STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155746	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKVIEW HAVEN	101 CONSTITUTION DR FRANCESVILLE, IN 47946

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K0000				
	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: 02/07/12 Facility Number: 000539 Provider Number: 155746 AIM Number: 100267280 Surveyor: Bridget Brown, Life Safety Code Specialist At this Life Safety Code survey, Parkview Haven 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 facility was located on one wing of a one story building determined to be of Type III (211)	K0000		

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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	construction which was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has the capacity for 41 and had a census of 41 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/13/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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K0048 SS=B	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1			
	Based on record review and interview, the facility failed to include the use of the kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on review of the facility Fire Plan on 02/07/12 at 4:10 p.m. with the maintenance supervisor, the plan did not include the use of	K0048	K048 B K Class Fire Extinguisher Corrective Action Explained to kitchen staff the use of the K class fire extinguisher on 2/16/2012. Added this phrase to the Fire Plan “There is a K class fire extinguisher located outside of the dietary manager’s office. This fire extinguisher can ONLY be used after the Anusl system has been activated”. Identification Inspection of facility was done to make sure no other fire extinguishers needed special mention in the fire plan. This deficient practice will affect all residents, staff and visitors in the vicinity of the kitchen until the corrective plan of action is completed. Systemic Change All employees were trained on the use of the K class fire extinguisher in relation to the	02/29/2012

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	the K class fire extinguishers located in the kitchen in relationship to the use of the kitchen overhead extinguishing system. The maintenance supervisor acknowledged at the time of record review, the fire extinguishers had not been included as part of the written plan. 3.1-19(b)		overhead extinguishing system on 2/29/2012. The use of the K class fire extinguisher was added to the fire plan. Monitoring Maintenance Manager and Administrator confirmed the addition of the K class fire extinguisher usage to the fire plan.	

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K0051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6			
	1. Based on record review and interview, the facility failed to provide evidence of sensitivity testing for 24 of 24 smoke detectors. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be	K0051	K051 F 1.Sensitivity Report 2. An unused smoke detector 1.Sensitivity Report Corrective action Maintenance Manager called alarm contractor and received the location of the sensitivity report. The report is available online. This report was printed out and reviewed and added to the Fire and Life Safety Binder.	02/24/2012

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	extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or 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 the following methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity shall not be tested or measured using any device that administers an		Identification This deficient practice affects all occupants. Systemic Change A reminder was added to the Inspection Compliance Schedule checklist to review the sensitivity report, confirm there are no deficiencies in the system and include a copy in the Fire and Life Safety Binder. Maintenance Manager was trained on 2/16/2012 to include the print out of this report in the Fire and Life Safety Binder. Maintenance Manager was also trained on 2/16/2012 that whenever there is an inspection at the facility, there must be a review with the contractor and the Maintenance Manager at the end of the inspection to confirm that there are no deficiencies or to remedy the deficiency immediately. All facility inspections will be reviewed at the Grassroots Quality Improvement meetings beginning at the February meeting on 2/24/2012. Monitoring The Administrator confirmed that the reminder to review, print and include sensitivity testing report in	

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	unmeasured concentration of aerosol into the detector." This deficient practice affects all occupants. Findings include: Based on a review of fire system test records with the maintenance supervisor on 02/07/12 at 5:05 p.m., a sensitivity record was not found. The maintenance supervisor called the fire system contractor immediately. The contractor said the facility was equipped with a "smart system" which was "always sensitive" and no record was made to evidence the absence or presence of trouble on the system. He could not explain why a "Loop 1" trouble on the fire system LED was explained to the maintenance supervisor as a smoke system problem or why it could not be identified. The maintenance supervisor said at the time of record review, he could not provide system information to review for the system installed. 3.1-19(b)		the Fire and Life Safety Binder was placed in Inspection Compliance Schedule checklist. Administrator confirmed that the sensitivity report test was printed and placed in the Binder. All facility inspections will be reviewed at the Grassroots Quality Improvement meetings beginning at the February meeting. Date of Completion 2/24/2012 2. Smoke Detector Corrective Action Per recommendation of alarm contractor, the smoke detector was removed on 2/8/2012. Identification All occupants could be at risk with this deficient practice. Reports were reviewed and found no further deficiencies. Systemic Change Per recommendation of alarm	

