STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15C0001151	A. BUILDING -- B. WING	11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BROADWEST SPECIALTY SURGICAL CENTER LLC	315 W 89TH 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 416.54 Survey Date: 11/24/2020 Facility Number: 011094 Provider Number: 15C0001151 AIM Number: 100274100A At this Emergency Preparedness survey, Broadwest Specialty Surgical Center, LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 416.54 The facility has 5 certified operating rooms. Quality Review completed on 12/04/20	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 416.44(b). Survey Date: 11/24/2020 Facility Number: 011094 Provider Number: 15C0001151 AIM Number: 100274100A At this LSC survey, Broadwest Specialty Surgical Center, LLC was found not in compliance with Requirements for Participation in	K 0000		

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

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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	Medicare/Medicaid, 42 CFR Subpart 416.44(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 21, Existing Ambulatory Health Care Occupancies. This facility was located on the first and second floors of a two story fully sprinklered building determined to be of Type V (111) construction. The facility has a fire alarm system with smoke detection in corridors and hazardous areas. Quality Review completed on 12/04/20			
K 0131 Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Ambulatory Health Care Facilities Multiple occupancies shall be in accordance with 6.1.14. Sections of ambulatory health care facilities shall be permitted to be classified as other occupancies, provided they meet both of the following: * The occupancy is not intended to serve ambulatory health care occupants for treatment or customary access. * They are separated from the ambulatory health care occupancy by a 1 hour fire resistance rating. Ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following: * Walls have not less than 1 hour fire resistance rating and extend from floor slab to roof slab. * Doors are constructed of not less than 1-3/4 inches thick, solid-bonded wood core or equivalent and is equipped with positive			

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	latches. * Doors are self-closing and are kept in the closed position, except when in use. * Windows in the barriers are of fixed fire window assemblies per 8.3. Per regulation, ASCs are classified as Ambulatory Health Care Occupancies, regardless of the number of patients served. 20.1.3.2, 21.1.3.3, 20.3.7.1, 21.3.7.1,42 CFR 416.44			
	Based on observation and interview, the facility failed to maintain a one hour fire resistive rating between occupancies per 21.3.7.1. LSC 21.3.7.1 requires that ambulatory health care facilities shall be separated from other tenants and occupancies and shall meet all of the following requirements: (1) walls shall have not less than a 1-hour fire resistance rating and shall extend from floor slab below to the floor or roof slab above. This deficient practice could affect all occupants. Findings include: During a facility tour with the PACU Manager, and the Business Manageron 11/24/2020 at 1:40 p.m., the West Wing separating wall contained an unsealed penetration around sprinkler piping where fire stop material had fallen out. Based on interview at the time of observation, the PACU Manager, and the Business Manager agreed that firestop material had fallen from the area around the pipe. This deficient practice was reviewed with the Business Manager at the time of exit.	K 0131	Jade Construction repaired the firestop material that had fallen from the area around the pipe in the westwing wall separating the surgery center from the westwing hallway. Jade Construction has added the weekly inspection of the firestop material in all areas as they do a weekly walkthrough with documentation to that affect. Jade Construction will be responsible for making sure that all firesafe material is in tact throughout the building. Jade Construction is not sure what causes the firemateria to come loose. There has been work down that may have caused the fire material to come loose. Jade will monitor each and every vendor and job that has the potential to come into contact wire fire stop material.	12/01/2020
K 0211 Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit			

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	discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full instant use in case of emergency, unless modified by 20/21.2.2 through 20/21.2.11. 20.2.1, 21.2.1, 7.1.10.1 Based on observation, the facility failed to ensure 1 of 5 corridors access were in accordance with Chapter 7. LSC 7.1.10.2.1 requires no furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to 2 patients. Findings include: During a facility tour with the PACU Manager, and Business Manager on 11/24/2020 at 1:30 p.m., 3 laundry carts were located in the corridor leading to the "Laundry" exit. Based on interview at the time of each observation, the PACU Manager agreed that laundry carts were obstructing the corridor and could impede egress. This deficient practice was reviewed with the Business Manager at the time of exit.	K 0211	An in-service was completed with all employees regarding the placement of laundry carts leading to the exit. No carts are to be obstructing the corridor at any time. The OR Manager or charge nurse will be responsible for making sure the carts are never placed near the exists causing an obstruction. The explanation the OR Manager has provided was we had a new cleaning person and that person forgot about the cart placement. All employees have been inserviced now and the OR Manager will make sure any and all new employees are inserviced as well.	12/01/2020
K 0323 Bldg. 01	NFPA 101 Anesthetizing Locations Anesthetizing Locations Areas designated for administration of general anesthesia (i.e., inhalation anesthetics) are in accordance with 8.7 and NFPA 99. Zone valves are located immediately outside each life-support, critical care, and anesthetizing location of moderate sedation,			

