STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155178	A. BUILDING -- B. WING	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

(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: 07/17/2023 Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310 At this Emergency Preparedness survey, Brickyard Healthcare - Fountainview Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 130 certified beds. All beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 69. Quality Review completed on 07/18/23	E 0000	/p> /p> /p> ="" p=""> ="" p=""> ="" p="">	
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: 07/17/2023 Facility Number: 000094 Provider Number: 155178 AIM Number: 100290310	K 0000	/p> /p> /p> ="" p=""> ="" p=""> ="" p="">	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roberta Shull	Executive Director	08/02/2023

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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	At this Life Safety Code survey, Brickyard Healthcare - Fountainview Care Center was found not in compliance with 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. This one story facility with partial basement was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The building is partially protected by a 350 kW diesel-powered generator. The facility has a capacity of 130 beds dually certified for Medicare and Medicaid and had a census of 69 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 the maintenance shed used for storage. Quality Review completed on 07/18/23			
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.)			

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	Based on observation and interview, the facility failed to ensure 1 of 1 exit signs were continuously illuminated. This deficient practice could affect approximately 10 residents and staff who use the pool area emergency exit. Findings include: Based on observations on 07/17/23 during a tour of the facility from 12:15 p.m. to 2:17 p.m. with the Maintenance Director, the Therapy Pool emergency exit sign above the exit door was not illuminated. Based on an interview with the Maintenance Director at the time of observation, he agreed that the exit sign was not illuminated even after pressing the test button and stated the sign would have to be fixed. The Finding was discussed with the Maintenance Director and Executive Director at exit conference. 3.1.19(b)	K 0293	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Maintenance immediately replaced light. What measures will be put into place and what systematic changes will be made to ensure that the Maintenance will monitor all emergency lighting thru TELS. Maintenance will print compliance validation report 1 x weekly for 8 weeks, then monthly x 4. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place. The results of the audits will be reviewed by the QAPI Committee for 6 months.	08/10/2023
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in			

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	accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 cook tops in the activities room was deactivated when unsupervised. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a	K 0324	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Maintenance immediately locked fuse box. What measures will be put into place and what systematic changes will be made to ensure	08/10/2023

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	restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect approximately 5 residents and staff. Findings include: Based on observation with the Maintenance Director on 07/17/23 between 12:15 p.m. and 2:17 p.m., there was a cooktop in the Activities Room, when tested, the cooktop was not deactivated and could produce heat. The room was unsupervised with two residents present in the room. Based on interview with the time of record review, the Maintenance Director stated that the cooktop should be deactivated and was unaware why it was not turned off. The finding was reviewed with Maintenance Director and Executive Director during the exit conference. 3.1-19(b) 2. Based on observation, record review and interview, the facility failed to maintain 1 of 1 kitchen commercial cooking equipment in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) as required by NFPA 101, Life Safety Code (2012), Section 9.2.3. NFPA 96, Section 10.2.6 states that automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and NFPA 17A(09), Standard for Wet Chemical Extinguishing Systems where applicable. This		that the Activity Director will be educated on locking fuse box Director and aides will audit this upon opening activity room for the day. Maintenance will monitor compliance. kitchen suppression system repaired as per the recommendation Maintenance or designee will validate compliance 5 x weekly x 1 week, then 3 times weekly x 3 weeks, then weekly x 8 weeks. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place. The results of the audits will be reviewed by the QAPI committee x 6 months	

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	deficient practice could affect approximately 20 residents who use the adjacent dining area and staff. Findings include: Based on record review with the Maintenance Director on 07/17/23 between 12:15 p.m. and 2:17 p.m., The Kitchen Suppression System Inspection dated 04/25/23 stated that "Excessive corrosion on/in nozzles, piping, and tank side. Recommend total distribution pipe and tank replacement." This was also stated in the Kitchen Suppression System Inspection from 10/19/22. A quote was sent from the inspection company to the facility that had an expiration date of 06/05/23. Based on interview at the time of record review, the Maintenance Director stated that they were aware of the issue and was currently in the process of getting a new quote due to the expiration date. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit			

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	sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 attic spaces in accordance with 19.3.5.1. NFPA 13, 2010 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 more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect approximately 15 staff and residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 07/17/23 from 12:15 p.m. to 2:17 p.m., above the drop ceiling next to resident room 105 contained a blocked sprinkler head. Insulation from the attic space fell down and draped over the sprinkler head leaving it barely visible and obstructed. Based on interview at the time of observation, the Maintenance Director agreed that the sprinkler head was obstructed from the strip of insulation.	K 0351	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Maintenance immediately removed the insulation. What measures will be put into place and what systematic changes will be made to ensure that the Maintenance will check sprinklers to ensure no obstruction and record in TELS. Inspection of sprinkle obstruction will be monthly and recorded in TELS. Maintenance will monitor weekly x 4 weeks, then monthly x 5 months. How the corrective action will be	08/10/2023

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	Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place. The results of the audits will be reviewed by the QAPI Committee x 6 months	
K 0353 SS=F 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 ensure 5 of 6 sprinkler heads in the laundry room and 2 of 3 sprinkler heads in dishwasher area were not loaded or covered with foreign material in accordance with LSC 9.7.5. 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	K 0353	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	08/10/2023

