CONCORDIA CARE
Transitional Care and Rehabilitation
NANSEMOND POINTE

June 12, 2019

Dear Mr. Rusty Chase:

Please find the enclosed Plan of Correction for the Life Safety survey conducted on May 28, 2019 for your review. If you have any questions about this plan of correction, please do not hesitate to call me.

Sincerely,

CONCORDIA CARE

Mel Epelle, LNHA, MHSA

Executive Director

757-539-8744

200 W Constance Road

Suffolk, VA 23434

Mellanby.epelle@concordiacare.net

COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Michael T. Reilly

EXECUTIVE DIRECTOR

State Fire Marshal's Office
Tidewater Division
102 Pratt Street
Suite 101
Ft. Monroe, Virginia 23651
Phone: (757) 848-5828
Fax: (757) 848-5813

06/02/2019

Mr. Mellanby Epelle,
Concordia Transitional Care Rehab-Nansemond Pointe
200 West Constance Road
Suffolk, VA 23434

Dear Mr. Epelle

This concerns the unannounced Life Safety Code survey of the referenced facility conducted 05/28/2019 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the Life Safety Code 2012 regulation.

All institutional buildings must meet all applicable Life Safety Code (NFPA 101) requirements in accordance with the federal Long Term Care certification requirements issued by the Centers for Medicare and Medicaid Services (CMS), in order to participate in the Medicare/Medicaid programs. The findings listed on the attached form, CMS 2567, "Statement of Deficiencies and Plan of Correction", demonstrate non-compliance with Title 42 Code Federal of Regulations, 483.70(a) et seq Life Safety from Fire.

Prior to making expenditures to correct the noted deficiencies, you should have an approved plan of correction. It is strongly recommended that you check with local officials, since compliance with this report does not excuse you from complying with local codes and ordinances.

The federal LTC Enforcement Regulations remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) and/or the Virginia Department of Medical Assistance Services (DMAS) for any failure or continued failure to demonstrate compliance with both the Health and Life Safety Code requirements (Title 42, Code of Federal Regulations). For example, a Denial of Payment for New Admissions at the 90th day after a survey, or the Termination of the Provider Agreement at the 180th day after a survey, could be a result of uncorrected Life Safety Code citations as well as Health citations.

If any deficient practice is identified within either the Health or Life Safety Code requirements, a Plan of Correction (POC) developed by the provider must be returned to the surveying entity by (*specify date that is ten (10) calendar days of the survey report is electronically transmitted or faxed to the facility. If mailed, add 5 days for mail to be delivered*). To be considered acceptable, the POC must include five (5) components:

1. Address the corrective action taken for the identified problem
2. Address how facility will identify similar occurrences of the problem
3. Identify measures/systemic changes to ensure deficient practice will not recur
4. Indicate how facility will monitor its performance
5. Date of correction, not to exceed 45th day after the survey.

NOTE: If correction/compliance by the 45th day after the survey is not possible, the facility's POC must be accompanied by a Time-Limited Waiver request with appropriate justification. The waiver request and supporting documentation will be reviewed by the State Fire Marshal's Office and the Virginia Department of Health for a final recommendation to CMS. Please be aware, the timeline involved in the Time Limited Waiver request and final approval process does not delay the potential imposition of enforcement actions.

If concerns regarding a citation are not resolved, in accordance with §488.331, the facility has one (1) opportunity to question cited deficiencies through the current Virginia Department of Health's informal dispute resolution (IDR) process . To be considered, the IDR request must be received by the State Fire Marshal's Office within 10 calendar days of your receipt of the enclosed survey findings. An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions taken by CMS or DMAS.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

If you have any questions or if we may be of assistance to you, please call (757) 848-5828

Sincerely,

Joseph R. Chase

Rusty Chase,
State Fire Marshal's Office

Attachment
/
cc: file

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-N	**200 WEST CONSTANCE ROAD SUFFOLK, VA 23434**

(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 000	INITIAL COMMENTS Description of structure:The facility is 1 story/stories frame structure with a construction type of V(000) Sprinkler status: Fully Sprinklered An unannounced recertification Life Safety Code survey was conducted 05/28/2019 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was found not to be in compliance with the Requirements for Participation Medicare and Medicaid	K 000	*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 provisions of federal and state law.*	7/8/2019
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be 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 shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.	K 741	K741 1. The Ashtray missing flap cover was removed/out of service and the Facility will replace the Ashtray with a flap cover. Facility will ensure that the self-closing cigarette butt Can remain free of trash. 2. This has the potential to affect our residents. 3. Executive Director and Maintenance Supervisor will conduct monthly inspections to ensure that designated residents smoking area has an Ashtray with flap cover, and the self-closing cigarette Can free from trash to maintain compliance. 4. Maintenance Supervisor or designee will report monthly to our Performance Improvement Committee and Safety Committee the results of audits performed on all corridor doors maintenance monthly. 5. Completion date will be July 08, 2019.	