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	2. Based on record review and interview, the facility failed to ensure 1 of 24 smoke detectors was maintained in accordance with NFPA 72. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-1.1.1 requires fire alarm systems shall be inspected, tested and maintained. NFPA 72, 7-5.2.2 requires a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice affects visitors, staff and 25 residents on the 200 hall. Findings include: Based on a review of the Fire Alarm and Life Safety System inspection report dated 01/12/12 with the maintenance supervisor on 02/07/12 at 5:00 p.m., the smoke detector Function Test record and the Discrepancy Report noted the smoke detector located in the clean linen storage room by room 203 failed the function test. The maintenance supervisor said, at the time of record review there was no record of a retest, cleaning or other maintenance done to the		contractor, the smoke detector was removed on 2/8/2012. Administrator trained Maintenance Manager was trained on 2/16/2012 to do a mandatory review of the inspector's findings with the alarm contractor when inspections are done. All facility inspections will be reviewed at the Grassroots Quality Improvement meetings beginning at the February meeting on 2/24/2012. Monitoring Administrator will confirm that Maintenance Manager coordinates with the alarm contractor at each inspection to ensure all recommendations are carried out. A review will be done at the February Grassroots Quality Improvement meetings to determine if further monitoring is necessary. Date of Completion 2/24/2012	

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	smoke detector because nothing had been done. 3.1-19(b)			

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K0052 SS=F	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			
	1. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with Section 9.6. LSC 9.6.1.4 requires all facilities maintain the fire alarm system in accordance with NFPA 72, the National Fire Alarm Code. NFPA 72 at 1-5.5.2.3 requires all apparatus requiring resetting to maintain normal operation shall be restored to normal as promptly as possible after each alarm and kept in normal condition for operation. This deficient practice could affect all clients. Findings include: Based on observation of the fire alarm control panel with the maintenance supervisor on 02/07/12 at 1:15 p.m., a trouble light was visible and the LED reading indicated a trouble with Loop 1. The maintenance supervisor said at the time of observation, he noted the trouble	K0052	K052 F 1. Trouble light; 2. Circuit breaker box 1.Trouble Light Corrective Action The alarm contractor was called out on 2/8/2012 to reset the Loop 1 trouble alarm Identification This deficient practice could affect all occupants. Systemic Change Maintenance Manager was trained on 2/16/2012 to call out alarm contractor immediately on appearance of a trouble alarm on the fire panel. Employees were trained on or before 2/29/2012 to report trouble alarms immediately to the Maintenance Manager.	02/29/2012

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	on 02/03/12 and called the fire alarm contractor. He was directed to unplug and reset components and the system returned to normal, however, the trouble condition reoccurred and nothing had been done to correct the problem yet. He said the contractor told him the Loop 1 reading referred to a smoke detector loop in the smart fire system. The fire alarm operated correctly when tested on 02/07/12 at 4:15 p.m. by the maintenance supervisor and an audible trouble alarm was heard. The alarm was silenced. The fire alarm contractor was called on 02/07/12 at 5:05 p.m. by the maintenance supervisor. The fire alarm contractor said the LED trouble referred to a smoke detector loop in the smart system although he could not say what the trouble was. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 1999		Monitoring Starting 2-20-12 the Maintenance Manager will perform a daily fire panel check for one month to ensure all troubles are reported. After 30 consecutive days of 100% compliance the checks will be done weekly for 3 months. After 3 consecutive months of 100% compliance, the quality team will determine if further review is needed and if employees have learned this practice. Date of Completion 2/29/2012 1. Circuit Breaker Box Corrective Action Circuit breaker box was locked on 2-8-12. Identification All occupants are at risk until corrective action is taken.	

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	Edition. NFPA 72, 1-5.2.5.2 requires the fire alarm circuit disconnecting means shall have a red marking, shall be accessible only to authorized personnel, and shall be identified as FIRE ALARM CIRCUIT CONTROL. This deficient practice could affect all residents as well as visitors and staff. Findings include: Based on observation with the maintenance supervisor on 02/07/12 at 4:10 p.m., the fire alarm system circuit breaker located in the exit corridor near the oxygen supply room was unlocked. The maintenance supervisor said at the time of observation, he was not aware the fire alarm circuit breaker access door had to be secured. 3.1-19(b)		Systemic Change Circuit breaker box was locked and labeled correctly inside and out to state that the fire panel breaker was located inside and to keep the panel locked on 2/8/2012. Monitoring On 2/8/2012 the Administrator ensured the breaker panel was locked and correctly labeled.	

