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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535033 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 08/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CASTLE ROCK CONVALESCENT CENTER | 1445 UINTA DRIVE<br>GREEN RIVER, WY 82935 |

| (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<br><br>Requirements for Long Term Care Facilities Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2000 edition of the Life Safety Code, Existing Health Care Occupancies, of the National Fire Protection Association.<br><br>The facility was a fully sprinkled, single-story building of Type V (111) construction built in 1987.The building was equipped with a supervised automatic wet sprinkler system with an anti-freeze loop and a zoned fire alarm system. The facility had a capacity of 59 certified Medicare and Medicaid beds with a census of 57. | K 000 | Reference Tag K 027, the Facility Maintenance Supervisor will ensure the smoke barrier double doors are smoke resistant. This will be accomplished by:<br><br>The north and west double smoke barrier doors have been disassembled, lubricated and checked for worn parts, to ensure they fully close into the door frames. | 09/04/12 |
| K 027 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7<br><br>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 2 of 6 smoke barrier double doors were smoke resistant. The findings were: | K 027 | All smoke barrier doors could be affected. The Maintenance Supervisor will conduct an in- service with all Maintenance staff in the importance of maintaining all smoke barrier doors during daily rounds of the facility. The Maintenance Supervisor will perform a monthly audit of smoke barrier doors and if any are found out of compliance, immediate corrective action will be taken.<br><br>The Maintenance Supervisor will change the maintenance task included in the (CMS) computerized maintenance system, that will generate a PM work order on a monthly basis. All monthly PM work orders, pertaining to Life Safety are monitored at 100% completion.<br><br>All deficiencies pertaining to Life Safety, will be reported to the Safety Committee on a quarterly basis. | 09/19/12<br><br>10/11/12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/24/12

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.

POC Accepted w/ Bobbi Jo Dietz, NHA, DN 9/27/12.

RECEIVED
WY Dept of Health
SEP 25 2012
Healthcare Licensing and Surveys

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535033 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 08/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CASTLE ROCK CONVALESCENT CENTER | 1446 UINTA DRIVE<br>GREEN RIVER, WY 82935 |

9/27/12

| (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 027 | Continued From page 1<br>Observation on 8/29/12 between 10:30 AM and 11:30 AM showed the north and west double smoke barrier doors both had one door that would not fully close into the door frames, with three attempts each. At 10:56 AM the maintenance director could not explain why the doors had not been noticed and repaired during the quarterly inspection. | K 027 | Reference Tag K 029, the Facility Maintenance Supervisor will ensure that hazardous areas are separated from use areas. This will be accomplished by:<br><br>The Housekeeping supply closet corridor door was equipped with a self-closing devise, to ensure the door remains in the closed position. | 8/31/12 |
| K 029 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure hazardous areas were separated from use areas in 1 of 6 smoke compartments. The findings were:<br><br>Observation on 8/29/12 at 9:52 AM showed paper towels and alcohol based hand rub solutions in quantities deemed hazardous by the authority having jurisdiction (AHJ) were stored in the housekeeping supply closet. Further observation showed the corridor door was not equipped with a self-closing device. At the time of the observation | K 029 | All hazardous areas equipped with a self closing devise could be affected. The Maintenance Supervisor will instruct all Maintenance staff in the importance of maintaining the self closing devices to ensure proper closure of the doors in all hazardous areas. The Maintenance Supervisor will will perform a monthly audit to check hazardous areas and ensure proper operation of the self-closure and if any are found out of compliance, immediate corrective action will be taken.<br><br>The Maintenance Supervisor will ensure that the housekeeping closet door, and all hazardous area doors, are included in the facility (CMS) computerized maintenance system that will generate a PM work order on a monthly basis. All PM work orders pertaining to Life Safety are monitored at 100% completion.<br><br>All deficiencies pertaining to Life Safety, will be reported to the Safety | 9/19/12<br><br>10/11/12 |

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

PRINTED: 08/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535033 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 08/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CASTLE ROCK CONVALESCENT CENTER | 1445 UINTA DRIVE<br>GREEN RIVER, WY 82935 |

