STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155700	A. BUILDING 01 B. WING	06/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/29/15 and 06/30/15 Facility Number: 002982 Provider Number: 155700 AIM Number: 200382090 At this Life Safety Code survey, Catherine Kasper Home 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 two story facility with a basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 81 and had a census of 72 at the time of this survey.	K 0000	Pleaseaccept this Plan of Correction to be our credible allegation ofcompliance. Submission of this Plan ofCorrection does not constitute admission of the allegations contained in theCMS 2567 for the survey which ended July 8, 2015.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	All areas where the residents have customary access were sprinklered with the exception of the pool area and the tunnel. All areas providing facility services were sprinklered.			
K 0018 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 1 finance office corridor doors closed and latched into the door frame. This deficient practice could affect any residents in or near the finance office. Findings include:	K 0018	**K018 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** The door will be provided with positive latching hardware that latches into the door frame. **How other residents having the potentialto be affected by the same deficient practice will be**	07/30/2015

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	Based on observation with the Executive Director and Maintenance Man 31 on 06/29/15 at 2:35 p.m., the corridor door entering the Admissions/Finance office was provided with only a dead bolt. The Executive Director agreed at the time of observation, the Admission/Finance office corridor door should be provided with positive latching hardware that latched into the door frame. 3.1-19(b)		**identified and whatcorrective action will be taken?** All doors within CKH will be audited to identify any others that require positive latching hardware and any such doors will have proper hardware installed. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** Any doors that require locking devices will be outfitted with proper latching hardware. Any such hardware will be installed or requested via facility work order to be installed only byqualified facility Maintenance staff who are familiar with FLS regulations. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** Quarterly Door audits will be completed by Maintenance staff to assure all doors areproperly equipped with latching hardware and functioning properly. **By what date the systemic changeswill be completed?** ByJuly 30, 2015	
K 0020 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1.			

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	Based on observation and interview, the facility failed to ensure 2 of 5 stairway doors on the first floor were provided with a fire resistance rating of at least one hour. This deficient practice could affect at least 10 residents in 2 of 5 smoke compartments. Findings include: Based on observation with the Executive Director and Maintenance Man #1 on 06/29/15 from 1:40 p.m. to 2:50 p.m., the D wing and B wing stairway doors were not provided with a tag affixed to the door indicating the fire resistance rating. Based on an interview with Maintenance Man #1 at the time of observations, he did not have documentation to confirm the fire resistance rating of the aforementioned stairway doors. 3.1-19(b)	K 0020	**K020 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** The doors identified on D wing and B wing stairways will have proper fire rating confirmed by qualified authority and proper tags will be affixed. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?** All doors will be audited to identify any other doors lacking proper fire resistance rating identification. Any doors identified will be properly assessed and proper tags will be affixed. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** Doors will be checked at least quarterly to assure proper rating identification tags remain intact on the doors. Any doors painted will avoid painting over the tags. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** Quarterly audits will be completed and summarized by Maintenance staff and presented to QA for any further recommendations. **By what date the systemic**	09/30/2015

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			changeswill be completed? By September 30, 2015	
K 0025 SS=E Bldg. 01	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 Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 5 of 7 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect any number of occupants.	K 0025	**K025 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** All identified unsealed or improperly sealed penetrations will be properly sealed. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?** All residents have the potential to be affected by the deficient practice. An auditwill be conducted of all smoke barrier walls in CKH to identify any other areasof penetration which may require proper sealing and any areas identified willbe properly sealed. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not**	09/30/2015

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	Findings include: Based on observations above the ceiling tile on 06/30/15 from 11:50 a.m. to 12:45 p.m., Maintenance Man #1 acknowledged the following smoke barrier walls had unsealed penetrations or penetrations that were improperly sealed: a) at the basement smoke barrier wall there was a 15 inch hole in the drywall and an additional unsealed penetration measuring two inches by four inches around conduit. b) at the smoke barrier wall entering B wing on the first floor there were penetration stuffed with fiberglass insulation. c) at the smoke barrier wall entering E wing on the second floor there was unsealed penetration measuring two inches around IT and TV cables d) at the smoke barrier wall entering A wing there were six penetrations measuring one inch around IT cables e) at the smoke barrier wall entering the second floor B wing there were three unsealed penetrating measuring one inch each around IT and fire alarm cables Maintenance Man #1 acknowledged the aforementioned penetrations discrepancies and provided the measurements at the time of observations.		**recur?** Any contractors accessing the smoke barrier walls requiring penetrations in orderto provide any necessary services will require review by CKH Maintenance Staffupon completion of the work performed. Maintenance Staff will immediately complete any necessary proper sealing of any new penetrations identified. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** Smoke Barrier walls will be assessed quarterly to identify any new penetrations not properly sealed. Results of audit will be summarized and provided to QAcommittee for further review and any recommendations. **By what date the systemic changeswill be completed?** By September 30, 2015	

