STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155740	A. BUILDING -- B. WING	08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

(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: 08/08/22 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Emergency Preparedness survey, Timbercrest Church of The Brethren Home was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 65 and had a census of 45 at the time of this survey. Quality Review completed on 08/10/22	E 0000	Timbercrest Senior Living Community is dedicated to keep its residents, their families, guests and staff save at all times. As such, Timbercrest aims for its building and its practices to be compliant with Life Safety Code regulations. Timbercrest requests desk review/paper compliance for the Plan of Correction submitted on 8/26/2022 for the deficiencies cited during the Life Safety Code survey on 8/8/2022.	
K 0000 Bldg. 01	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: 08/08/22 Facility Number: 000448 Provider Number: 155740 AIM Number: 100275140 At this Life Safety Code survey, Timbercrest Church of The Brethren Home was found not in compliance with Requirements for Participation in	K 0000	Timbercrest Senior Living Community is dedicated to keep its residents, their families, guests and staff save at all times. As such, Timbercrest aims for its building and its practices to be compliant with Life Safety Code regulations. Timbercrest requests desk review/paper compliance for the Plan of Correction submitted on 8/26/2022 for the deficiencies cited during the Life Safety Code survey on 8/8/2022.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 01 B. WING	08/08/2022

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TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

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	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. This one-story facility was determined to be of Type V (111) construction and the basement was determined to be of Type II (222). The facility was fully sprinklered, has a fire alarm system with hard wired smoke detection in the corridors, areas open to the corridor, and in 16 resident rooms in rehabilitation. Battery operated smoke detectors were installed in 45 health care resident rooms. The facility has a capacity of 65 and had a census of 45 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached maintenance garage. Quality Review completed on 08/10/22			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout			

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	155740	A. BUILDING 01 B. WING	08/08/2022

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	by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 2 sets of separation fire doors maintained a minimum two-hour fire resistance rating by ensuring the 90-minute separation fire door was not damaged in accordance with LSC Chapter 8. This deficient practice could affect 18 residents in the 400-hall. Findings include: Based on observations with the Maintenance Director and Maintenance Technician on 08/08/22 at 12:30 p.m., the set of separation fire doors in the 400-hall that separates Health Care from Assisting Living had open holes and gouges in the surfaces of the fire door set. This condition did not ensure the integrity of the fire-resistant rating of the fire door assembly. Based on interview at the time of observation, the Maintenance Director stated there were holes that went halfway through the fire door and gouges on the surface of the fire door set. This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)	K 0131	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The noted fire door set has been restored to ensure the integrity of the fire-resistant rating. An inspection of all other fire doors is currently in process with any deficiencies to be corrected immediately. The integrity of the facility's fire doors will be monitored by utilizing the newly established "Life Safety Code Inspection Check Off" which will be performed by the Director of Facility Management or his designee. Monitoring will be weekly x 4 weeks, then monthly. Results of these audits will be reported to the Safety Committee and summary reports submitted to	08/26/2022

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			the QAA committee until substantial compliance is determined.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors			

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	upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 3 of 8 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. This deficient practice could affect all Health Care residents.	K 0222	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is	08/29/2022

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	Findings include: Based on observation with the Maintenance Director and Maintenance Technician on 08/08/22 between 12:30 p.m. and 3:00 p.m., the exit doors on 100-hall, 200-hall, and in the dining room; were marked as a facility exits, were magnetically locked, and could be opened by with a key-FOB that was only carried by staff. This condition does not allow someone without a key-FOB to open the exit door during an emergency. Based on interview at the time of observation, the Maintenance Director agreed only staff had access to open the aforementioned exit doors. This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)		submitted as the facility's credible allegation of compliance. New Era Technology company was immediately contacted to switch the key fob device on the three identified exit doors to key pads. The earliest available date for hardware plus installation is August 29, 2022. During a fire drill the doors were tested successfully ensure they unlock and allow for emergent exit without use of fob/swipe card.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 exit paths in the basement had an exit sign that was not obstructed from view. This deficient practice could affect staff in the basement. Findings include:	K 0293	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees,	08/26/2022