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

Executive Director 06/12/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-N	**200 WEST CONSTANCE ROAD SUFFOLK, VA 23434**

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K 741	Continued From page 1 (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based upon observations a self closing ashtray was out of service. Findings include. On 05/28/19 between 9:00 AM and 12:00 PM it was observed in the resident smoking area that an ashtray was missing a flap cover exposing used cigarette butts, trash was also observed inside the dedicated self closing cigarette butt can. The above deficiency was observed by the Maintenance Assistant.	K 741	*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 provisions of federal and state law.* K919 1. The broken ground prong was removed from the outlet wall. The hairdryer was removed, commissioned out of service, and replaced with new hairdryer. The Light fixture on Butler Hall shower room was secured back to the ceiling. 2. This has the potential to affect our residents. 3. Executive Director and Maintenance Supervisor will conduct monthly inspections to ensure that the hairdryer, Light fixtures and the receptacles/outlets meet requirement and free from defects to maintain compliance. 4. Maintenance Supervisor or designee will report monthly to our Performance Improvement Committee and Safety Committee the results of audits performed on all corridor doors maintenance monthly. 5. Completion date will be July 08, 2019.	7/8/2019
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based upon observations of the electrical system that the required maintenance of the system is not being maintained. Findings include	K 919		

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K 919	Continued From page 2 On 05/28/19 between 9:00 AM and 12:00 PM it is observed in the beauty parlor a broken ground prong inside outlet wall, hairdryer plug with exposed wires. Light fixture in use hanging by the wires on Butler Hall in the shower room. The above deficiencies were observed by the Maintenance Assistant.	K 919		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING **02 - BUILDING 02** B. WING _____	**05/28/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE REHAB-N	**200 WEST CONSTANCE ROAD SUFFOLK, VA 23434**

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K 000	INITIAL COMMENTS Description of structure:The facility is 1 story/stories frame structure with a construction type of V(000) Sprinkler status: Fully Sprinklered An unannounced recertification Life Safety Code survey was conducted 05/28/2019 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was found not to be in compliance with the Requirements for Participation Medicare and Medicaid	K 000	*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 provisions of federal and state law.*	7/8/2019
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based upon observations of the electrical system that the required maintenance of the system is not being maintained.	K 223	K223 1. Facility have replaced the damage magnetic wall mount at the Kitchen side entrance door. Facility will ensure that all magnetic door mount is maintained to ensure compliance. 2. This has the potential to affect our residents. 3. Executive Director and Maintenance Supervisor will conduct monthly inspections to ensure that all magnetic door mount is not separated from the wall to maintain compliance. 4. Maintenance Supervisor or designee will report monthly to our Performance Improvement Committee and Safety Committee the results of audits performed on all corridor doors maintenance monthly. 5. Completion date will be July 08, 2019.	

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

Executive Director 06/12/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495247	A. BUILDING **02 - BUILDING 02** B. WING _____	**05/28/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 223	Continued From page 1 Findings include On 05/28/19 between 9:00 AM and 12:00 PM it is observed behind the side entrance kitchen door the magnetic wall mount had separated from the wall. The above deficiencies were observed by the Maintenance Assistant.	K 223	*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 provisions of federal and state law.*	7/8/2019
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based upon observations of the sprinkler system that the required maintenance of the system is not being maintained. Findings include On 05/28/19 between 9:00 AM and 12:00 PM it is observed that the escutcheon ring was missing	K 353	K353 1. Facility have replaced the missing escutcheon ring from the sprinkler head in the water room located inside the laundry room. Facility will maintain Sprinkler system to comply with NFPA 25 standard for the inspection. 2. This has the potential to affect our residents. 3. Executive Director and Maintenance Supervisor/designee will conduct monthly inspections to ensure that all Sprinkler heads meets NFPA 25 standard for inspection to maintain compliance. 4. Maintenance Supervisor/designee will report monthly to our Performance Improvement Committee and Safety Committee the results of audits performed on all corridor doors maintenance monthly. 5. Completion date will be July 08, 2019.	

