STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155618	A. BUILDING 01 B. WING	03/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(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: 03/20/17 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 At this Life Safety Code survey, Manor Care Health Services Summer Trace was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2012 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 was determined to be of Type I (332) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms.	K 0000	The statement made in this plan of correction is not an admission to and does not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take actions set forth in the following Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	The facility has a capacity of 104 and had a census of 46 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/22/17 - DA			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to			

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	release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 12 exits were readily accessible for residents without a clinical	K 0222	**Corrective actions accomplished for resident found to be affected by this alleged practice** The stair well exit door to the	04/14/2017

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	diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 15 residents, staff and visitors on the second floor if needing to exit the facility. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 03/20/17, the stairwell exit door to the outside of the facility on the second floor by the oxygen storage and transfilling room was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned facility exit was marked as a facility exit and could be opened by entering a four digit code but the code was not posted. Based on exit interview at 3:45 p.m., the Administrator acknowledged all second floor residents did not have a clinical diagnosis requiring		outside of the facility on second floor by the oxygen and storage and transfilling room has signage indicating the code to unlock the door. The exit door to the first floor vestibule near the nurse station has the necessary signage indicating the door is able to open after 15 seconds of pushing. **Other residents having the potential to be affected by this alleged deficient practice will identified and correction action will be taken.** All residents have the potential to be affected by this alleged deficient practice. The stair well exit door has signage indicating the code to unlock the door. The exit door in first floor vestibule has the necessary signage indicating the door is able to open after 15 seconds of pushing. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur:** The maintenance director or designee will audit the exit doors throughout the facility to verify that	

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	specialized security measures. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release		there is signage indicating the code to unlock the door. The maintenance director or designee will audit the exit doors to verify that the necessary signage is in place that indicates the door is able to open after 15 seconds of pushing. This will be monitored using the Maintenance Director Monitoring tool 5x weekly x 2 weeks, 3x weekly x 2 weeks, and 1 x weekly x 2 months. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur** The administrator will review the Maintenance Director Monitoring tool weekly x 3 months to verify that the audits are completed and that the alleged deficient practice does not recur. - **What quality assurance program will be put into place** The QAPI committee will review the audit tool monthly to verify the audits are ongoing and the deficient practice does not recur. The QAPI committee will review for 3 months and then continue or recommend discontinuation of the audit if the committee demeans it is successful.	

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	the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 15 residents, staff and visitors on the first floor if needing to exit the facility. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 03/20/17, the exit door to the first floor vestibule near the nurse's station was marked with an exit sign as a facility exit			

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	but the exit was not equipped with the necessary signage indicating the door was a delayed egress door and could be opened after pushing for 15 seconds. The exit door was a delayed egress door and released when attempted to open by pushing for 15 seconds. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned facility exit door was a delayed egress door but was not provided with the necessary signage indicating it was a delayed egress door. 3.1-19(b)			
K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 1. Based on observation and interview, the facility failed to ensure doors at 1 of 3 horizontal exits were arranged to minimize air leakage. LSC, 7.2.4.3.9 requires all fire door assemblies in horizontal exits shall be designed and installed to minimize air leakage. In addition NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, 6.3.1.7.1 states the clearances between the meeting edges of steel doors swinging in pairs shall be	K 0226	**Corrective actions accomplished for resident found to be affected by this alleged practice** The horizontal exit steel fire door set by the assisted living dining room has an astragal in place to minimize air leakage Maintenance loosed the handle on the south exit door and dogged the latch into the frame.	04/14/2017

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	1/8th's inch plus or minus 1/16th's inch. This deficient could affect 15 residents, staff and visitors on the first floor near the south exit of the facility. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 03/20/17, the horizontal exit steel fire door set by the Assisted Living Dining Room on the first floor near the south exit of the comprehensive care facility had a one half inch gap in between the center meeting edges of the door set when in the fully closed position which did not minimize air leakage. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned horizontal exit door set had a gap between the meeting edges of the door set which did not minimize air leakage. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 3 horizontal exit doors were arranged to automatically close and latch. Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In		**Other residents having the potential to be affected by this alleged deficient practice will identified and correction action will be taken.** All residents have the potential to be affected by this alleged deficient practice. The horizontal exit steel frame fire door set by the assisted living dining room and the south exit door has been repaired. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur:** The maintenance director or designee will audit the fire door to verify that astragals and latching devices are in place. This will be monitored using the Maintenance Director Monitor tool 5x weekly x 2 weeks, three x weekly x 2 weeks ,and 1 x weekly x 2 months. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur** The administrator will review the Maintenance Director Monitoring tool weekly x 3 months to verify that the audits are completed and that the alleged deficient practice does not recur.	