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	Based on observation with the Maintenance Director and Maintenance Technician on 08/08/22 at 12:30 p.m., in the basement by the separation fire door the exit sign was blocked by a storage unit. Based on an interview at the time of observation, the Maintenance Director agreed the exit sign was blocked from complete view due to the position of the storage unit. This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)		agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The storage cage, obstructing the exit sign, has been dismantled, and the exit sign is found to be in good working condition.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 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 observation and interview, the facility failed to maintain the ceiling construction of 1 of 2 storage rooms with roof access. The ceiling tiles trap hot air and gases around the	K 0353	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists.	08/26/2022

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	sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 20 residents in one smoke compartment. Findings include: Based on observation with the with the Maintenance Director and Maintenance Technician on 08/08/22 at 12:30 p.m., in the 400-hall electrical room in the suspended ceiling there were no ceiling tiles around the ladder access to the roof and was exposed to the roof hatch about three to four feet above the suspended ceiling. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Director agreed there were no ceiling tiles around the ladder opening. #2, Based on observation and interview, the facility failed to ensure 1 of 1 sprinklers in the dish washroom were free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 20 residents in one smoke compartment.		This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The identified opening in the ceiling of the 400-hall electrical room has been closed. To ensure no other residents are affected by this deficient practice a facility walk thru was done by the Director of Facility Management with no further issues noted. VFP Fire Systems company was scheduled immediately to replace the corroded sprinkler head in the dish room with a new sprinkler head. The facility policy "Sprinkler System" was reviewed and revised. The visual inspection of sprinkler heads was added to the monthly occurring "Inspection of the Sprinkler System - Work order". The completion of the inspections is monitored by the administrator, or designee, for at least two (2) months with its findings reported to the Safety Committee and summary report provided to the QAA Committee until it is determined that substantial compliance is being maintained.	

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	Findings include: Based on observation with the Maintenance Director and Maintenance Technician on 08/08/22 at 1:30 p.m., the sprinkler head above the dishwasher was green and showed signs of corrosion. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler in the dish washroom showed signs of corrosion. This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is			

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	applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 3 of 8 linen closets corridor doors were provided with a means suitable for keeping the door closed. This deficient practice could affect 30 residents in three smoke compartments. Findings include: Based on observation with the Maintenance Director and Maintenance Technician on 08/08/22 between 12:30 p.m. and 2:13 p.m., the double corridor doors to the 200, 300, 400 halls did not latch into the frame when tested. The left door leaf on the 200 hall was missing the latching mechanism, and the 300 and 400 hall left door leaves had broken latches. Based on interview at the time of observation, the Maintenance Director stated the corridor doors to the linen closets did not latch into the door frames.	K 0363	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The linen closet doors in 200, 300 and 400 halls were repaired. Sign to inform staff of keeping doors closed and who to inform was created and posted inside each closet. The administrator, or her designee, will monitor compliance	08/26/2022

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	This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)		during regular rounding. The inspection of closet doors is part of the newly established monthly Life Safety Code inspection performed by the Director of Facility Management or his designee. Findings will be reported to the monthly QAPI meeting and a summary of findings will be reported to the QAA committee until substantial compliance is determined.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure penetrations through 1 of 4 smoke barrier walls smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or	K 0372	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction.	08/30/2022

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	from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 20 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director and Maintenance Technician on 08/08/22 at 3:00 p.m., above the drop ceiling of the smoke wall in the 300-hall smoke wall there was a four-inch gap around a pipe. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed penetrations in the 300-hall smoke barrier. This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)		This plan of correction is submitted as the facility's credible allegation of compliance. The deficiency has been corrected using approved materials. As a reminder to maintain the integrity of smoke and fire walls, a sign was placed in each compartment, "Firewall Do Not Penetrate". The policy, "Inspection of Fire/Smoke Walls" was reviewed and revised. Maintenance staff is being re-educated on the policy and trained on the location of fire walls and smoke barriers in the facility.	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 6 of 6 fire door assemblies were completed in accordance with NFPA 80 5.2.1 which states fire door assemblies shall be inspected and tested not less than	K 0761	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault	08/26/2022