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K 353	Continued From page 2 from sprinkler head in the washer room located inside the laundry room. The above deficiencies were observed by the Maintenance Assistant.	K 353	*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 provisions of federal and state law.*	7/8/2019
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based upon observations, there is evidence that the fire extinguishers are not being maintained properly. Findings include On 05/28/19 between 9:00 AM and 12:00 PM, it is observed that the K-Fire Extinguisher located in the kitchen was on the floor, safety pin had been removed and monthly documentation had not been performed. Out of date Fire Extinguisher observed in the Courtyard awning area. The above deficiency was observed by the Maintenance Assistant.	K 355	K355 1. Facility have properly installed the K-Fire extinguisher located in the Kitchen with the safety pin in place. Facility have updated the Fire extinguisher in the Courtyard awning area. Facility will ensure that all fire extinguishers are maintained properly to ensure compliance. 2. This has the potential to affect our residents. 3. Executive Director and Maintenance Supervisor will conduct monthly inspections to ensure that all Fire extinguishers are being maintained to ensure compliance. 4. Maintenance Supervisor/designee will report monthly to our Performance Improvement Committee and Safety Committee the results of audits performed on all corridor doors maintenance monthly. 5. Completion date will be July 08, 2019.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		

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	495247	A. BUILDING **02 - BUILDING 02** B. WING _____	**05/28/2019**

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K 521	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based upon observations vent/duct returns need to be cleaned. Findings include On 05/28/19 between 9:00 AM and 12:00 PM , it is observed in the dining room the vent/duct returns needs to be cleaned of dust and debris. The above deficiency was observed by the Maintenance Assistant.	K 521	*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 provisions of federal and state law.* K521 1. The Vent/duct returns in the dining room has been cleaned of dust and debris. Facility will ensure all Vent/duct are clean to ensure compliance. 2. This has the potential to affect our residents. 3. Executive Director and Maintenance Supervisor will conduct monthly inspections to ensure that all Vent/duct returns are cleaned and free from dust and debris to maintain compliance. 4. Maintenance Supervisor or designee will report monthly to our Performance Improvement Committee and Safety Committee the results of audits performed on all corridor doors maintenance monthly. 5. Completion date will be July 08, 2019.	7/8/2019
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based upon observations of the electrical system that the required maintenance of the system is not being maintained. Findings include On 05/28/19 between 9:00 AM and 12:00 PM it is observed in the kitchen electric tape around plug to coffee maker, electrical plug to blender bent in a 45 degree angle pressed up against electrical outlet The above deficiencies were observed by the Maintenance Assistant.	K 919		
K 920	Electrical Equipment - Power Cords and Extens	K 920		

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K 920 SS=D	Continued From page 4 CFR(s): NFPA 101 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 This REQUIREMENT is not met as evidenced by: Based upon observations the electrical systems that there is non-approved power strips being used in patient care areas. Findings include On 05/28/19 between 9:00 AM and 12:00 PM, it is observed that there is a non approved power strip located in use at the Holiday Hall nursing station. The above deficiency was observed by the Maintenance Assistant.	K 920	*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 provisions of federal and state law.* K919 1. Facility will ensure that all electric cords/equipment are free from tape, and defects to ensure compliance. 2. This has the potential to affect our residents. 3. Executive Director and Maintenance Supervisor will conduct monthly inspections to ensure that all electrical cords are free from tapes and defects to maintain compliance. 4. Maintenance Supervisor or designee will report monthly to our Performance Improvement Committee and Safety Committee the results of audits performed on all corridor doors maintenance monthly. 5. Completion date will be July 08, 2019.	7/8/2019

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CONCORDIA TRANSITIONAL CARE REHAB-N	**200 WEST CONSTANCE ROAD SUFFOLK, VA 23434**

(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 920 SS=D	Continued From page 4 CFR(s): NFPA 101 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 This REQUIREMENT is not met as evidenced by: Based upon observations the electrical systems that there is non-approved power strips being used in patient care areas. Findings include On 05/28/19 between 9:00 AM and 12:00 PM, it is observed that there is a non approved power strip located in use at the Holiday Hall nursing station. The above deficiency was observed by the Maintenance Assistant.	K 920	*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 provisions of federal and state law.* K920 1. The non-approved power strip located in Holladay Hall nurse station has been removed and will be replaced with approved power strip UL1363A required to ensure compliance. 2. This has the potential to affect our residents. 3. Executive Director and Maintenance Supervisor will conduct monthly inspections to ensure that all power strips used meets the requirement UL1363A to maintain compliance. 4. Maintenance Supervisor or designee will report monthly to our Performance Improvement Committee and Safety Committee the results of audits performed on all corridor doors maintenance monthly. 5. Completion date will be July 08, 2019.	7/8/2019