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	addition NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, 6.1.4.3.1 states the fire door shall latch upon closure. This deficient could affect 15 residents, staff and visitors on the first floor near the south exit of the facility. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 03/20/17, the horizontal exit fire door set by the Assisted Living Dining Room on the first floor near the south exit of the comprehensive care facility failed to latch into the frame. The panic bars for each door in the door set were "dogged down" and prevented the door set from latching into the frame. Based on interview at the time of observation, the Maintenance Director acknowledged the panic bars for each door in the door set were "dogged down" and prevented the door set from latching into the frame. 3.1-19(b)		- **What quality assurance program will be put into place** The QAPI committee will review the audit tool monthly to verify the audits are ongoing and the deficient practice does not recur. The QAPI committee will review for 3 months and then continue or recommend discontinuation of the audit if the committee demeans it is successful.	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and			

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	ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to maintain protection of 2 of 3 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. Existing penetrations shall be protected in accordance with 8.3.5. This deficient practice could affect 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Technician during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 03/20/17, the following was noted: a. a four inch in diameter hole for the passage of four data cables was noted in	K 0311	**Corrective actions accomplished for resident found to be affected by this alleged practice** The maintenance director repaired the 4 inch diameter hole in the second floor stairwell wall by the oxygen room by patching and fire caulking. The maintenance director repaired the 1 ½ inch diameter hole in the stairwell wall by room 242 by patching and fire caulking. **Other residents having the potential to be affected by this alleged deficient practice will identified and correction action will be taken.** All residents have the potential to be affected by this alleged deficient practice. The maintenance director repaired the 4 inch diameter hole and 1 ½ inch diameter hole using patching and fire caulking. **Measures put into place/systemic**	04/14/2017

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	the stairwell wall above the suspended ceiling by the second floor oxygen storage and transfilling room. b. a one half inch in diameter hole for the passage of two data cables was noted in the stairwell wall above the suspended ceiling by Room 242. Each of the aforementioned holes did not maintain the fire resistance rating of the stairwell vertical opening. Based on interview at the time of the observations, the Maintenance Technician acknowledged the openings in the two stairwell walls failed to maintain the fire resistance rating of the aforementioned interior stairwells. 3.1-19(b)		**changes made to ensure the alleged deficient practice does not recur:** The maintenance director or designee will do an audit of walls and ceilings for penetrations. This will be monitored using the Maintenance Director Monitor tool 5x weekly x 2 weeks, 3 x weekly x 2 weeks and 1 x weekly x 2 months. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur** The administrator will review the Maintenance Director Monitoring tool weekly x 3 months to verify that the audits are completed and that the alleged deficient practice does not recur. **What quality assurance program will be put into place** The QAPI committee will review the audit tool monthly to verify the audits are ongoing and the deficient practice does not recur. The QAPI committee will review for 3 months and then continue or recommend discontinuation of the audit if the committee demeans it is successful.	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220)			
	Based on observation and interview, the facility failed to ensure 2 of 11 hazardous areas such as combustible storage rooms over 50 square feet in size were separated	K 0321	**Corrective actions accomplished for resident found to be affected by this alleged practice** The corridor door providing access	04/14/2017

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	from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the first floor combustible supply storage rooms. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 03/20/17, the corridor door providing access to each of two adjoining combustible storage rooms over 50 square feet in size on the first floor was removed but its self closing hinges were still in place attached to the door frame. Each of the two adjoining rooms measured greater than 50 square feet in size and were used to store combustible supplies on shelving such as diapers, linens and sterile supplies in plastic wrapping. The entry doors to each of the two adjoining rooms were not equipped with self closing devices. Based on interview at the time of the observations, the Maintenance Director acknowledged the entry door to the aforementioned two hazardous areas was not equipped with a self closing device. 3.1-19(b)		to each of two adjoining combustible storage room door now have self-closing devices. **Other residents having the potential to be affected by this alleged deficient practice will identified and correction action will be taken.** All residents have the potential to be affected by this alleged deficient practice. Therefore maintenance added self-closing devices to each of the two adjoining combustible storage room doors. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur:** The maintenance director or designee will do an audit of all doors to hazardous areas requiring self-closing devices . This will be monitored using the Maintenance Director Monitor tool 5x weekly x 2 weeks, 3x weekly x2 weeks and 1 x weekly x 2 months. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur**	

