STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING -- B. WING	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/24/23 Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890 At this Emergency Preparedness survey, Spring Mill Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 64 certified beds. At the time of the survey, the census was 54. Quality Review completed on 08/28/23	E 0000		
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/24/23 Facility Number: 010739 Provider Number: 155674 AIM Number: 200856890 At this Life Safety Code survey, Spring Mill Health Campus was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lakeithia Webb	Executive Director	09/15/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	155764	A. BUILDING 02 B. WING	08/24/2023

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(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. Spring Mill Health Campus is a two-story skilled nursing facility of Type II (111) construction built in 2007 that is attached to a two-story assisted living building of Type V (111) construction that was built in 1998. The skilled nursing facility is separated from the assisted living building by a 2-hour rated fire wall. The skilled nursing building is fully sprinklered and has supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The facility is protected by a 150-kW diesel generator. The facility has a capacity of 64. All 64 beds are certified for Medicare and 10 (21) beds are dually certified for Medicaid. At the time of the survey, the census was 54. Quality Review completed on 08/28/23			
K 0100 SS=E Bldg. 02	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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.			
	Based on observation and interview, the facility failed to maintain latching hardware on 1 of 5 smoke barrier doors in the facility. LSC 4.6.12.3 requires existing life safety features obvious to	K 0100	**K100- NFPA 101 General Requirements** **The facility requests paper**	09/08/2023

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	the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation with the Administrator and VP of Regional Operations on 08/24/23 between 12:30 p.m. and 1:35 p.m., the set of smoke barrier doors on the second floor near the elevator room was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the VP of Regional Operations agreed the smoke doors were equipped with latching devices, but the doors did not properly latching when tested. The finding was reviewed with the Administrator and VP of Regional Operations during the exit conference. 3.1-19(b)		**compliance for this citation.** *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.* 1)**Immediate actions taken for those residents identified:** · Second floor smoke barrier doors adjusted and tested for proper function of latching hardware. **2) How the facility identified other residents:** · Visitors, staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **1) Measures put into place/ System changes:** · The Maintenance Director or Designee will inspect smoke barrier doors weekly for one month	

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			and monthly thereafter to ensure the latching hardware is working properly and will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator designee by 9/7/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 9/8/23**	
K 0225 SS=E Bldg. 02	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2			

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	Based on observation and interview, the facility failed to ensure 1 of 4 stairway enclosure doors were in accordance with 7.2. LSC Section 7.2.1.5.10 requires a latch or other fastening device on a door leaf to be provided with a releasing device that has an obvious method of operation and is readily operated under all lighting conditions. This deficient practice affects approximately 10 residents and staff. Findings include: Based on observation during the tour of the facility with the Administrator and VP of Regional Operations between 12:30 p.m. and 1:35 p.m. on 08/24/23, the door for the second floor stairwell exit door near the elevator was self-closing, but did not completely latch into the frame after testing three times. Based on interview at the time of observation, the VP of Regional Operations agreed that the stairwell door did not latch into the frame and acknowledged the deficiency. Findings were discussed with the VP of Regional Operations and Administrator at exit conference. 3.1-19(b)	K 0225	**K225- NFPA 101 Stairways and Smokeproof Enclosures** **The facility requests paper compliance for this citation.** *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.* 1)**Immediate actions taken for those residents identified:** · The Second-floor stairwell door was adjusted to ensure proper closure. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:**	09/08/2023

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			· The Maintenance Director or Designee will inspect stairwell doors weekly for one month and monthly thereafter to ensure compliance. The Maintenance Director will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 9/7/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 9/8/23**	
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and			

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	Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and VP of Regional Operations on 08/24/23 between 12:30 p.m. and 1:35 p.m., the last fire system inspection dated 06/14/23 by the facility's fire alarm vendor indicated two duct detectors are located in the building. The two devices were not inspected due to the inspection company not being able to locate the devices. Based on interview at the time of record review, the Administrator stated that the fire alarm company is scheduled to be out at the facility and will work on getting the two devices inspected or tested. Findings were discussed with the Administrator and VP of Regional Operations at exit conference. 3.1-19(b)	K 0345	**K345 NFPA 101 Fire Alarm System- Testing and Maintenance** **The facility requests paper compliance for this citation.** *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.* **1)Immediate actions taken for those residents identified:** · The two duct detectors were inspected on 9/7/23. **2) How the facility identified other residents:**	09/08/2023

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			· Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 9/7/23. · · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly for compliance. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 9/8/23**	
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 02	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 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical	K 0353	**K353 NFPA 101 Sprinkler System- Maintenance and Testing** The facility requests paper compliance for this citation. *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*	09/08/2023