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	deep sedation, or general anesthesia for medical gas or vacuum; readily accessible in an emergency; and arranged so shutting off any one anesthetizing location will not affect others. Area alarm panels are provided to monitor all medical gas, medical-surgical vacuum, and piped WAGD systems. Panels are at locations that provide for surveillance, indicate medical gas pressure decreases of 20 percent and vacuum decreases of 12 inch gauge HgV, and provide visual and audible indication. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies. The EES critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits, and EES equipment system supplies power to ventilation system. Heating, cooling, and ventilation are in accordance with ASHRAE 170. Medical supply and equipment manufacturer's instructions for use are considered before reducing humidity levels to those allowed by ASHRAE, per S&C 13-58. 21.3.2.3, NFPA 99 5.1.4.8.7, 5.1.4.8.7.2, 5.1.9.3.4, 6.4.2.2.4.2			
	Based on record review and interview, the facility failed to ensure the humidity in 3 of 5 Operating Rooms were eater than 20 percent. NFPA 99 9.3.1.1 requires heating, cooling, ventilating, and process systems serving spaces or providing health care functions covered by this code or listed within ASHRAE 170, Ventilation of Health Care Facilities. ASHRAE 170, requires mechanical ventilation system supplying anesthetizing locations shall have the capability of controlling	K 0323	Physical Environment SURG#408 policy regarding the humidity in the OR's has been updated and implemented. The OR Manager will be responsible for monitoring the temperatures on a daily basis and cart placement. The OR Manager has created a new form to monitor both of these deficiencies.	12/17/2020

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	the relative humidity at a level of 20 percent or greater. This deficient practice could affect staff and up to 3 patients. Findings include: Based on record review with the PACU Manager, the OR Manager, and the Business Manager on 11/24/2020 at 11:40 a.m., the following were indicated in the Operating Room Humidity documentation: a. Operating Room #4 was under 20 percent for 2 of the last 365 days (11/02/20; 11/17/20). b. Operating Room #2 was under 20 percent for 5 of the last 365 days (01/17/20; 1/20/20; 02/14/20; 02/19/20; 02/20/20). c. Operating Room #1 was under 20 percent for 2 of the last 365 days (01/20/20; 02/21/20). No other further documentation was available to show what response was performed. Based on interview at the time of record review, the OR Manager, confirmed the operating rooms were under 20 percent on the dates indicated, stated that there was no documented response, nor written policy indicating which response should occur. This deficient finding was reviewed with the Business Manager at the time of exit.		Each morning all rooms are checked for humidity and checked off on the spreadsheet tomake sure we are complaint. The spreadsheet is kept in a log book and the OR Manager is responsible for making sure it is maintained on a daily basis.	
K 0345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm Systems - Testing and 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.			

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	Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1) Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: During record review with the PACU Manager and Business Manager on 11/24/2020 at 10:30 a.m. the facility could not provide documentation of a current semi-annual visual inspection of the fire alarm system. The most recent documented test and inspection was dated 12/20/2018. Based on interview at the time of record review, the Business Manager agreed that she could not provide the most recent inspection. This deficient finding was reviewed with the Business Manager at the time of exit. 2) Based on record review, observation and interview; the facility failed to ensure all fire alarm	K 0345	The semi annual fire inspections were actually completed in 6.7.19 and 6.12.20. Those reports were emailed to the facility but our email was down at the time. Those reports have all been delivered and the binder is up to date and current. The smoke detector sensitivity test was actually done in March of 2020. The report has been placed in the binder and is current. The fire inspection was completed December 23, 2020 and is attached to this poc. Jade Construction is responsible to make sure these test are all completed in a timely fashion. The Business Manager will be monitoring the binder and make sure that all copies of all tests are completed and logged in that binder. The reason for the reports not being readily available is because of email and computer issues on both parties part. From now on they will email a copy of all reports but will also follow up with hard copies in the mail to ensure we receive them.	12/01/2020

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	system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance with the schedules in Table 14.4.5. Table 14.4.5 requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect all building occupants. Findings include: During record review with the PACU Manager and Business Manager on 11/24/2020 at 10:30 a.m. the facility could not provide documentation of a current annual test and visual inspection of the fire alarm system. The most recent documented test and inspection was dated 12/20/2018. Based on interview at the time of record review, the Business Manager agreed that she could not provide the most recent test or inspection. This deficient finding was reviewed with the Business Manager at the time of exit. 3) Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 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, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in			

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	accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states smoke dtetector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: During record review with the PACU Manager and Business Manager on 11/24/2020 at 10:35 a.m. the facility could not provide documentation of a current smoke detector sensitivity test. The most recent documented sensitivity test was dated 01/04/2018. Based on interview at the time of record review, the Business Manager agreed that she could not provide most recent smoke detector sensitivity test. This deficient finding was reviewed with the Business Manager at the time of exit.			
K 0351 Bldg. 01	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation Sprinkler systems (if installed) are installed per NFPA 13. Where more than two sprinklers are installed in a single area for protection, waterflow devices shall be provided to sound the building fire alarm system or to notify a constantly attended location such as a PBX, security office, or emergency room. 20.3.5.1, 20.3.5.2, 21.3.5.1, 21.3.5.2, 9.7.1.2, 9.7, NFPA 13 Based on observation and interview, the facility failed to ensure the spray pattern for sprinklers	K 0351	The sprinkler head in the PAT Room will be moved and another	01/15/2021

