

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 07/18/2016
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NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN 46307
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K 0000 Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/18/16</p> <p>Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000</p> <p>At this Life Safety Code survey, Crown Point Christian Village was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This facility was located on the west side of the first floor and the entire lower level of a two story building. The facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, in spaces open to the corridors and in resident rooms. The facility has a</p>	K 0000	<p>K 000</p> <p>This Plan of Correction is the center's credible allegation of compliance. 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 statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the revision of federal and state law.</p>	

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 0029 SS=D Bldg. 01	<p>capacity of 146 and had a census of 125 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered. The detached waste water treatment plant, fire system pump house and equipment storage garages were unsprinklered.</p> <p>Quality Review completed on 07/20/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD 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 Based on observation and interview, the facility failed to ensure the corridor door to 1 of 1 fuel fired Mechanical/Boiler room, a hazardous area, was provided with a coordinating device and would latch into the frame. This deficient practice was not in a resident care but could affect facility staff.</p> <p>Findings include:</p>	K 0029	<p>REQUEST DESK COMPLIANCE</p> <p>K 029 1. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice? a. No visitors, residents or staffs wereharmed by this practice b. A new door coordinating device has beenordered 7/25/16. (see attachment #1)</p>	08/17/2016

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K 0048 SS=E	Based on observation with the Maintenance Supervisor on 07/18/16 at 11:56 a.m., the Mechanical/Boiler room contained fuel fired appliances. The set of corridor doors latched into each other but not into the frame. Both doors swung in the same direction and contained an astragal. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition. 3.1-19(b) NFPA 101 LIFE SAFETY CODE STANDARD		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: a. Facility staff have the potential to be affected. b. The maintenance supervisor will re-check this door to ensure proper closing after new door coordinator is installed. c. Other doors were reviewed to determine if any other doors are affected. No other doors were found to be needing a door coordinating device at this time. (see attachment #2) 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. The identified new door hardware will be placed on preventive maintenance checklist. (See attachment #1, 2 & 3) 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. a. The Maintenance Supervisor or designees are responsible for compliance. b. Maintenance Supervisor will report on installation and operation of new door hardware at the August QA meeting to ensure compliance. Compliance by August 17, 2016		

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Bldg. 01	<p>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</p> <p>Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:</p> <ol style="list-style-type: none"> (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 <p>This deficient practice could affect staff and at least 22 residents.</p> <p>Findings include:</p> <p>Based on a record review with the Maintenance Supervisor on 07/18/16 between 10:48 a.m. and 1:50 p.m., the facility had a written fire policy that horizontal evacuation would be performed by crossing a smoke barrier. However, there were corridor doors that were not complete smoke or fire barriers which could cause staff to evacuate</p>	K 0048	<p>Request Desk Compliance</p> <p>K 048</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>1. The facility has modified the verbiage in the current fire evacuation plan to clarify evacuation procedures away from the potential area of danger through fire doors as directed by person in charge. (see attachment #3)</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken?</p> <p>1. All staff and 22 residents have potential to be affected. The facility has modified the current evacuation policy and procedure. The facility staff will be trained on the new guidance provided by the modifications to the fire evacuation plan. (see attachment #4)</p> <p>What measures will be put into place on what systemic changes you will make to ensure that the deficient practice does not reoccur?</p> <p>1. The newly developed fire drill</p>	08/17/2016

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K 0050 SS=F Bldg. 01	<p>residents to a different part of the same smoke compartment and not to an adjacent compartment in the event of a fire. Based on observation, there were sets of doors separating the Haven Hall that were added for security and not a complete barrier. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2</p>		<p>logs will include a question and answer response section to verify staff is clear on fire evacuation procedure to include additional training if warranted by the question and answer results of the fire drill and log. (see attachment #5)</p> <p>How the facility plan to monitor its performance to make sure the solution is sustained</p> <p>1. The facility will review the results of the monthly fire drill and perform additional training and education as determined by the results of the monthly fire drill. Results of these inspections will be reviewed monthly at the facility safety meeting and presented to the Quality Assurance Committee at least quarterly for 6 months.</p> <p>Compliance by August 17, 2016</p>	

