

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155392	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  02/12/2013
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NAME OF PROVIDER OR SUPPLIER  HICKORY CREEK AT KENDALLVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1433 S MAIN ST KENDALLVILLE, IN 46755
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K0000	<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: 02/12/13</p> <p>Facility Number: 000402 Provider Number: 155392 AIM Number: 100288120</p> <p>Surveyor: Amy Kelley, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Hickory Creek at Kendallville was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a</p>	K0000		

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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	<p>capacity of 36 and had a census of 17 at the time of this survey.</p> <p>All areas where the residents have customary access are sprinklered. The facility does have a barn providing facility services which was not sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/18/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>			

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K0046 SS=F	<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.</p> <p>Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency light fixtures of at least 1½ hour duration was tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires 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 a 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 an observation with the</p>	K0046	<p>Dear Ms. Rhoades, Attached for your review and anticipated approval, you will find the completed Plan of Correction for the recent Life Safety Code Survey, (Event ID XN1721), conducted on Feb 12, 2013 at Hickory Creek of Kendallville, Kendallville, IN. Please be advised that it is our intent to have this Plan of Correction also serve as our Allegation of Compliance. Compliance is effective on March 6, 2013. A desk review of this Plan of Correction is respectfully requested. Should you have any questions regarding the attached Plan of Correction, please do not hesitate to contact me. Sincerely, Annette Weber, RN, HFA (Facility: 402) (Provider No: 15 5392) K 0046 It is the practice of this facility to conduct the required annual testing on the battery powered emergency lighting system for no less than a 90 minute duration. Equipment shall be fully operational for the duration of the annual test.</p> <p>WHAT CORRECTIVE ACTION(S) WILL BE DONE BY THE FACILITY? The Maintenance Director has been educated to this fact. The Regional Maintenance Consultant came to the facility on the</p>	03/06/2013	

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	<p>Administrator on 02/12/13 at 2:15 p.m., a battery operated emergency task light was observed at the emergency generator. Based on record review with the Administrator at 1:12 p.m., the only documentation regarding the battery operated emergency task light at the generator was a monthly test for February 2013. Based on an interview with the Administrator at the time of record review, she could provide no other documentation.</p> <p>3.1-19(b)</p>		<p>afternoon of the survey to complete the required annual test for the lighting. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? At the time of this deficient practice, no residents were affected. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE THAT THIS PRACTICE DOES NOT RECUR? This procedure has been reviewed with the Maintenance Director and he has been inserviced regarding this annual test. When the annual test is completed, the documented results will be submitted to the Administrator. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR AND WHAT QA MEASURES WILL BE PUT IN PLACE? The facility will continue to check the lighting weekly, included in the weekly generator tests done by the Maintenance Director and/or his designee; these completed results will be submitted x 4 months to the QA Committee which meets monthly and is overseen by th Administrator. The annual due date for the next 90 minute emergency lighting test has been scheduled for November, 2013 and both Maintenance Director and</p>		

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			Administrator are aware.		

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K0062 SS=D	<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>Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 3 sprinkler heads in resident room 15 was unobstructed. LSC 9.7.5 requires all automatic sprinkler systems 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, Section 2-2.1.2 states unacceptable obstructions to spray patterns shall be corrected. This deficient practice was in resident room 15 which is currently under renovation therefore only staff are affect.</p> <p>Findings include:</p> <p>Based on observation with the Administrator on 02/12/13 at 2:03 p.m., the spray pattern for one of the three sprinkler heads in resident room 15 was obstructed by a plastic cup that had been placed over the top of the sprinkler head. Based on an interview with the Administrator at the time of observation, she could not explain why the plastic cup was placed on the sprinkler head but the</p>	K0062	<p>K 0062 It is the practice of this facility to ensure required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. WHAT CORRECTIVE ACTION WILL BE DONE BY THE FACILITY? The plastic cup obstructing the spray pattern of one of three sprinkler heads in Room 15, which is under renovation, unoccupied, and safety locked, was immediately removed at on Feb 12, 2013. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ATION WILL BE TAKEN? At the time of this deficient practice, no residents were affected. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE THAT THIS PRACTICE DOES NOT RECUR? All sprinkler heads in any room that is being renovated, unoccupied and safety locked will be inspected by the Maintenance Director and/or his designee each time the room is exited to ensure that all sprinkler heads are unobstructed. This will be</p>	03/06/2013			