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	were not obstructed in 1 of 1 PAT rooms and 1 of 1 EEG Room in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, and NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, as required by LSC 19.3.5.1. NFPA 25 Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Section 5.2.1.3 states stock, furnishings, or equipment closer to the sprinkler deflector than permitted by the clearance rules of the installation standard shall be corrected. NFPA 13, 2011 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane less than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect all building occupants. Findings include: During a facility tour with the PACU Manager and Business Manager on 11/24/2020 at 1:10 p.m. the walls of the PAT and EEG rooms was found to terminate approximately 6 inches below the ceiling and height of sprinklers. It could not be determined if this obstructed the sprinkler pattern, creating an unprotected area. Based on interview at the time of observation, the PACU Manager agreed that the spray pattern could be obstructed. This deficient finding was reviewed with the Business Manager at the time of exit.		added in EEG room to comply with the standards for spray pattern for sprinkler heads. Rask fire will be handling this issue and Jade Construction is responsible for making sure this repair is done by 1.15.21	

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K 0353 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 Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections,	K 0353	A log will be kept in the sprinkler room including dates, person performing the test, values checked, gauges check. Jade Construction will be performing these tasks and will keep a excel spreadsheet in the sprinkler room on a clipboard. The excel spreadsheet has gauges/valves/pressure stats and will be completed every week by Jade Construction and documented and kept on a clipboard in the sprinkler room.	01/15/2021

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	tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all patients and staff. Findings include: During record review with the PACU Manager and Business Manager on 11/24/2020 at 11:35 a.m. the facility could not provide any documentation of weekly or monthly inspections of the wet or dry sprinkler systems within the most recent 12 months. Based on interview at the time of record review, the Business Manager agreed that the inspections were not conducted. This deficient finding was review with the Business Manager at the time of exit.			
K 0761 Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 21.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) Based on observation, records review, and interview, the facility failed to ensure annual	K 0761	The doors that need to be fire rated will be repaired and	01/22/2021

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(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
	inspection and testing of 19 of 19 fire door assemblies were maintained. LSC 4.6.12.1 requires that whenever or wherever any device, equipment, system, condiction, arrangement, level or protection, fire-resistive construction, or any other feature is required to compliance with the provision of this Code, such device, equipment, system, condiction, arrangement, level or protection, fire-resistive construction, or any other feature shall there after be continuously maintained. LSC 8.3.3.1 states that openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than 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.		certified. The doors that are not required to be fire rated will also be repaired by 1.22.21 The PACU Manager will be monitoring to ensure repairs are completed in a timely manner and Jade Construction will be doing those repairs.	

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	15C0001151	A. BUILDING 01 B. WING	11/24/2020

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	(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 occupants. Findings include: During record review with the PACU Manager and Business Manager on 11/24/2020 at 10:40 a.m., the annual inspection of the fire door assemblies, dated 8/20/2020, indicated 19 of 19 doors in fire rated assemblies failed inspections. Based on interview at the time of record review, the PACU Manager and Business Manager, agreed that the doors failed inspections and that the repairs have not been completed. This deficient finding was reviewed with the Business Manager at the time of exit.			
K 0918 Bldg. 01	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			

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	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 months for four 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 and readily identifiable. 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)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.3 states Type 1 EES (Essential Electrical System) generator maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test	K 0918	The generator will have a 4 hour load test performed as well as the oil/filter change/coolant/fuel samples completed by Altorfer Power Systems. A copy of this test and preventative maintenance report will bee kept in the generator log book. The PACU manager is responsible	01/16/2021

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	shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all occupants. Findings include: During record review with the PACU Manager and Business Manager on 11/24/2020 at 11:30 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review for the most recent 12 month period. The most recent documented test was 05/17/2019. Based on interview at the time of records review, the PACU Manager agreed the test was completed more than a year prior. This deficient finding was reviewed with the Business Manager at the time of exit.		for making sure the fuel sample is collected and tested on an annual basis and has been added to the generator log book and as well as the documentation to be able to reviewed.	
K 0920 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			

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	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 flexible cords were not used as a substitute for fixed wiring according to 9.1.2. 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 staff only. Findings include: During a facility tour with the PACU Manager and the Business Manager on 11/24/2020 at 1:08 p.m. an extension cord was found powering electronics in the front office admissions area. Based on interview at the time of observation, the PACU Manager and Business Manager agreed that there was an extension cord being used to power electronics. This deficient finding was reviewed with the Business Manager at the time of exit.	K 0920	The power strip located in the front office area has been removed. The extension cord was used because the copier was moved and would not reach the powerstrip. The cord was removed and another power strip was put in its place. The Business Manager will be responsible for making sure no extension cords are ever used in any area of the building.	11/24/2020