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	<p>Based on record review and interview, the facility failed to conduct fire drills quarterly on each shift for 1 of the last 4 calendar quarters. This deficient practice could affect all occupants.</p> <p>Findings include: Based on record review of the "Fire Drills" forms with the Maintenance Supervisor on 07/18/16 at 9:33 a.m., the documentation for a second shift fire drill for the first quarter of 2016 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the lack of documentation.</p> <p>3.1-19(b) 3.1-51(c)</p>	K 0050	<p>REQUEST DESK COMPLIANCE</p> <p>K 050</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. No visitors, residents or staffs were harmed by this practice</p> <p>b. Monthly fire drills will be done on a different shift each quarter as required by code.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. All residents, staff and visitors have the potential to be affected.</p> <p>b. All drills will be documented on a monthly fire drill report sheet and signed off on by Executive Director upon completion. (see attachment #6)</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. All monthly fire drills will be presented for review on a monthly basis to the Safety Committee at their monthly meeting by Maintenance Supervisor.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>a. The maintenance supervisor will discuss details of all fire drills at the monthly Quality Assurance</p>	08/17/2016

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K 0051 SS=E Bldg. 01	<p>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 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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 smoke detectors in the D Hall foyer and 1 of 1 smoke detectors in the Haven bathroom connected to the fire alarm system were properly separated from an air supply.</p>	K 0051	<p>Committee Meetings. b. The committee will ask questions as they feel appropriate.</p> <p>Compliance by August 17, 2016</p> <p>REQUEST DESK COMPLIANCE</p> <p>K 051 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. No visitors, residents or</p>	08/17/2016

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	<p>LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 2-3.5.1 requires spaces served by air handling systems, detectors shall not be located where airflow prevents operation of the detectors. This deficient practice could affect visitors, staff, and at least 24 residents.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 07/18/16 at 11:06 a.m. then again at 1:16 p.m., a smoke detector was located about 18 inches from an air vent in the D Hall foyer. Then again, a smoke detector was located about five inches from an air vent in Haven bathroom. Based on interview at the time of observation, the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p>		<p>staffs were harmed by this practice</p> <p>b. The following smoke detectors will be removed for proper separation from air supply vents:</p> <ul style="list-style-type: none"> · 1 detector in D Hall foyer · 1 detector in Haven Unit bathroom <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <ul style="list-style-type: none"> a. Facility staff, visitors and at least 24 residents have the potential to be affected. b. All smoke detectors were examined for proper separation from air supply vents. No other smoke detectors were found to be without proper separation from air supply vents. (See attachment #7) <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <ul style="list-style-type: none"> a. The (2) identified smoke detectors will be moved, separating them from air supply vent, therefore no further audit required. (See attachment #8 & 9 pictures) <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <ul style="list-style-type: none"> a. The maintenance supervisor will discuss details of the need for installation and future sensitivity testing at the Quality Assurance Committee. b. The committee will ask 	

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K 0062 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to replace painted and/or corroded sprinkler heads. LSC 33.2.3.5.2 refers to LSC section 9.7. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect staff and up to 49 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 07/18/16 between 11:12 a.m. and 1:14 p.m., the following was discovered</p> <p>a) 2 of 2 corroded sprinkler heads in D Hall Angel Spa</p>	K 0062	<p>questions as they feel appropriate.</p> <p>Compliance by August 17, 2016</p> <p>REQUEST DESK COMPLIANCE</p> <p>K 062</p> <p>1.What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1.The following sprinkler heads will be replaced(see attachment #10):</p> <ul style="list-style-type: none"> ·2 corroded heads in D Hall Angel Spa. ·1 corroded and 1 painted head in D Hall Garden Spa. ·1 corroded head in D Hall Nurse's Station ·1 corroded head in lower level kitchen area ·1 corroded head in resident room 258 ·1 corroded head and 1 painted head in Haven Hallway resident room M. ·3 painted heads in Conference Room. ·2 heads in resident room 127. <p>1.How other residents having</p>	08/17/2016