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	room is currently being renovated by the District Maintenance Man and he had not been in the facility since Friday Feb. 8, 2013.  3.1-19(b)		documented on the designated form which is located in the room being renovated, unoccupied and safety locked. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR AND WHAT QA MEASURE WILL BE PUT IN PLACE? Documentation will be submitted x 4 months by the Maintenance Director at the monthly QA meeting which is overseen by the Administrator.		

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K0064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10</p> <p>Based on observations and interview, the facility failed to ensure 1 of 1 portable fire extinguisher pressure gauge readings in the smoking shed was in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2 (c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect 2 residents and facility staff who smoke.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator on 02/12/13 at 2:20 p.m., the gauge on the portable fire extinguisher in the smoking shed indicated the extinguisher needed to be recharged. This was acknowledged by the Administrator at the time of observation.</p> <p>3.1-19(b)</p>	K0064	<p>K 0064 It is the practice of this facility to ensure that all fire extinguishers' pressure gauges are within the acceptable range to function correctly. WHAT CORRECTIVE ACTION WILL BE DONE BY THE FACILITY? The fire extinguisher in the smoking shed was replaced on Feb 12, 2013, with a fire extinguisher that had a pressure gauge within the acceptable range. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? All fire extinguishers in the facility were re-checked to ensure that all gauges read within the acceptable range. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE THAT THIS PRACTICE DOES NOT RECUR? The fire extinguisher in the smoking shed will be checked weekly x 4 weeks by the Maintenance Director and/or his designee, then ongoing monthly and the results recorded to ensure that the gauge reading is within the acceptable range. HOW WILL THE CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR</p>	03/06/2013			

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			AND WHAT QA WILL BE PUT IN PLACE? The documentation will be submitted x 4 months to the QA Committee which meets monthly and is overseen by the Administrator.		

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K0069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was maintained in proper working order. NFPA 96, 10-6.5 requires inspection and testing of the total operation and all safety interlocks in accordance with the manufacturer's instructions shall be performed by qualified service personnel a minimum of once every 6 months or more frequently if required. This deficient practice was not in a resident area but could affect kitchen staff.</p> <p>Findings include:</p> <p>Based on record review with the Administrator on 02/12/13 at 12:47 p.m., the 360 Degree Services kitchen hood cleaning report titled "Service Report" dated 08/29/12 stated, "Inaccessible areas exists ductwork, fan and bowl. Cleaned all accessible areas of exhaust system. Fan base is made of wood. Ductwork is not attached to anything. Just laying on the ansul system. Expose wiring in ductwork." Based on an interview with the Administrator at the time of record review, she was unable to confirm the inaccessible areas have been properly cleaned and the repairs had been made.</p>	K0069	<p>K 0069 It is the practice of this facility to ensure that cooking areas are protected in accordance with Life Safety Codes. WHAT CORRECTIVE ACTION WILL BE DONE BY THE FACILITY? The kitchen exhaust system mentioned in the report of 2/12/2013, has been completely replaced and all areas mentioned have been installed with new materials. This work was completed on Feb 21, 2013 and confirmation was received from 360 Services that the issues on the report of 2/12/2013 were resolved. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? At the time of this deficient practice, no residents were affected. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE THAT THIS PRACTICE DOES NOT RECUR? All future inspection reports from 360 Services will be submitted to the Administrator for review and evaluation with the Maintenance Director to ensure all issues mentioned in the report are resolved immediately. HOW WILL CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES</p>	03/06/2013			

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	3.1-19(b)		NOT RECUR AND WHAT QA WILL BE PUT IN PLACE? All inspection reports from 360 Services will be submitted x 4 inspections for review/completion of reported issues to the QA Committee which meets monthly and is overseen by the Administrator.	

