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

POC ACCEPTABLE 1/6/20

PRINTED: 12/11/2019
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
	056063	A. BUILDING 01 B. WING #16279	11/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INFINITY CARE OF EAST LOS ANGELES	101 S FICKETT STREET LOS ANGELES, CA 90033

(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
E 000	Initial Comments The following reflects the findings of the California Department of Public Health, during an Emergency Preparedness recertification survey. The facility is in substantial compliance with 42 Code of Federal Regulations 483.73; Requirement for Long Term Care Facilities, during an Emergency Preparedness recertification survey. Representing the Department of Public Health: Evaluator #: 16279, REHS, HFE I	E 000		
K 000	INITIAL COMMENTS This facility was surveyed under 42 Code of Federal Regulations, Part 483.70(a), Life Safety Code NFPA 101, 2012 Edition, Chapter 19 Existing Health Care Occupancies, and other applicable codes. The following reflects the findings of the California Department of Public Health during the Life Safety Code Survey. Representing the Department of Public Health: Evaluator #: 16279, REHS, HFE I Resident census: 92 Bed capacity: 99 Highest Severity & Scope: F	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321		

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

Executive Director

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

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K 321	Continued From page 1 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. 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, 19.3.5.9 Area Automatic Sprinkler Separation 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 K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous areas were maintained with a one-hour fire rated construction, regarding a self-closing device on one door. In the event of a fire, the separation of the medical records office would not be achieved, which would allow smoke and/or fire to travel from one area to another. Findings:	K 321		

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K 321	Continued From page 2 On November 26, 2019, between 8:15 a.m. and 11:10 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 9:58 a.m., upon entering the medical records office, it was observed that there were papers and paper products throughout the office. A closer observation revealed that the medical records office door did not have a self-closing device to automatically close, latch and maintain the door in the closed position. During a brief interview with the maintenance supervisor, it was determined that this room was 280 square feet (sq. ft.). According to NFPA 101, Life Safety Code Handbook, 2012 Edition, Protection from Hazards, 19.3.2.1.5(7), all hazardous areas or rooms and spaces larger than 50 sq. ft. used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction, and shall have doors that are self-closing. In an interview at the time of the LSC tour, the maintenance supervisor was informed that because the medical records office is considered a hazardous area, the door requires a self-closing device to prevent the possibility of fire and/or smoke from spreading. At the end of the interview, the maintenance supervisor stated he would install a self-closing device on the door, as soon as possible. The deficient practice affected one of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator	K 321	self-closing device for Med. Rec. Ordered on ____; installed on ____	

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K 321	Continued From page 3 and the maintenance supervisor.	K 321		
K 331 SS=E	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview; the facility failed to maintain a Class A, B, or C flame spread rating finish of walls and ceilings by having penetrations at six rooms, thereby compromising the fire rated surfaces. In the event of a fire, the separation of these areas would not be achieved because these penetrations would allow smoke and/or fire to travel from one area to another. Findings: On November 26, 2019, between 8:15 a.m. and 11:10 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed: 1. At 8:30 a.m., in the ice machine room there was: a) a 4-inch by 4-inch penetration (where a light switch cover plate was missing), which	K 331	→ switch cover plate ordered on ____ installed on ____	