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	<p>b) 1 of 2 corroded and 1 of 2 painted sprinkler heads in the D Hall Garden Spa</p> <p>c) 1 of 1 corroded sprinkler head in the D Hall Nurses' station</p> <p>d) 1 of 1 corroded sprinkler head in the Lower Level Kitchen area</p> <p>e) 1 of 2 corroded sprinkler head in Resident Room 258</p> <p>f) 1 of 2 corroded and 1 of 2 painted sprinkler head in the Haven Hall Room M</p> <p>three sprinkler heads were covered in paint in the Conference Room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler heads in resident room 127 was maintained. This deficient practice could affect 2 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 07/18/1 at 12:42 p.m., resident room 127 was missing two escutcheons. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the missing escutcheons at the time of</p>		<p>the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken:</p> <p>1.Facility staff and at least 49 residents havethe potential to be affected.</p> <p>2.The corrections are being made to protectresidents, staff and visitors.</p> <p>3.Contractor will inspect all sprinkler heads infacility for compliance (see attachment #10).</p> <p>2.What measures will be put into place or whatsystemic changes will be made to ensure that the deficient practice does notrecur:</p> <p>a. The facility Maintenance Supervisor willperform annual sprinkler system checks to assurethat the sprinkler heads are inspected, tested and maintained in accordance with NFPA 101.</p> <p>3.How the corrective action(s) will be monitoredto ensure the deficient practice will not recur: i.e., what quality assurance program will beput into place.</p> <p>1.The maintenance supervisor/designee is responsible for ongoing compliance.</p> <p>2.Thecorrections and changes will be in place by</p>	

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K 0066 SS=D Bldg. 01	<p>observation.</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</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 area where smoking was permitted for staff and residents were maintained and the metal container with a self-closing cover was used for an ashtray. This deficient practice could affect staff and up to 2 residents.</p>	K 0066	<p>August 17, 2016.</p> <p>REQUEST DESK COMPLIANCE</p> <p>K 066</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. No visitors, residents or staffs were harmed by this practice</p> <p>b. Smoking policy rewritten to better identify where smoking is permitted</p>	08/17/2016
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K 0070	<p>Findings include:</p> <p>Based on observations with the Maintenance Supervisor on 07/18/16 at 10:56 a.m., there were about 100 cigarette butts on the ground in the designated smoke area. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101</p>		<p>outside the facility (see attachment #11).</p> <p>c. Identified smoking areas will be supplied with approved ashtray receptacles (see attachment #12)</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>a. Facility staff and up to 2 residents have the potential to be affected.</p> <p>b. All staff will be educated on the new smoking policy as well as policy will be posted for all residents and visitors to review.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. Smoking areas will be monitored by Maintenance on a weekly basis to ensure receptacles are in place and being utilized and policy is being adhered to.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>a. The maintenance supervisor will report on smoker compliance at the monthly Quality Assurance Committee meeting.</p> <p>b. The committee will ask questions as they feel appropriate.</p> <p>Compliance by August 17, 2016</p>		

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SS=D Bldg. 01	<p>LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 space heaters was equipped with a heating element which would not exceed 212 degrees Fahrenheit (F). This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 07/18/16 at 11:45 a.m., a space heater was discovered in the Housekeeping/Laundry Supervisor office. Based on interview at the time of observation, the Maintenance Supervisor was unable to provide documentation to confirm the space heater element did not exceed 212 degrees (100 degrees C).</p> <p>3.1-19(b)</p>	K 0070	<p>REQUEST DESK COMPLIANCE</p> <p>K 070</p> <p>1. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice?</p> <p>a. No visitors, residents or staffs wereharmed by this practice</p> <p>b. Space heater was removed fromHousekeeping/Laundry Supervisor's office and disposed of.</p> <p>2. How otherresidents having the potential to be affected by the same deficient practicewill be identified and whatcorrective action(s) will be taken:</p> <p>a. Staff and residents have the potentialto be affected.</p> <p>b. All office areas were searched for spaceheaters. None were found (see attachment#13)</p> <p>3. Whatmeasures will be put into place or what systemic changes will be made to ensurethat the deficient practice does notrecur:</p> <p>a. Maintenance staff will perform officeara inspections every 6 months for space heaters (see attachment #14).</p> <p>4. How thecorrective action(s) will be monitored to ensure the deficient</p>	08/17/2016
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K 0144 SS=C Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 generator was in accordance with NFPA 99, 3-6.4.1.1 Maintenance and Testing Transfer Switches states the general shall be maintained as to be capable of supplying service with the shortest time practical and within 10 seconds. This deficient practice could affect all staff, residents, and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Maintenance Supervisor on 07/18/16 at 10:22 a.m., the generator log form documented the generator transfer time</p>	K 0144	<p>practice will not recur; i.e., what quality assurance program will be put into place.</p> <p>a. The maintenance supervisor will report results of office area searches for space heaters at the Quality Assurance Committee meeting.</p> <p>b. The committee will ask questions as they feel appropriate.</p> <p>Compliance by August 17, 2016</p> <p>REQUEST DESK COMPLIANCE</p> <p>K 144</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>a. No visitors, residents or staffs were harmed by this practice</p> <p>b. Generator service contractor reviewed operation of generator and transfer time and confirmed it to be operating correctly, transferring power within 10 seconds as required (see attachment #15).</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p>	08/17/2016

