do monthly checks on 10% of the sprinkler heads to check thecondition of the sprinkler head for any corrosion or damage.</p>		

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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 0066 SS=E Bldg. 01	<p>observation, the Lead Maintenance Technician acknowledged the sprinkler head was corroded and pitted.</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 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 2 of 2 areas where smoking was permitted for staff and residents were maintained. This deficient practice could affect 45 residents and staff in the smoking area in the event of any emergency.</p>	K 0066	<p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b></p> <p>1.All cigarette butts were removed from the groundand placed in a noncombustible ashtray.</p> <p>2.All cigarette butts were removed from the groundand</p>	09/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155364	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		X3) DATE SURVEY COMPLETED  08/25/2015
NAME OF PROVIDER OR SUPPLIER  BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818		
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	<p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations on 08/24/15 between 12:40 p.m. and 12:50 p.m., the following was noted:</p> <p>a.) the staff designated smoking area by the exit of Friendship Corner was provided with an approved container with a long neck used for cigarette butts. At least 75 cigarette butts were observed on the ground in the smoking area.</p> <p>b.) the resident designated smoking area by the exit of Friendship Corner was provided with four approved containers with a long neck used for cigarette butts. At least 50 cigarette butts were observed on the ground and in the grass around the smoking area.</p> <p>Based on interview, this was acknowledged by the Director of Plant Operations at the time of observations.</p> <p>3.1-19(b)</p>		<p>grass and placed in a noncombustible ashtray.</p> <p><b>How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken.</b></p> <p>1.All staff who use this area could potentially beaffected by this practice.</p> <p>2.All residents who use this area couldpotentially be affected by this practice.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</b></p> <p>1.Allstaff who smoke will be in-serviced regarding the importance of discardingcigarette butts in approved noncombustible containers.</p> <p>2.All residents who smoke will be in-servicedregarding the importance of discarding cigarette butts in approvednoncombustible containers.</p> <p><b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur.i.e., what quality assurance program will be put into place.</b></p> <p>1.The Director of Environmental Services, or hisdesignee, will monitor the area weekly to ensure there are no cigarette buttson the ground. The results of thismonitoring will be reviewed at QAPI for compliance.</p> <p>2.The Director of Environmental</p>		

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K 0147 SS=B Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 2 of 2 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 could affect 4 residents in room 12-19 and facility staff in the third floor social service office.</p> <p>Findings include:</p> <p>Based on observations during a tour of the facility with the Director of Plant Operations and the Lead Maintenance Technician on 08/24/15 between 11:00 a.m. and 12:00 p.m., a refrigerator was plugged into an extension cord power strip in room 12-19 and in the third floor social service office. Based on interview,</p>	K 0147	<p>Services, or hisdesignee, will monitor the area weekly to ensure there are no cigarette buttson the ground or in grass. The resultsof this monitoring will be reviewed at QAPI for compliance.</p> <p><b>What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice?</b> All of the power strips were removed.</p> <p><b>How other residentshaving the potential to be affect by the same deficient practice will beidentified and what corrective action(s) will be taken.</b> All residents living in the affected area have the potentialto be affected by this practice.</p> <p><b>What measures will beput into place or what systemic changes will be made to ensure that thedeficient practice does not recur.</b> The administrative staff and residents will be in-servicedon proper extension cord use.</p> <p><b>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur.i.e., what quality assurance program will be put into place.</b> The Director of Environmental</p>	09/24/2015

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	the Director of Plant Operations and the Lead Maintenance Technician acknowledged and removed the power strips at the time of observations.  3.1-19(b)		Services, or his designee, will monitor all administrative offices and resident rooms monthly to ensure the proper use of extension cords is ongoing. This log will be reviewed in the QAPI meeting to ensure compliance.		