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	3.1-19(b)			
K 0045 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to provide exterior emergency lighting for 1 of 2 A wing emergency exits. LSC Section 7.9.1.1 requires emergency lighting for means of egress shall be provided for the exit access and exit discharge. This deficient practice could affect 8 residents on the A wing second floor and any number of occupants in the office wing below. Findings include: Based on observation with the Executive Director and Maintenance Man #1 on 6/29/15 at 2:20 p.m., exterior lighting fixtures were mounted on the building with additional Ballard lights in the courtyard at the A wing courtyard emergency exit. Based on an interview with Maintenance Man #1 at the time of observation, he was unable to confirm the light fixtures would receive power from the emergency generator in the event of a	K 0045	**K045 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** The exterior light fixtures identified at the A wing courtyard emergency exit receive power from the emergency generator. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?** All exterior light fixtures to emergency exits will be assessed to determine if receive power from the emergency generator. Any discovered to require power from emergency generator will be corrected. Any residents using an emergency exit could be affected. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficient practicedoes not recur?** All exterior lights will be assessed monthly by	07/30/2015

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	power outage. 3.1-19(b)		Maintenance staff during generator testing to assure proper operation during emergency power. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** Exterior light testing during generator testing results will be summarized and presented to QA committee monthly for 6 months. As long as 100% compliance is maintained,the audits presented to the committee may be discontinued if determined no longer necessary by the committee. **By what date the systemic changeswill be completed?** By July 30, 2015.	
K 0048 SS=C Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD 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 provide a written plan that included the evacuation of a smoke compartment within the evacuation instruction of 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: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms	K 0048	**K048 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** The Codes and Procedures have been updated to include evacuation of a smoke compartment for the second floor residents. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?**	07/30/2015

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	(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 residents on the 2nd floor. Findings include: Based on a record review on 06/30/15 at 1:42 p.m., the Executive Director and Maintenance Man #1 agreed at the time of record review the "Codes and Procedures" manual didn't included evacuation of a smoke compartment for second floor residents. 3.1-19(b)		All residents of the second floor have the potential to be affected, so the evacuation plan will be amended to include evacuation procedure for the residents of the second floor. Staff and residents will be in-serviced on the new procedure. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** Evacuation procedure will be reviewed by Administrative Leadership Team to determine if any other elements need to be amended. Any changes made will be presented to staff and residents through in-service education. Evacuation procedures will be reviewed annually by the Administrative Leadership Team. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** Evacuation procedure will be reviewed by Administrative Leadership Team and presented toQA for any further recommendations. **By what date the systemic changeswill be completed?** By July 30, 2015	
K 0056 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for			

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	all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure complete automatic sprinkler system was provided for 1 of 1 exit foyers from the first floor B wing and 1 of 1 tunnels in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. This deficient practice could affect at least 10 residents in B wing and at least 5 residents using the Therapy room on the lower level. Findings include: a) Based on observation with the Executive Director and Maintenance Man #1 on 06/29/15 at 2:40 p.m.,, the exit foyer from the B wing lacked sprinkler coverage. The Executive Director and Maintenance Man #1 agreed at the time of observation, the exit foyer from the B wing lacked a sprinkler head. b) Based on observation with the Executive Director and Maintenance Man	K 0056	**K056 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** a)A sprinkler head will be placed in the foyer from B wing. b)The Metal Doors leading to the pool and to the tunnel will be properly documented and latching to meet the required 2-hour fire wall requirement between Health Care and adjoining occupancy in order to void sprinkler coverage requirement identified in this deficiency. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?** Any residents requiring egress access to the B-wing foyer or who utilize the Therapy room on the lower lever could be affected. All egress foyer areas will be evaluated for presence of proper sprinkler coverage and any required missing coverage will be added and any improperly documented or latching doors will be	09/30/2015

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	#1 on 06/30/15 at 11:15 a.m., the pool area and the tunnel lacked sprinkler coverage. Both sets of double door entering the pool area and the tunnel were non-rated metal doors with manually latching hardware. Based on an interview with the Executive Director and Maintenance Man #1 at the time of observation, the pool area was not used by the facility residents and neither were aware of the two hour fire wall requirement between the Health Care and adjoining occupancies. 3.1-19(b)		corrected. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** All foyer areas will be properly sprinkled and all areas considered to be outside of the Health Care occupancy will be properly separated with properly documented 2-hour fire wall rated and properly latching doors. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** An audit of all foyers and door considered to be separating Health Care and adjoining occupancy will be performed by Maintenance staff and summary of results will be presented to QA for further recommendations. **By what date the systemic changeswill be completed?** By September 30, 2015	
K 0064 SS=D Bldg. 01	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 Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguisher pressure gauge readings was in the acceptable range in the A wing. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly	K 0064	**K064 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** The fire extinguisher has been removed and properly recharged. **How other residents having**	07/30/2015