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K 331	Continued From page 4 extended through one wall, and b) two 1-and-1/2-inch penetration (with two 1-inch pipes going through each penetration), which extended through the same wall. 2. At 10:07 a.m., there was a 2-inch penetration which extended through the bathroom wall (under the sink), inside Room 201. Two residents were inside this room. 3. At 10:32 a.m., there was a 1-inch penetration (with a computer cable going through), which extended through one wall (above the doorway), inside the rehabilitation room. 4. At 10:38 a.m., in the first floor dining room there was: a) a 3-inch by 4-inch penetration (where an electrical outlet cover plate was missing), which extended through one wall, and b) a 2-inch penetration (with a computer cable going through), which extended through another wall. 5. At 10:48 a.m., there was a 2-inch penetration (with two computer cables going through), which extended through one wall, inside the assistant administrator's office. 6. At 10:52 a.m., there was a 2-inch penetration which extended through the ceiling (with two computer cables going through), inside the business office. In an interview at the time of the LSC tour, the maintenance supervisor stated that he understood that the penetrations must be sealed to prevent the possibility of fire and/or smoke from spreading. At the end of the interview, the maintenance supervisor added that he would seal	K 331	penetration sealed on ____ using approved Fire Dept. sealant penetration sealed on ____ sealed on ____ switch cover plate attached on ____ penetration sealed on ____ penetration sealed on 11/26/19 sealed on 11/26/19	

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K 331	Continued From page 5 these penetrations with an approved fire retardant sealant and approved cover plates. The deficient practice affected four of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 331		
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish a detailed fire watch policy when the fire alarm system goes out of service for more than 4 hours in a 24-hour period. In the event the fire alarm system goes out of service, a fire watch policy will assist with the appropriate emergency procedures to be implemented. Findings: On November 26, 2019, at 1:05 p.m., a review of the facility's fire watch policy and procedure was conducted. The policy, dated August 1, 2007, stated to notify the fire department and the DHS	K 346		

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	056083	A. BUILDING 01 B. WING	11/26/2019

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K 346	Continued From page 6 (Department of Health Service) of the loss of the fire alarm system. It was noticed that this policy did not state that the facility will began a fire watch when the facility's fire alarm system goes out of service for more than 4 hours. At 2:50 p.m., an interview was conducted with the administrator and the maintenance supervisor regarding this fire watch policy and procedure. The administrator and the maintenance supervisor was informed that there were no detailed procedures, regarding the fire watch being implemented after the fire alarm system goes out of service for more than 4 hours in a 24-hour period. The administrator stated that the fire watch policy would be revised. The deficient practice affected six of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 346	→ Fire watch policy was revised on ____ to include when fire watch is to be implemented → in-service given to nursing staff regarding fire watch revision	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.	K 351		

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K 351	Continued From page 7 In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems, 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure and maintain an 18 inch clearance below the sprinkler deflectors at storage areas throughout the facility. Unobstructed areas below the sprinkler deflectors will ensure an effective response of the fire sprinklers to provide water discharge in a horizontal plane and will function as designed, in case of fire emergencies. Findings: On November 26, 2019, between 8:15 a.m. and 11:10 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed: 1. At 10:25 a.m., there were three cardboard file boxes (measuring 9 inches by 11 inches by 17 inches) stored on the top shelf, inside the staff developer's supply closet (by Room 210). These boxes were 12 inches from the deflector. 2. At 10:43 a.m., there was a 3-inch binder and a stack of plastic trays (measuring 4-inches by 4-inches by 8-inches) stored on the top shelf, inside the first floor medication room. These items were 6 inches from the deflector.	K 351	→ boxes removed to avoid obstruction of sprinkler(s) and safely stored elsewhere. → new shelving installed in first floor med. room. on ____) this shelving has a clearance of ____ inches.	

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K 351	Continued From page 8 During the LSC tour, the maintenance supervisor was informed that there should be an 18-inch clearance between the deflectors and the nearest objects. The maintenance supervisor stated that all these items would be removed. The deficient practice affected two of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 351		
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish a detailed fire watch policy when the automatic sprinkler system goes out of service for more than 10 hours in a 24-hour	K 354	→ fire watch policy revised on ___, by ___, to now include procedures for implementing fire watch after the auto. sprinkler system is out of service for 10 hrs or more in a 24-hour period	