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K0066 SS=E	Smoking regulations are adopted and include no less than the following provisions: (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. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (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, interview, and record review; the facility failed to enforce the facility wide smoking policy and ensure 1 of 2 designated smoking areas was provided with a self closing metal container for ashtray waste disposal. This deficient practice affects residents, staff and visitors in and around the service corridor exit where 6 staff were observed. Findings include: Based on observation with the	K0066	K066 E Improper smoking waste Corrective Action On 2/16/2012 proper ashtrays and metal container with self closing lid were placed in the smoking area. Identification This deficient practice would affect residents, staff and visitors near the smoking area.	02/29/2012

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	maintenance supervisor on 02/07/12 at 2:35 p.m., a designated smoking area outside the employee entrance exit from the service corridor had no metal container with a self closing lid into which ash trays could be emptied. There was no separate receptacle for trash. A coffee can was half filled with cigarette butts and empty plastic and paper cigarette packs. The same was noted on the ground surrounding the receptacle. The maintenance supervisor said at the time of observation, the receptacle had been "knocked over." Based on a review of the facility smoking policy with the maintenance supervisor on 02/07/12 at 4:40 p.m., the policy did not include the proper receptacles and procedure for cigarette waste and packaging materials disposal. 3.1-19(b)		Systemic Change Proper ashtrays and self closing metal container will be added to the smoking area. Smoking policy was changed to state smoking only in smoking enclosure. Employees were trained on 2/29/2012 as to the policy revision. Monitoring Maintenance Manager will daily check for cigarette butts not properly disposed of. When two weeks have gone by with 100% compliance, inspections will be done once a week. When 4 weeks have gone by with 100% compliance, the quality team will if there is a need for further inspections. Administrator confirmed that ashtrays and self closing metal container was placed in the smoking area on 2-16-12. Completion Date 2/29/2012	

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K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96			
	1. Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was cleaned by properly trained and qualified people. NFPA 96. section 8-3.1 requires that hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a properly trained, qualified, and certified company or person. This deficient practice could affect kitchen staff, and 20 or more visitors and residents in the main dining room. Findings include: Based review of the kitchen exhaust cleaning contractor cleaning report invoice dated 08/31/11 with the maintenance supervisor on 02/07/12 at 4:30	K0069	K069 E 1. Kitchen exhaust ductwork 2. Tilt skillet placement 1 Kitchen exhaust ductwork Corrective Action A contractor was called for kitchen range hood inspection and cleaning. Contractor arrived on 2/15/2012. He viewed the ductwork and found it to be accessible and in good condition. An inspection and cleaning was done on 2/20/2012. Identification This deficient practice could affect kitchen staff and occupants near the kitchen. Systemic Change A new contractor has been hired who will do a complete inspection and cleaning bi-annually. Maintenance Manager was	02/29/2012

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	p.m., the kitchen ductwork and exhaust fans were not cleaned. The report noted, "Ductwork and exhaust fans are inaccessible, No measurable amount of grease found on accessible interior surfaces of the exhaust system. Cleaning is not required at this time." The maintenance supervisor said at the time of record review, he did not know anything about the cleaning of the exhaust system. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 commercial cooking extinguishing systems provided complete coverage for all cooking equipment. NFPA 96, 9.1.2.2 requires cooking appliances requiring protection shall not be moved, modified, or rearranged without prior reevaluation of the fire extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Exception: Cooking appliances moved to perform maintenance and cleaning		trained on 2/16/2012 to review the inspection with the contractor at the time of inspection to ensure that there are no deficiencies. All inspections including this inspection will be reviewed at the Grassroots Quality Improvement meetings beginning with the February meeting on 2/24/2012. Monitoring The Maintenance Manager will ensure that the hood range inspection is complete at the bi-annual inspection as stated on the Parkview Haven Life-Safety Checklist. All inspections including this inspection will be reviewed at the Grassroots Quality Improvement meetings beginning with the February meeting on 2/24/2012. Date of Completion 2/20/2012 2. Tilt Skillet Placement Corrective Action	

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	provided the appliances are returned to their original positioning prior to cooking operations, and any disconnected fire extinguishing system nozzle attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. This deficient practice could affect kitchen staff, and 20 or more visitors and residents in the main dining room. Findings include: Based on observation of the commercial kitchen range hood protection system with the maintenance supervisor on 02/07/12 at 3:10 p.m., protection was not provided for half of the tilt skillet which was not positioned under the hood fire protection nozzles. The maintenance supervisor said at the time of observation, a new range and tilt skillet had been installed and the position of appliances moved. 3.1-19(b)		Tilt Skillet was moved under the overhead fire suppression system. Identification It was found that this deficient practice could affect kitchen staff and occupants around the kitchen area. All other appliances were correctly placed. Systemic Change It was found that the tilt skillet was the only appliance that needed to be placed under the over head fire suppression system. The tilt skillet was fastened to the floor to guard against being moved again. The kitchen staff was trained on or before 2/29/2012 to be sure all appliances requiring protection are placed under the overhead fire suppression system. Monitoring The Administrator confirmed the proper placement and fastening of the kitchen appliances. The quality team will assess if there is further monitoring to be done at the February Grassroots Quality Improvement meeting.	