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	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 approximately 20 staff and residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 07/17/23 between 12:15 p.m. and 2:17 p.m. the following sprinkler heads were coved in dust or showed signs of loading, a) Five sprinkler heads in the laundry room were loaded with dirt and lint and could barely see the color of the bulbs. b) Two sprinkler heads in the dishwasher room in the kitchen were covered with dust and lint. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed dirt accumulation and loading and would start the process of getting the sprinkler heads cleaned. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any		actions will be taken: All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place and what systematic changes will be made to ensure that the Maintenance will check sprinklers for to ensure secured and no foreign material monthly and record in TELS. Maintenance will document weekly x 4 weeks then monthly x 5. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place. The results of the audits will be reviewed by the QAPI Committee x 6 months	

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	sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation with the Maintenance Director on 07/17/23 between 12:15 p.m. and 2:17 p.m., the spare sprinkler cabinet in the riser room was not large enough to contain all sprinkler heads and prevent damage to the sprinkler heads. When the cabinet in riser room was opened, the cabinet contained three more sprinkler heads than spots available. Based on interview at the time of the observations, the Maintenance Director agreed there were loose sprinkler heads in the cabinet that were unsecured. This finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b)			
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10			

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	Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers were not obstructed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.3 states portable fire extinguishers shall not be obstructed or obscured from view. This deficient practice could affect approximately 3 staff and an unknown amount of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/17/23 between 12:15 p.m. and 2:17 p.m., one ABC portable fire extinguisher located in the laundry area next to the washer was blocked by waste receptacle that had linens on top which limited the visibility of the fire extinguisher. Based on interview at the time of observation, the Maintenance Director acknowledged the blocked fire extinguisher by the linens and receptacle and moved the objects during observation. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0355	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. Maintenance immediately removed waste receptacle that had linens on top which limited the visibility of the fire extinguisher. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Maintenance immediately removed waste receptacle that had linens on top which limited the visibility of the fire extinguisher. What measures will be put into place and what systematic changes will be made to ensure that the Education of laundry personnel was provided. Executive Director will complete visual inspections while rounding to maintain compliance daily x 4 weeks and then weekly x 5 months. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place. The results of the audits will be reviewed by the QAPI Committee	08/10/2023

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			x 6 months	
K 0363 SS=D 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 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.			

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BRICKYARD HEALTHCARE - FOUNTAINVIEW CARE CENTER	609 W TANGLEWOOD LN MISHAWAKA, IN 46545

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	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 1 of 33 resident room corridor doors in Unit "B" were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 2 residents in room 136. Findings include: Based on observation with the Maintenance Director on 07/17/23 between 12:15 p.m. and 2:17 p.m., the corridor door to resident room 136 did not latch into the frame when tested twice. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame and would need to be adjusted. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. Maintenance immediately fixed the door to ensure proper closure. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Maintenance immediately fixed the door to ensure proper closure. What measures will be put into place and what systematic changes will be made to ensure that the Resident advocates will be educated on proper door closure and will ensure compliance weekly x 4 weeks then monthly x 5. Any concerns will immediately be reported to Maintenance, Administrator, or TELS. How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into	08/10/2023

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			place. The results of the audits will be reviewed by the QAPI Committee x 6 months.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical panel in the Activity Room was secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect approximately 5 residents and staff. Findings include: Based on observation with Maintenance Director on 07/13/23 between 12:15 p.m. and 2:17 p.m., the electrical panel in the Activity Room was	K 0511	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. Maintenance immediately locked the electrical panel. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Maintenance immediately locked the electrical panel. What measures will be put into place and what systematic changes will be made to ensure that the Activity personnel has been educated on the importance of	08/10/2023

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	unlocked when tested. The panel included breakers to the lights, outlets, and range/stove top in the Activity Room. Based on interview at the time of observation, the Maintenance Director stated the electrical panel will need to be locked and secured it upon observation. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		verifying electrical panel is locked daily. Executive Director will ensure compliance daily while rounding x 4 weeks then weekly x 5 months . How the corrective action will be monitored to ensure the deficient practice will not recur ie what quality assurance will be put into place. The results of the audits will be reviewed by the QAPI Committee x 6 months	
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			

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	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 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 up to 5 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 07/17/23 between 12:15 p.m. and 2:17 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in resident room 223 and another minifridge (high power draw equipment) was plugged into and supplied power by a power strip in the DCE Office. Based on interview at the time of observation, the Maintenance Director acknowledged power strips were supplying power to high power draw equipment. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0920	What corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. Maintenance immediately unplugged power strips. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken: All residents have the potential to be affected by the alleged deficient practice. Maintenance immediately unplugged power strips. What measures will be put into place and what systematic changes will be made to ensure that the Power strip in resident room was immediately replaced with medical grade power strip. DCE office was immediately plugged into the wall outlet. Maintenance rounds identified no additional concerns Resident Advocate will monitor daily x 5 with rounds, then weekly x 4 months. Maintenance will complete round weekly x 6 months and record in TELS. How the corrective action will be monitored to ensure the deficient practice will not recur ie what	08/10/2023

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			quality assurance will be put into place. The results of the audits will be reviewed by the QAPI Committee x 6 months	