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	155618	A. BUILDING 01 B. WING	03/20/2017

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			The administrator will review the Maintenance Director Monitoring tool weekly x 3 months to verify that the audits are completed and that the alleged deficient practice does not recur. - **What quality assurance program will be put into place** The QAPI committee will review the audit tool monthly to verify the audits are ongoing and the deficient practice does not recur. The QAPI committee will review for 3 months and then continue or recommend discontinuation of the audit if the committee demeans it is successful.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions			

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	include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after monthly load tests for 3 of 12 months. Chapter 6.4.4.1.1.4(A) of 2012 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 8. NFPA 110, 2010 Edition, Section 6.2.10 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shutdown. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less)	K 0918	**Corrective actions accomplished for resident found to be affected by this alleged practice** The generator load test form been modified to include cool down time. **Other residents having the potential to be affected by this alleged deficient practice will identified and correction action will be taken.** All residents have the potential to be affected by this alleged deficient practice. The maintenance will do his monthly generator test using the modified form that includes cool down time.	04/14/2017

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	air-cooled prime movers. NFPA 110, Section 8.3.4 states a permanent record of the Emergency Power Supply Systems (EPSS) inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Power Generators: Test Generator Under Load" documentation with the Maintenance Director during record review from 9:40 a.m. to 12:40 p.m. on 03/20/17, documentation for monthly load tests conducted on 01/05/17, 02/02/17 and 03/02/17 did not include cool down time for each of the three monthly load tests. Based on interview at the time of record review, the Maintenance Director stated the emergency generator is load tested monthly for at least one half hour with a minimum twelve minute cool down time period for a total run time of 42 minutes but acknowledged cool down time was not recorded for the aforementioned three month period. Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 03/20/17, manufacturer's nameplate information affixed to the emergency generator located outside the facility		**Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur:** The maintenance director or designee will verify using the Maintenance Director Audit that the generator load test form using monthly includes the cool down time. This will be done monthly for 3 months. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur** The administrator will review the Maintenance Director Monitoring tool weekly x 3 months to verify that the audits are completed and that the alleged deficient practice does not recur. **What quality assurance program will be put into place** The QAPI committee will review the audit tool monthly to verify the audits are ongoing and the deficient practice does not recur. The QAPI committee will review for 3 months and then continue or recommend discontinuation of the audit if the committee	

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	indicated it was rated at 400 kW. 3.1-19(b)		demeans it successful. - -	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply	K 0920	**Corrective actions accomplished for resident found to be affected by this alleged practice** The power strip in the Administrative Director of Nursing	04/14/2017

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	with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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 10 residents, staff and visitors in the vicinity of the Administrative Director of Nursing Services office on the second floor. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:10 p.m. to 3:30 p.m. on 03/20/17, a coffee pot was plugged into a power strip in the Administrative Director of Nursing Services office on the second floor. The power strip had no affixed documentation indicating its UL listing. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was being used as a substitute for fixed wiring at the aforementioned location. 3.1-19(b)		Services has been removed and the coffee pot is now plugged in to the wall. **Other residents having the potential to be affected by this alleged deficient practice will identified and correction action will be taken.** All residents have the potential to be affected by this alleged deficient practice and all department managers have in-serviced regarding not having power strips in offices. **Measures put into place/systemic changes made to ensure the alleged deficient practice does not recur:** The maintenance director or designee will do an audit offices to verify that there are no power strips. This will be monitored using the Maintenance Director Monitor tool 5x weekly x 2 weeks, 3 x weekly x 2 weeks, and 1 x weekly x 2 months. **How this corrective action will be monitored to ensure the alleged deficient practice will not recur** The administrator will review the	

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			Maintenance Director Monitoring tool weekly x 3 months to verify that the audits are completed and that the alleged deficient practice does not recur. **What quality assurance program will be put into place** The QAPI committee will review the audit tool monthly to verify the audits are ongoing and the deficient practice does not recur. The QAPI committee will review for 3 months and then continue or recommend discontinuation of the audit if the committee demeans it successful.	