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K0074 SS=D	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3			
	Based on observation and interview, the facility failed to ensure 2 of 2 privacy curtains in the physical therapy room were rendered flame resistant. LSC 19.7.5.1 requires draperies, curtains, including cubicle curtains, and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of	K0074	K074 D Therapy Curtains Corrective Action Privacy curtains were not in use so they were destroyed Identification All occupants could be affected by this deficient practice. A search was done and fire rating information was found for all remaining existing curtains. Systemic Change	02/29/2012

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	Textiles and Films. This deficient practice affects visitors, staff and residents in the physical therapy room where 3 residents could be treated simultaneously. Findings include: Based on observation with the maintenance supervisor on 02/07/12 at 1:30 p.m., two plastic privacy curtains hung from swinging arms beside therapy treatment areas in the physical therapy room. The maintenance supervisor said at the time of observation, he had no evidence the materials were treated to render them flame resistant. 3.1-19(b)		Employees were trained on 2/29/2012 that all new curtains and fabrics that are brought into the facility need to be fire rated or treated with a fire retardant. Maintenance Manager will keep a record of all curtains and fabrics in a secured accessible location in the Maintenance Manager's office. Monitoring The quality team will assess the records to determine if any further monitoring needs to be done at the February 24, 2012 Grassroots meeting. Completion Date 2/29/2012	

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K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2			
	Based on observation and interview, the facility failed to ensure liquid oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations was stored in an area where electrical fixtures were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect visitors, staff and 25 or more residents on the 200 and 300 halls.	K0143	K143 E Outlets and switches Corrective Action Electrical Contractor called immediately to move light switches and outlets. Identification This practice can affect the occupants in the 200 and 300 halls until the electrical units are moved. Systemic Change Switches and plugs will be	03/02/2012

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	Findings include: Based on observation with the maintenance supervisor on 02/07/12 at 3:30 p.m., the oxygen storage supply and transfer room had six 181 liter capacity liquid oxygen storage tanks stored in the room. The light switch on the wall measured 49 inches from the floor. An electrical outlet measured 46 inches from the floor. The measurements were taken by the maintenance supervisor at the time of observation. He said he was unaware the location of these electrical source locations could cause a problem. 3.1-19(b)		re-installed by 3/2/2012 Monitoring Administrator will confirm the completion of the placement of the switches and outlets on that date. The quality team will assess if there is further monitoring to be done at the February Grassroots Quality Improvement meeting. Completion Date 3/2/2012	

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K0147 SS=E	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 3 of 3 flexible cords were not used as a substitute for fixed wiring. NFPA 70 (National Electrical Code), 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect visitors, staff, and 25 or more residents on the 200 hall. Findings include: a. Based on observation with the maintenance supervisor on 02/07/12 at 4:45 p.m., a power strip extension cord was used to charge medical equipment in the clean utility room on the 200 hall. The maintenance supervisor acknowledged the practice and said there were not enough outlets to plug in each device individually. b. Based on observation with the maintenance supervisor on 02/07/12 at 4:45 p.m., an extension cord was piggy backed	K0147	K147 E Power strips and extension cords Corrective Action The Maintenance Manager removed the subject flexible cords and plugged equipment into direct wiring on 2/8/2012. Examined entire facility and found no further flexible electrical cords. Immediately called electrician to install additional outlets. Identification This deficient practice could affect all occupants Systemic Change On or before 2/29/2012 trained staff on the danger of the use of flexible cords and power strips. Also trained on the prohibition of flexible cords and the prohibition of power strips throughout the facility unless specifically permitted per Article 400-8 of the code. Trained that power strips are not permitted for use on medical equipment, heat producing appliances or battery	02/29/2012

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	to a power strip to provide power to a sound system in the 200 hall activities room. The maintenance supervisor said at the time of observation, he did not realize the equipment was being powered in this way. 3.1-19(b)		chargers. Power strips that are approved for use must be approved and labeled by the Maintenance Manager. Monitoring The Maintenance Manager will examine the facility weekly for 4 weeks for improper use of flexible cords. After 4 consecutive weeks of 100% compliance, Maintenance Manager will perform the examination once a month for 2 months. After 2 consecutive months of 100% compliance the quality team will look at the results of monitoring to determine the employees have learned the practice and if any further monitoring is needed. Date of Completion 2/29/2012	