9/27/12

| (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 029 | Continued From page 2<br>the maintenance director could not explain why the closure had not been installed. | K 029 | | |
| K 046 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure the emergency generator was equipped with a remote emergency stop button. The findings were:<br><br>Observation of the emergency corridor lights showed they were supplied with power from the emergency generator. Observation of the generator on 8/29/12 at 11:31 AM showed it was located inside the building in the main electrical room. Further observation showed the generator was not equipped with an emergency stop button. At the time of the observation the maintenance director reported he was unaware an emergency stop button was required.<br><br>Reference, NFPA 101, 2000 Edition, 19.2.9.1, 7.9.2.3, NFPA 110, 1999 Edition;<br>3-5.5.6 All Level 1 and Level 2 installations shall have a remote manual stop station of a type similar to the break-glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building. | K 046 | Reference K Tag 046, the Maintenance Supervisor will ensure that the emergency generator is equipped with an emergency stop button. This will be accomplished by:<br><br>Hiring an electrical sub-contractor, to prepare drawings and submittals to forward to the Wyoming Department of Health for approval to install an emergency stop button. Upon approval from the Wyoming Department of Health, the sub-contractor will install an emergency stop button per approved plans.<br><br>The facility has only one emergency generator that is affected by this deficiency.<br><br>Upon completion of installation a photograph will be taken and submitted to the State. | 10/10/12 |
| K 050 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under | K 050 | Reference Tag K050, the Maintenance Supervisor will ensure that a fire drill is conducted one per shift per quarter. This will be accomplished by: | 08/31/12 |

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535033 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 08/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CASTLE ROCK CONVALESCENT CENTER | 1446 UINTA DRIVE<br>GREEN RIVER, WY 82935 |

9/25/12

| (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 050 | Continued From page 3<br>varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure a fire drill was held on each shift during one of the past four quarters. The findings were:<br><br>Review of the fire drill records showed the first shift occurred between 6 AM and 2 PM. Further review showed a fire drill had not been conducted on the first shift during the fourth quarter of 2011. On 8/29/12 at 12:40 PM the maintenance director confirmed the fire drill had not been conducted. He could not explain why the drill was not conducted. | K 050 | The Maintenance Supervisor will ensure that all fire drills are conducted during the proper times, 6 AM and 2 PM for day shift, 2 PM and 10 PM for swing shift and 10 PM and 6 AM for midnight shift. All fire drills are included in the facility (CMS) computerized maintenance system, to generate a PM work order on a monthly basis.<br><br>All fire drills have the potential of being conducted at the wrong time if they are being performed close to the shift change hour. The Maintenance Supervisor will ensure that the time that a fire drill is performed, is not with in close proximity to the shift change hours.<br><br>All deficiencies pertaining to Life Safety will be reported to the Safety Committee on a quarterly basis. | 10/11/12 |
| K 052<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 | K 052 | | |

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

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 |
|---|---|---|---|
| | 535033 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 08/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CASTLE ROCK CONVALESCENT CENTER | 1445 UINTA DRIVE<br>GREEN RIVER, WY 82935 |

9/27/12

| (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 052 | Continued From page 4<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to ensure 2 of 10 fire alarm system components were tested. The findings were:<br><br>1. Review of the fire alarm system testing records showed the system was last tested on 5/17/11. Further review showed the semi-annual load voltage had not been performed on the batteries in the fire alarm control panel in the past six months. On 8/29/12 at 12:40 PM the maintenance director could not explain why this test had not been added to the preventative maintenance schedule.<br><br>2. Review of the fire alarm system testing records showed the system receiver had not been tested during the months of August and November 2011, and February 2012. On 8/29/12 at 12:40 PM the maintenance director reported the receivers were normally checked by fire drill activations, but the aforementioned months had silent drills. He could not explain why the system was not activated by some other means.<br><br>Reference NFPA 101, 2000 Edition, 19.3.4.1, 9.6.1.4, NFPA 72, 1999 Edition;<br>Table 7-3.2 Testing Frequencies.<br>6. Batteries-Fire alarm systems<br>d. Sealed Lead-Acid Type<br>1. Charge Test,.....annually<br>(Replace batteries every 4 years.)<br>2. Discharge Test ... ... ... ... ... .... ...annually | K 052 | Reference Tag K 052, the Maintenance Supervisor will ensure that all fire alarm system components are tested. This will be accomplished by:<br><br>Maintenance Supervisor has contacted the sub-contractor, responsible for the battery semi-annual load voltage and had them perform the required test.<br><br>The Maintenance Supervisor will ensure that the system receiver will be activated and tested following a silent alarm test.<br><br>The fire alarm system has the potential for failure if these tests are not performed. The Maintenance Supervisor will include the battery semi-annual load test to the facility (CMS) computerized maintenance system to generate a PM work order on a semi-annual basis. The Maintenance Supervisor will include, on the silent fire drill generated PM work order, the testing of the system receiver before the work order can be completed.<br><br>All Life Safety PM work order are monitored for 100% completion.<br><br>All deficiencies pertaining to Life Safety will be reported to the Safety Committee on a quarterly basis. | 09/06/12<br><br>8/29/12<br><br>10/11/12 |