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	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) Operating instructions on nameplate legible and facing outward, (d) Safety seals and tamper indicators not broken or missing, (e) Fullness determined by weighing or hefting, (f) Examination for obvious physical damage, corrosion, leakage or clogged nozzle and (g) Pressure gauge reading or indicator in operable range or position, shall be subjected to applicable maintenance procedures. This deficient practice could affect 8 residents on A wing. Findings include: Based on an observation with the Executive Director and Maintenance Man #1 on 06/29/15 at 1:08 p.m., the gauge on the portable fire extinguisher near the shower room in A wing indicated the extinguisher was overcharged. The Executive Director and Maintenance Supervisor agreed at the time of observation, the gauge reading was not in the normal operating range and did not know if it would affect the operation of the fire extinguisher. 3.1-19(b)		**thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?** All extinguishers have been assessed to assure no others are overcharged and any identified will be replaced or properly recharged. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** Within the same month of annual fire extinguisher inspection and recharge, the Maintenance staff will conducted follow up audit of all extinguishers to verify that all have been correctly recharged. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** An audit of all fire extinguishers will be completed monthly and results summarized and presented to the QA for further recommendations. **By what date the systemic changeswill be completed?** By July 30, 2015	

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K 0067 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 2 dampers in the ventilation ductwork was inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects residents in the first floor office wing. Findings include: Based on observation on 06/30/15 at 12:28 p.m., Maintenance Man #1 confirmed there was a smoke/fire damper in the ventilation duct the penetrated the first floor office wing smoke barrier wall. Based on an interview with Maintenance	K 0067	**K067 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** The smoke/fire damper identified has been disabled for years upon completion of a remodel. The penetration in the wall for the unnecessary ductwork will beproperly removed and sealed. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?** Any residents accessing the first floor office wing would have potential to be affected. The smoke damper and unnecessary duct work will be removed and the penetrations will be properly sealed. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficient practicedoes not recur?** An audit of all other smoke dampers will be performed to assure all have beenproperly inspected and to assure proper maintenance has been provided timely. **How the corrective action will bemonitored to ensure the**	07/30/2015

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	155700	A. BUILDING 01 B. WING	06/30/2015

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	Man #1 at the time of observation, he was unaware of the smoke/fire damper and confirmed the damper had not received an inspection and was provided with necessary maintenance within the last four years. 3.1-19(b)		**deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** All smoke dampers will be audited by Maintenance staff to assure timely inspections have occurred. Results of the audit will be summarized and presented to the QAfor any further recommendations. This audit will occur annually or as often as determined necessary by the QA committee. **By what date the systemic changeswill be completed?** By July 30, 2015.	
K 0073 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 Based on observation, the facility failed to ensure 1 of 1 facility chapel remains free of combustible decorations. This deficient practice affect any resident in or near the chapel. Findings include: Based on observation and interview on 06/29/15 at 3:25 p.m., Maintenance Man #1 acknowledged and extinguished the lit candle located in the chapel area that was unoccupied at the time of observation. Based on an interview with the Executive Director at 3:30 p.m., the lit candle with an open flame was designed to remain lit	K 0073	**K073 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** The wax candle will be replaced by a battery operated device. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?** Any residents utilizing the chapel have the potential to be affected. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficient practicedoes not recur?** The	07/30/2015

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	at all times. 3.1-19(b)		candle of the eternal flame will be replaced by a battery operated device. The Sisters and the Priest will be educated as to the FLS regulations. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** The Spiritual Wellness Coordinator/designee will monitor the presence of the Battery Operated device weekly for 2 months, and as long as 100% compliance is achieved will monitor once monthly for an additional 4 months. As long as 100% compliance continues to be maintained, the audits may be discontinued. Theaudits will be presented monthly to the QA for further review and any recommendations. **By what date the systemic changeswill be completed?** By July 30, 2015.	
K 0144 SS=C Bldg. 01	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. Based on record review and interview, the facility failed to provide the complete documentation for testing 1 of 1 emergency generators providing power to the emergency lighting systems. NFPA 99, Section 3-4.1.1.8 states the generator set shall have sufficient capacity to pick up the load and meet the minimum	K 0144	**K144 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** The time for the transfer of power from the main source to the generator will be properly recorded when tested monthly. **How other residents having thepotential to be**	07/30/2015