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K 354	Continued From page 9 period. In the event the automatic sprinkler system goes out of service, a fire watch policy will assist with the appropriate emergency procedures to be implemented. Findings: On November 26, 2019, at 1:05 p.m., a review of the facility's fire watch policy and procedure was conducted. The policy, dated August 1, 2007, stated to notify the fire department and the DHS (Department of Health Services) of the loss of the automatic sprinkler system. It was noted that this policy did not indicate that the facility would begin a fire watch when the facility's automatic sprinkler system goes out of service for more than 10 hours (as indicated in NFPA 25, Standard for the Inspection, Testing and Maintenance of the Water-Based Fire Protection Systems). At 2:50 p.m., an interview was conducted with the administrator and the maintenance supervisor regarding this fire watch policy and procedure. The administrator and the maintenance supervisor were informed that there were no detailed procedures, regarding the fire watch being implemented after the automatic sprinkler system goes out of service for more than 10 hours in a 24-hour period. The administrator stated that the fire watch policy would be revised. The deficient practice affected six of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 354		

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K 364 K 364 SS=E	Continued From page 10 Corridor - Openings CFR(s): NFPA 101 Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain fixed window assemblies in approved frames on corridor doors. Two unapproved window assemblies on corridor doors may compromise the integrity of these doors and allow smoke or fire to pass from rooms into the corridors, during a fire emergency. Findings: On November 26, 2019, between 8:16 a.m. and 11:10 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During this LSC tour, it was observed that there were a few corridor doors that had fixed window assemblies and the	K 364 K 364		

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K 364	Continued From page 11 following were observed: 1. At 9:59 a.m., the medical records office door had a 24-inch wide by 29-inch high window assembly on it. A closer observation revealed that this window assembly was not the approved type. 2. At 10:47 a.m., the doctor's office door had a 19-inch wide by 30-inch high window assembly on it. A closer observation revealed that this window assembly was not the approved type. During this LSC tour, the maintenance supervisor was informed that the window assemblies on these doors should be fire protection-rated glazing window assemblies, or wired glass (1/4 inch thickness) with fire-rated glazing materials in approved frames. At the end of the interview, the maintenance supervisor stated that these windows would be replaced with the approved fire rated window assemblies. The deficient practice affected two of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 364	→ Med. Rec. door's glass was replaced with approved materials on ____ → Doctor's Lounge door glass was replaced with approved materials on ____	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no	K 511		

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(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 511	Continued From page 12 hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain all equipment using gas or related gas piping and/or electrical wiring and electrical equipment in compliance with NFPA 54, National Fuel Gas Code, and NFPA 70, National Electrical Code, respectively. Two of four dryers' lint screens were unsecured and allowed lint to pass through the dryer, which could lead to a fire hazard. Findings: On November 26, 2019, between 8:15 a.m. and 11:10 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. At 8:35 a.m., upon entering the laundry room, it was observed that there were four dryers. It was noted that the dryers' lint traps were metal squared frames (measuring 20 inches by 12 inches by 12 inches) with 16-mesh screens on five sides (A 16-mesh screen consists of 16 rows and 16 columns equaling 256 squares, per every square inch of the screen). A closer observation revealed that two of the four dryers had unsecured lint screens, which allowed lint to pass through the dryer and possibly cause a fire hazard. Dryer #2 had a 1-inch separation on it's lint screen and Dryer #4 had a 2-inch separation on it's lint screen.	K 511	lint screens were adjusted/repaired for both Dryers #2 and #4 in order to prevent lint passing through the dryer. This was done on ____ ordered new part ____ installed on ____	

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	056083	A. BUILDING 01 B. WING	11/26/2019

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K 511	Continued From page 13 During this LSC tour, an interview was conducted with the maintenance supervisor regarding the unsecured lint screens. The maintenance supervisor was informed that these screens allowed lint to travel through the dryer and near the flame, which heats up the dryer. The lint can accumulate in the dryers' tubing, preventing the air from circulating through the dryer, and can cause a fire hazard. At the end of the interview, the maintenance supervisor stated that he would replace these lint screens with tight-fitting lint screens, immediately. The deficient practice affected one of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 511		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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	K 918		