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K 0147 SS=E Bldg. 01	<p>for the last twelve months was recorded at 15 seconds. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 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 to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition,</p>	K 0147	<p>a. All residents, staff and visitors have the potential to be affected.</p> <p>b. All Maintenance staff will be retrained in proper monitoring and recording of generator transfer time, confirming the within 10 second transfer time is achieved.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: a. Maintenance Supervisor will review all log sheets weekly for accuracy.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. a. The maintenance supervisor will report results of monitoring at the monthly Quality Assurance Committee Meeting. b. The committee will ask questions as they feel appropriate.</p> <p>Compliance by August 17, 2016</p> <p>REQUEST DESK COMPLIANCE</p> <p>K 147</p> <p>1. What corrective action (s) will be accomplished for those residents found to have been</p>	08/17/2016	

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	<p>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 and up to 4 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 07/18/16 at 11:02 a.m. then again at 11:04 a.m. a surge protector was powering a refrigerator in resident room 137. Then again, a surge protector was powering a refrigerator in resident room 147. Based on interview at the time of observation, the Maintenance Supervisor acknowledged each aforementioned condition.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Nourishment room electrical receptacles, a wet location client care area, was provided with a ground fault circuit interrupter (GFCI) protection against electric shock. LSC sections 9.1.2 requires all electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, Article 210.8 Ground-Fault</p>		<p>affected by the deficient practice.</p> <p>a. The refrigerators in rooms 137 and 147 were moved to where the appliances could be plugged directly into the wall and surge protectors were removed from rooms.</p> <p>b. GFCI receptacle in Nourishment Room was replaced with new unit and then immediately tested for proper operation.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</p> <p>1. Facility staff and up to 4 residents have the potential to be affected.</p> <p>2. The corrections being made to protect residents, and staff.</p> <p>3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</p> <p>a. Staff, residents as well as families of residents will be educated regarding not allowing any of the following in resident rooms, resident areas, and other areas in the facility (see attachment #16):</p> <p>1. No power strips plugged into power strips</p>		

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	<p>Circuit-Interrupter Protection for Personnel, in 210.8(A), Dwelling Units, requires ground-fault circuit-interrupter (GFCI) protection for all personnel in bathrooms and kitchens where the receptacles are intended to serve the countertop surfaces. Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff only.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Supervisor on 07/18/16 at 11:23 a.m., the Nourishment room had one GFCI receptacle within three feet of the hand sink. When the GFCI tester button was pressed, power was not interrupted on the GFCI receptacle. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>		<p>2. No extension cords 3. No multiplug devices 4. High amp. draw items must be plugged directly into designated outlets.</p> <p>4.How the corrective action(s) will bemonitored to ensure the deficient practice will not recur: i.e., what quality assurance program will beput into place.</p> <p>1.The maintenance supervisor/designee is responsible for ongoing compliance. 2.Toensure that this practice does not recur, the housekeeping department willconduct weekly audits for power strips plugged into power strips, extensioncords and multi-plug devices for six months (see attachment #18). All auditswill be submitted to the Quality Assurance committee for compliance. 3.GFCItesting will be conducted on an annual basis (see attachment #17)</p> <p>Compliance byAugust 17, 2016</p>	