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	155740	A. BUILDING 01 B. WING	08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

(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
	annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director and Maintenance Technician on 08/08/22 at 10:19 a.m., no documentation of an annual		by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Appropriate staff was educated on the newly created "Fire Door Annual Inspection" sheet. The annual inspection of all fire doors has been completed. The integrity of the facility's fire doors will be monitored by utilizing the newly established "Life Safety Code Inspection Check Off" which will be performed by the Director of Facility Management or his designee. Monitoring will be weekly x 4 weeks, then monthly. Results will be reported to the Safety Committee and summary reports will be submitted to the QAA Committee until substantial compliance is determined.	

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	inspection for the six fire door assemblies were available for review. Based on observation between 12:00 p.m. and 3:00 p.m., there were two separation fire door assemblies and four fire doors to stair wells. Based on interview at the time of records review and observation, the Maintenance Director stated the annual fire door inspection documentation could not be found. This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.			

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	10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 #1. Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice affects four residents. Findings include: Based on observations with the Maintenance Director and Maintenance Technician on 08/08/22 at 12:50 p.m. and 1:10 p.m., two power-strips in therapy and one power-strip in room 408 were in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed power-strips were in use in resident care areas and did not meet 1363A or 60601-1. #2, Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect staff in the basement. Findings include: Based on observation with the Maintenance Director and Maintenance Technician on 08/08/22 at 12:30 p.m., in the wood shop an extension cord was in use and was plugged into a power-strip. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged an extension cord was in use and remove the extension cord.	K 0920	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The deficient power strips and electrical cord were removed immediately. The facilities policy on "Extension Cords and Power Strips" was reviewed and revised. Staff was re-educated on the facility's policy and practice. A notice of facility's policy will be added to the admission packet. Monitoring the use power strips and extension cords is part of the newly established monthly Life Safety Code Inspection Check performed by the Director of Facility Management or his designee. Monitoring will occur weekly x 4 weeks, then monthly. Findings will be reported to the monthly QAPI meeting and a summary of findings will be reported to the QAA committee until substantial compliance is determined.	08/26/2022

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	This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the			

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	supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	#1. Based on observation and interview, the facility failed to ensure 9 of 9 oxygen (O2) cylinders were segregated from full and empty cylinders and are marked to avoid confusion. NFPA 99, Health Care Facilities Code, 2012 Edtion, Section 11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Maintenance Technician on 08/08/22 at 1:10 p.m., the O2 storage room contained empty and full O2 cylinders mixed together and the full and empty O2 cylinders were not identified or separated Based on interview at the time of observation, the Maintenance Director stated there were O2 cylinders together on the floor that were both full and empty. #2. Based on observation and interview, the facility failed to ensure 1 of 9 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with	K 0923	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. The identified deficiencies were corrected immediately by securing the tank and by identifying O2 cylinders using the following signage: "Full" for those containers with wrap intact; "In Use" for tanks in current use; "Empty" to note that they are empty Empty tanks are currently being returned to the provider. The nursing department's administrative staff will label new tanks brought into the facility and those refilled. Using a newly created monitoring tool, the administrative staff will monitor	08/26/2022

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	11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Maintenance Technician on 08/08/22 at 1:10 p.m., an oxygen cylinder was standing upright on the floor of the oxygen storage/trans-filling room and was not properly chained or supported in a stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged an oxygen cylinder in the oxygen storage/trans-filling room was not properly chained or supported. This finding was reviewed with the Administrator, Maintenance Director, and Maintenance Technician during the exit conference. 3.1-19(b)		signage at least weekly and when tanks are refilled. The administrator will audit for compliance weekly x 4 weeks and report findings to the Safety Committee and provide summary report to the QAA until it is determined that substantial compliance is being maintained.	