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K0070 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F. (100 degrees C) 19.7.8</p> <p>Based on observation, interview and record review; the facility failed to provide a written policy for the use of 1 of 1 portable space heaters in the facility. This deficient practice could affect residents in the main dining room with seating for 10 residents.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator and Housekeeper # 1 on 02/12/13 at 1:36 p.m., a portable electric fire place with a heater was located in the main dining room. Based on an interview with Housekeeper # 1 at the time of observation, the heater unit was enabled and produced heat when plugged in. Based on an interview with the Administrator at 12:30 p.m. on 02/12/13, she stated space heaters are not allowed in the facility but was unable to locate a written policy.</p> <p>3.1-19(b)</p>	K0070	<p>K 0070 It is the practice of this facility to ensure the safety of the residents and staff by upholding the Life Safety Code Standards. WHAT CORRECTIVE ACTION WILL BE DONE BY THE FACILITY? The portable electric fire place located in the main dining room does not, in fact, produce any heat. Housekeeper #1, referred to in the 2567, erroneously stated that the fire place emitted heat. That decorative fire place unit does not produce heat. The heating element in that decorative unit was disabled/disarmed by the Regional Maintenance Consultant when the fire place was purchased a few years ago. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? No residents are affected. Portable space heating devices are prohibited in the facility. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE THAT THIS PRACTICE DOES NOT RECUR? Housekeeper #1 was instructed</p>	03/06/2013			

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			<p>about the fire place, specifically regarding the "control knobs", and that even though there are control knobs, they don't control any heat because the heating component was disabled long ago. HOW WILL CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR AND WHAT QA WILL BE PUT IN PLACE?</p> <p>Current staff and new employees will be instructed regarding the fire place and the fact that it is for decorative purposes only. This will be added to the "new hire" packet and submitted to the QA Committee which meets monthly and is overseen by the Administrator.</p>		

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K0144 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>1. Based on observation and interview, the facility failed to maintain 1 of 1 emergency generators in working order. Section 4.6.12.1 states whenever or wherever any device, equipment, or system is required for compliance with the provisions in this Code, such device, equipment, or system shall thereafter be continuously maintained in accordance with applicable NFPA requirements or as directed by the authority having jurisdiction. NFPA 99, 3-4.1.1.2 states essential electrical systems shall have a minimum of two independent sources of power: a normal source generally supplying the entire electrical system and one or more alternate sources for use when the normal source is interrupted. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>a. Based on observation with the Administrator and the Director of Operations on 02/12/13 at 3:30 p.m., the emergency generator did start but shut down automatically after a few seconds and the overspeed light of the generator</p>	K0144	<p>K 0144 PART 1 It is the practice of the facility to ensure that generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA. WHAT CORRECTIVE ACTION WILL BE DONE BY THE FACILITY? The Regional Maintenance Consultant was notified immediately on Feb 12, 2013, upon discovering the problem with the generator. The generator was repaired the same day, Feb 12, 2013, by the Regional Maintenance Consultant and was fully operational by 5:45 p.m. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? At the time of the deficient practice, no residents were affected. WHAT MEASURE WILL BE PUT INTO PLACE TO ENSURE THAT THIS PRACTICE DOES NOT RECUR? Weekly tests which are conducted and documented by the Maintenance Director will be submitted to the Administrator. The Maintenance Director will be instructed regarding the completion of the weekly and monthly tasks surrounding the operation of the</p>	03/06/2013	