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K 918	Continued From page 14 months for 4 continuous hours. Scheduled test under load conditions 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, readily identifiable, and separate from normal power circuits. 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) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide documentation that the facility's generator had four hours of continuous exercise once every 36 months. The facility had not performed four hours of continuous exercise once every 36 months to its generator in accordance with NFPA 110, Standards for Emergency and Standby Power Systems, 2010 Edition, Routine Maintenance and Operational Testing. Findings: On November 26, 2019, at 1:05 p.m., a review of the facility's fire inspection reports and documentation was conducted. During this review, it was noted that the generator was	K 918		

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	056063	A. BUILDING 01 B. WING	11/26/2019

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K 918	Continued From page 15 serviced, on September 8, 2019, but there was no documentation that the generator had four hours of continuous exercise within the past 36 months. At 2:50 p.m., an interview was conducted with the maintenance supervisor regarding the generator routine maintenance testing. It was indicated that the facility had no documentation that the generator had four hours of continuous exercise once every 36 months in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8, Routine Maintenance and Operational testing, 8.4.9-8.4.9.2. The maintenance supervisor stated that he was unaware of this requirement. The deficient practice affected six of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 918	Facility has revised PRP regarding emergency generator to include the 4 hour testing requirement BS will schedule these tests and provide this schedule to the Administrator for final approval. BS ran the generator for 4 hours continuously on ___ at ___ (time).	
K 920 SS=E	Electrical Equipment - Power Cords and Extens 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	K 920	next scheduled 4-hour continuous test is on ___ (On or within 36 months)	

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K 920	Continued From page 16 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 on observation and interview, the facility failed to plug electrical equipment directly into electrical outlets without the use of domestic electrical extension cords and power strips plugged into domestic electrical extension cords or other power strips. The use of domestic electrical extension cords and power strips plugged into domestic electrical extension cords or other power strips could create the possibility of an electrical overload and/or possible fire. In addition, electrical extension cords are not to be substituted for fixed electrical wiring of a structure. Findings: On November 26, 2019, between 8:15 a.m. and 11:10 a.m., the evaluator and the maintenance supervisor conducted a Life Safety Code (LSC) tour of the facility. During the LSC tour, the following were observed: 1. At 9:55 a.m., in the activity office there was: a) an air conditioning unit plugged into a power strip,	K 920	→ facility removed residential power strip on	

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K 920	Continued From page 17 which was plugged into a domestic electrical extension cord. This domestic electrical extension cord was plugged into an electrical wall outlet, and b) a microwave oven plugged into a domestic electrical extension cord, which was plugged into another electrical wall outlet. 2. At 10:14 a.m., an electric fan were plugged into a domestic electrical extension cord, which was plugged into an electrical wall outlet, in a central supply closet (near Room 218). 3. At 10:40 a.m., a coffeemaker and a refrigerator were plugged into a power strip, which was plugged into another power strip. This second power strip was plugged into an electrical wall outlet, at the first floor ("Cancun") employee lounge area. During this LSC tour, an interview was conducted with the maintenance supervisor regarding these electrical problems. The maintenance supervisor was informed that the use of domestic electrical extension cords and power strips plugged into domestic electrical extension cords or other power strips, were unapproved practices and could lead to a fire hazard. At the end of the interview, maintenance supervisor stated that he would correct these problems. The deficient practice affected three of six smoke compartments. On November 26, 2019, the above findings were acknowledged during the survey process and during the exit conference, with the administrator and the maintenance supervisor.	K 920	→ approved extension cord is now used as a replacement for residential strip → removed residential power cord on ___, replaced with approved power strip on 12/10/19 → removed residential power cord on ___, replaced with approved power strip on 12/10/19 → facility staff were verbally counseled to never plug power strips into other power strips due to the inherent fire hazard posed by that practice – 11/26/19 → staff counselled to inform the BS and/or his designee if extension cords are needed and to first recieve approval from the B.S. before using extension cords → 11/26/19	