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	frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants. Findings include: Based on review of the generator log titled "Generator Log" with the Executive Director and Maintenance Man #1 on 06/29/15 at 11:20 a.m., the emergency generator was tested monthly under load for at least 30 minutes, however, the monthly load test record did not include the time for the transfer of power from the main source to the generator. This was acknowledged by the Executive Director at the time of record review. 3.1-19(b)		**affected by the same deficient practice will be identified andwhat corrective action will be taken?** All residents have the potential to be affected. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** The Generator Log has been amended to include a place to record the time for the transfer of power from the main source to the generator when tested monthly. **How the corrective action will be monitoredto ensure the deficient practice will not recur, i.e. what Quality Assuranceprogram will be put into place?** The Generator Logs will be audited monthly by the Executive Director/designee to assure transfer of time of power from the main source to the generator has been properly recorded and do not exceed the required 10 seconds after loss ofinitial power. Results of the audits will be presented to the QA monthly for 6months for further recommendations. As long as 100% compliance has been maintained, the audits may then be discontinued if approved by the QA committee. **By what date the systemic changeswill be completed?** By July 30, 2015.	
K 0147 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in			

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	accordance with NFPA 70, National Electrical Code. 9.1.2 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power strips was not used as a substitute for fixed wiring to provide power to medical equipment and 2 of 2 flexible cord power strips, 2 of 2 multiplug adapters and 3 of 3 extension cords were not used as a substitute for fixed wiring. 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 approximately 6 residents. Findings include: Based on observations and interview on 06/29/15 from 1:09 p.m. to 2:30 p.m. and on 06/30/15 from 11:30 p.m. to 12:15 p.m., Maintenance Man #1 acknowledged the following: a) a multiplug adapter was plugged in and supplying power to a lamp and a chair in resident room 227 b) a multiplug adapter was plugged in and supplying power to a refrigerator in resident room 231 c) a power strip was plugged in a supplying power to a concentrator in	K 0147	**K147 What corrective action will beaccomplished for those residents found to have been affected by the deficientpractice?** 1. a and b) The multiplug adapters identified were removed at time of survey. c)The power strip was removed and the concentrator was plugged directly into the wall receptacle. d)The extension cords were removed and the power strips were plugged directly into a wall receptacle. e)The extra power strip has been removed. f) The extension cord was removed. 2.The electrical wiring above the ceiling tile has been properly confined within a junction box. **How other residents having thepotential to be affected by the same deficient practice will be identified andwhat corrective action will be taken?** 1)All residents and staff could be affected. All extension cords used in CKH have been removed. Power strips will be plugged directly into a wall receptacle and no power strips will be pluggedinto other power strips. No medical devices will be plugged into power strips. Any exposed electrical wiring will be properly confined in a junction box. An audit of every resident room and office in CKH will be conducted to assure no extension cords remain and power strips are properly used and any	07/30/2015

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	resident room 235 d) an extension cord was plugged in and supplying power to two swinging machines and another extension cord was plugged in and supplying power to a power strip in the sewing room e) a power strip was plugged in and supplying power to another power strip in the laundry room f) an extension cord was plugged in and supplying power to a camera monitor in the maintenance office 3.1-19(b) 2. Based on observation and interview, the facility failed to provide a covered junction box for electrical wiring above the ceiling tile at 1 of 1 A wing smoke barrier walls. NFPA 70, National Electrical Code, 1999 Edition, Article 370-28(c) requires exposed electrical wires be confined within a junction box with a cover compatible with the box. This deficient practice was not in a resident care area but could affect facility staff. Findings include: Based on observation and interview on 06/30/15 at 12:40 p.m., Maintenance Man #1 acknowledged the end of the electrical wiring above the ceiling tile at		discovered will be removed or properly plugged into wall receptacles. 2)An audit of the smoke barrier walls will be conducted to include identification of any improperly exposed wiring and any identified will be correctly confined. **What measures will be put intoplace or what systemic changes will be made to ensure that the deficientpractice does not recur?** 1)A letter will be drafted and send out to families and residents reminding them not to bring in any extension cords, multiplug adapters. The letter will be provided to new Admissions. Any use of power strips will be assessed for safety by the Maintenance staff prior to use in a resident room, common area or staff office. Staff will be educated on proper use of Medical Devices to be plugged only directly into wall receptacles, and proper use of power strips. 2)Maintenance staff have been educated on proper coverage of exposed wiring. **How the corrective action will bemonitored to ensure the deficient practice will not recur, i.e. what QualityAssurance program will be put into place?** 1)An audit of 4 rooms per hall per floor will be performed monthly by Maintenance staff/designee for the next 6 months to assure 100% compliance has been maintained. Results will be summarized and presented to the	

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	the A wing smoke barrier wall should be in a covered junction box. 3.1-19(b)		monthly QA Committee for further recommendations. 2) The audit of the Smoke Barrier walls will be conducted initially by July 30, 2015, then again quarterly with results summarized and presented to the QA committee the month following the audit. Audits will continue until the QA Committee determines no longer necessary. **By what date the systemic changeswill be completed?** By July 30, 2015	