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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>panel was illuminated. Based on an interview with the Director of Operations at the time of observation, the generator will not stay running.</p> <p>b. Based on observation with the Administrator on 02/12/13 at 2:45 p.m., the generator annunciator panel horn switch was turned to the off position and the overspeed red indicator light was illuminated, indicating there was a problem with the generator. The generator annunciator panel was located at the nurses' station. Based on an interview with the Administrator at the time of observation, the generator ran on Friday but she was unsure how long the generator annunciator panel horn switch was turned to the off position and the overspeed light was illuminated.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of the last 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be</p>		<p>generator. In addition, all staff was inserviced on Feb 13, 2013, regarding the panel at the Nurses' Station. Inspection of this panel will be done on a daily basis x 30 days, then weekly x 8 weeks by the Maintenance Director and/or his designee. HOW WILL CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR AND WHAT QA WILL BE PUT IN PLACE? Reports mentioned above will be submitted x 4 months to the QA Committee which meets monthly and is overseen by the Administrator. K 0144 PART 2 It is the practice of the facility to maintain a complete written record of monthly generator load testing WHAT CORRECTIVE ACTION WILL BE DONE BY THE FACILITY? The Regional Maintenance Consultant was notified immediately on Feb 12, 2013, and he came to the facility the same day and tested the generator for the required operating conditions. The generator was repaired and fully functional by 5:45 p.m. on Feb 12, 2013. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? At the time of the deficient practice, no residents were affected. WHAT MEASURE WILL BE PUT INTO</p>				

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	<p>exercised under operating conditions or not less than 30 percent of the EPS nameplate rating, whichever is greater, at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the generator log "Monthly Generator Inspection Sheet" with the Administrator on 02/12/13 at 12:15 p.m., documentation of a monthly load test for the month of July 2012 was not available for review. Based on an interview with the Administrator at the time of record review, she was not on staff at this facility at that time and could provide no additional documentation.</p> <p>3.1-19(b)</p>		<p>PLACE TO ENSURE THAT THIS PRACTICE DOES NOT RECUR? The monthly load test will be conducted and recorded by the Maintenance Director on an ongoing basis in accordance with NFPA requirements. HOW WILL CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR AND WHAT QA WILL BE PUT IN PLACE? Monthly test logs/reports will be submitted x 4 months to the QA Committee which meets monthly and is overseen by the Administrator.</p>		

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K0147 SS=D	<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 1 of 1 flexible cords such as an extension cord was 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. This deficient practice was in resident room 15 which is currently under renovation therefore only staff are affected.</p> <p>Findings include:</p> <p>Based on an observation with the Administrator on 02/12/13 at 2:04 p.m., a heavy weight extension cord was plugged in and providing power to a drill in resident room 15. Based on an interview with the Administrator at the time of observation, the District Maintenance Man is working on the renovation project and has not been in the facility since Friday Feb. 8, 2013.</p> <p>3.1-19(b)</p>	K0147	<p>K 0147 It is the practice of this facility to ensure that electrical wiring and equipment is in accordance with NFPA, National Electric Code. WHAT CORRECTIVE ACTION WILL BE DONE BY THE FACILITY? The heavy weight extension cord which was plugged into the wall outlet was immediately removed from the outlet in Room 15 which is currently being rennovated, unoccupied and safety locked. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? No residents were affected by this deficient practice. WHAT MEASURE WILL BE PUT INTO PLACE TO ENSURE THAT THIS PRACTICE DOES RECUR? Maintenance Director was instructed on Feb 25, 2013, as to the use of extension cords and the associated electrical code. Upon exit from the unoccupied room, the Maintenance Director will record on the designated form that all electrical equipment is not plugged into any wall outlet. HOW WILL CORRECTIVE ACTION BE MONITORED TO ENSURE THE DEFICIENT</p>	03/06/2013	

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			PRACTICE DOES NOT RECUR AND WHAT QA WILL BE PUT IN PLACE? The Maintenance Director will submit the report monthly x 4 months to the QA Committee which meets monthly and is overseen by the Administrator.	