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	damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Administrator and VP of Regional Operations on 08/24/23 between 10:11 a.m. and 12:28 p.m., there was no quarterly sprinkler system inspection report available for the second quarter (April, May, and June) of 2023. During an interview at the time of record review, the VP of Regional Operations stated that the sprinkler company had conducted two types of inspections the beginning of July 2023 which could have been conducted in lieu of a second quarter inspection, but was unable to provide documentation of a sprinkler inspection during the second quarter of 2023 Findings were discussed with the VP of Regional Operations and Administrator at exit conference. 3.1-19(b) 2. Based on record review, observation, and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch		*federal and state law.* **1)Immediate actions taken for those residents identified:** · Sprinkler Quarterly inspections is current and in compliance. · The 5-year inspection for the Internal Pipe is scheduled to be completed on October 12th and October 13, 2023. **2) How the facility identified other residents:** · Staff, Visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete monthly visual inspection of Sprinkler Heads and monthly inspection of the wet pipe system to include gauges and valves. Inspections will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 8/23/23. · The Maintenance Director is responsible for compliance.	

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	line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and VP of Regional Operations on 08/24/23 between 10:11 a.m. and 12:28 p.m., the Sprinkler Annual report dated 07/06/23 stated that the Healthcare portion of the building of the second floor and pump room were due for an internal pipe inspection. The item was listed as a deficiency of the inspection. Based on observation during a tour of the facility between 12:30 p.m. and 1:35 p.m. with the Administrator and VP of Regional Operations, a tag located on the sprinkler riser indicated the last internal pipe inspection was completed 01/2018. Based on interview at the time of record review and observation, the VP of Regional Operations stated they were unaware of the deficiency and was unaware if the internal pipe inspection was completed or not. Findings were discussed with the Administrator and VP of Regional Operations at exit conference. 3.1-19(b)		**4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance Worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 10/20/23**	
K 0918 SS=C Bldg. 02	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			

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	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 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)			
	1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5 minute cool down period after a load test. 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, 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	K 0918	**K918 NFPA 101 Electrical Systems- Essential Electric System** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not*	09/08/2023

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	cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review with the Administrator and VP of Regional Operations on 08/24/23 between 10:11 a.m. and 12:28 p.m., the Generator Checklist form documented the generator was tested weekly for at least 30 minutes under load, however, there was no documentation on the form that showed the generator had a cool down time following its load test. Based on interview at the time of record review, the VP of Regional Operations stated that the forms used are templates from the company who does servicing for the generator. They further stated that they run their generator under load weekly and confirmed cooldown times have not been recorded on the sheets provided and those were the only generator sheets available during record review. This finding was reviewed with the Administrator and VP of Regional Operations at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust		*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.* **1)Immediate actions taken for those residents identified:** · The Generator Load Bank Test checklist form was updated to include recording of cool down time, load percentage and transfer time to the alternate power source. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete Generator weekly inspection and monthly 30 minutes under load testing and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program	

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	155764	A. BUILDING 02 B. WING	08/24/2023

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	gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on review of generator load testing documentation with the VP of Regional Operations and Administrator from 10:11 a.m. to 12:28 p.m. on 08/24/23, the load information to show the actual load percentage for the diesel powered generator was not documented. Based on interview at the time of record review, the VP of Regional Operations stated that the generator runs under load weekly, however documentation provided at the time of the survey did not show the load percentages for each load. This finding was reviewed with the Administrator and VP of Regional Operations at the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to document the transfer time to the alternate power source on the monthly load tests		by the Administrator /designee by 9/7/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative Maintenance worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 9/8/23**	

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	for 12 of the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 08/24/23 between 10:11 a.m. and 12:28 p.m. with the VP of Regional Operations and Administrator, the Generator Checklist documentation over the past year was reviewed and lacked the transfer time from normal power to emergency power Based on interview at the time of record review, the VP of Regional Operations indicated that the generator runs under load on a weekly basis and is documented on the Generator Checklist sheets provided at the survey. She further acknowledged that the transfer times were missing and stated that's the only documentation available at record review. Findings were discussed with the VP of Regional Operations and Administrator at exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 02	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			

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	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 Social Services office did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects approximately 2 staff and an unknown number of residents. Findings include: Based on observation with the VP of Regional Operations and Administrator on 08/24/23 between 12:30 p.m. and 1:35 p.m., the Social Services Office contained a multi-plug adaptor powering equipment. Based on interview at the time of observation, the VP of Regional Operations agreed a multi-plug adaptor was in use. Findings were discussed with the VP of Regional Operations and Administrator at exit conference.	K 0920	**K920 NFPA 101 Electrical Equipment- Power Cords and Extension Cords** **The facility requests paper compliance for this citation.** *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.* **1)Immediate actions taken for those residents identified:**	09/08/2023

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	3.1-19(b)		· The Multi-plug adaptor was removed from the Social Services Office. **2) How the facility identified other residents:** · Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director or Designee will complete visual weekly inspection audit tool to ensure multi-plug adaptor are not in use. · IDT will be re-educated in the use of power cords and extension cords and multi-plug adaptors. · The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 9/7/23. · The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** · The Administrator will review the Preventative	

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			Maintenance worksheets monthly. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5)Date of compliance: 9/8/23**	