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535033 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 08/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CASTLE ROCK CONVALESCENT CENTER | 1445 UINTA DRIVE<br>GREEN RIVER, WY 82935 |

9/27/12

| (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 052 | Continued From page 5<br>(30 minutes)<br>3. Load Voltage Test,.....semi-annually | K 052 | Reference Tag K 064, the Maintenance Supervisor will ensure that all portable fire extinguishers are properly maintained. This has been | |
| K 064 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure portable fire extinguishers were properly maintained in 1 of 6 smoke compartments. The findings were:<br><br>Observation of the kitchen on 8/29/12 at 10:05 AM showed the "K" type fire extinguisher had a hydrostatic test performed in 2005. Further observation showed a five year hydrostatic test had not been performed since the 2005 test. At the time of the observation the maintenance director reported he relied upon the service contractor to perform the inspections and test as required. He could not explain why the test had not been performed on a 5 year basis.<br><br>Reference NFPA 101, 2000 Edition, 19.3.5.6, 9.7.4.1, NFPA 10, 1998 Edition;<br>Table 5-2 Hydrostatic Test Intervals for Extinguishers<br>Wet Agent----------5 years | K 064 | accomplished by:<br><br>The maintenance supervisor has contacted the sub-contractor, to perform a required 5 year hydrostatic test on the wet agent "K" type fire extinguisher located in the kitchen area.<br><br>All portable fire extinguishers have the potential for failure if these tests are not performed. The Maintenance Supervisor will instruct the Maintenance staff to check the date on the inspection tag and the date on the extinguisher during the monthly preventive maintenance checks. These dates will be entered on the monthly fire extinguisher check list. The Maintenance Supervisor will also ensure that the annual service performed by the sub-contractor is included in the facility (CMS) computerized maintenance system to generate a PM work order on an annual basis.<br><br>All Life Safety PM work orders are monitored for 100% completion. | 09/04/12 |
| K 147 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 | K 147 | All deficiencies pertaining to Life Safety will be reported to the Safety Committee on a quarterly basis. | 10/11/12 |

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

PRINTED: 09/14/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 535033 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 08/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CASTLE ROCK CONVALESCENT CENTER | 1445 UINTA DRIVE<br>GREEN RIVER, WY 82935 |

9/27/12

| (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 147 | Continued From page 6<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure temporary electrical wiring did not replace permanent fixed wiring in 1 of 6 smoke compartments. The findings were:<br><br>1. Observation on 8/29/12 at 10:14 AM showed the administrative assistant ' s computer was plugged into a surge protector which was plugged into an extension cord. At the time of the observation the maintenance director could not explain why the extension cord had not been noticed and removed during the monthly safety inspections.<br><br>2. Observation of resident room #33 on 8/29/12 at 11:01 AM showed the television set was plugged into a 3-way adapter which was plugged into an extension cord. At the time of the observation the maintenance director could not explain why the electrical adapters had not been noticed and removed during the monthly safety inspections.<br><br>Reference NFPA 101, 2000 Edition, 19.5.1, 9.1.2, NFPA 70, 1999 Edition;<br>400-8. Uses not permitted. Unless specifically permitted in section 400-7, flexible cords and cables shall not be used for the following:<br>(1) As a substitute for the fixed wiring of a structure<br>(2) Where run through holes in walls ...<br>(3) Where run through doorways, windows, or similar openings<br>(4) Where attached to building surfaces | K 147 | Reference Tag K 147, the Maintenance Supervisor will ensure that extension cords will not be used. This will be accomplished by:<br><br>The extension cord plugged into the surge protector by the administrative assistants desk has been removed and replaced with a surge protector. The extension cord plugged into the 3-way adapter in room #33 has been removed.<br><br>A monthly work order has been generated to address inspection of all power strips and extension cords in use.<br><br>The Maintenance Supervisor will ensure that all Life Safety PM work orders are maintained at 100% completion.<br><br>All deficiencies pertaining to Life Safety will be reported to the Safety Committee on a quarterly basis. | 08/31/12<br><br>10/11/12 |