STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155287	A. BUILDING -- B. WING	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RENSSELAER CARE CENTER	1309 E GRACE ST RENSSELAER, IN 47978

(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: 03/19/24 Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840 At this Emergency Preparedness survey, Rensselaer 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 157 certified beds. At the time of the survey, the census was 84. Quality Review completed on 03/21/24	E 0000		
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: 03/19/24 Facility Number: 000185 Provider Number: 155287 AIM Number: 100290840 At this Life Safety Code survey, Rensselaer Care Center was found not in compliance with	K 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Rensselaer Care Center agrees with the allegations and citations listed. Rensselaer Care Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Costello	Executive Director	04/04/2024

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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. The facility was determined to be Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has the capacity for 157 and had a census of 84 at the time of this survey. All areas where residents have customary access were sprinklered except for two detached sheds that were used for general storage that were not sprinklered. Quality Review completed on 03/21/24		correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request a desk review.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 7 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice	K 0271	**K 271 Discharge from Exits** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?***	04/17/2024

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	could affect approximately 20 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 03/19/24 between 12:40 p.m. and 3:34 p.m., the exit discharge leading from 400 hall was made of concrete for about approximately six feet. However, the last couple of feet of the sidewalk was made from gravel, dirt, and other material that was not a hard packed, all weather resistant surface. Based on interview at the time of record review, the Maintenance Director confirmed that the sidewalk was incomplete and stated it had been that way for awhile. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		· The exit discharge leading from the 400 (west) hall consisted of approximately 6 feet of concrete, with the remaining portion of exit discharge not consisting of hard packed material, vendor to replace concrete on 4/15/2024. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** · 20 residents and staff have the potential to be affected. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and, no additional concerns noted regarding remaining exit discharges. · The Maintenance Director and/or designee will include identified areas in the current preventative maintenance program and conduct routine rounds according to facility protocol. · The Director of Maintenance was educated by the Executive Director on requirement all exit discharges to consist of hard packed material on 3/20/2024. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur:***	

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			· The Maintenance Director and/or designee will conduct observations in facility weekly for next 6 months to ensure the completion of all required inspections are complete and up to date, and will be ongoing. Any concerns identified will be addressed immediately. · The results of these will be discussed at the monthly facility Quality Assurance Committee meeting and reviewed for a total of 3 months and then quarterly thereafter once compliance.¿ QAPI will determine the need for further audits. Compliance date: April 17, 2024. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview, and observation; the facility failed to ensure documentation for the preventative maintenance	K 0300	**K 300 Protection-Other** ***What corrective action(s) will be accomplished for those***	04/17/2024

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	of 89 of 89 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review with the Maintenance Director on 03/19/24 between 9:48 a.m. and 12:35 p.m., documentation titled "Detectors: Test all battery-operated smoke detectors in resident rooms" indicated that 89 of 89 battery smoke alarms passed inspection, however the list was not itemized to indicate all smoke alarms had been inspected. During a tour of the facility between 12:40 p.m. and 3:34 p.m., all observed resident rooms contained battery-operated smoke alarms and some were noted in offices. Based on interview at the time of record review, the Maintenance Director confirmed that the documentation was not itemized and that the facility does have battery-operated smoke alarms. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		***residents found to have been affected by the deficient practice?*** · Itemized documentation regarding smoke alarms were not available for review, requested itemization of smoke alarms added through TELS on 3/20/2024. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** · All residents, staff, and visitors have the potential to be affected. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Itemization of smoke alarms is now available to be monitored through TELS. · The Maintenance Director and/or designee will include identified areas in the current preventative maintenance program and conduct routine rounds according to facility protocol. · The Director of Maintenance was educated by the Executive Director on requirement of need for smoke alarm itemization on 3/20/2024. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur:*** · The Maintenance Director	

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			and/or designee will conduct observations in facility monthly for next 6 months to ensure the itemization of smoke alarms are complete and up to date, and will be ongoing. Any concerns identified will be addressed immediately. · The results of these will be discussed at the monthly facility Quality Assurance Committee meeting and reviewed for a total of 3 months and then quarterly thereafter once compliance.¿ QAPI will determine the need for further audits. Compliance date: April 17, 2024. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - 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. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to 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	K 0345	**K 345 Fire Alarm System-Testing and Maintenance** ***What corrective action(s) will be accomplished for those residents found to have been***	04/17/2024

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	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 affects all occupants in the facility. Findings include: During records review with the Maintenance Director on 03/19/24 between 9:48 a.m. and 12:35 p.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 04/24/23. The visual inspection should have been conducted approximately around 10/2023. Based on interview at the time of records review, the Maintenance Director acknowledged the lack of documentation and stated contracted companies have been switched within the past and was unaware if they were supposed to be doing two inspections instead of one. This finding was reviewed with the Maintenance Director and Executive Director at the exit conference. 3.1-19(b)		***affected by the deficient practice?*** · No documentation regarding a visual inspection of the fire alarm system 6 months after annual fire alarm inspection (4/24/23) was available for review, documentation was located post review with post 6 month inspection of 10/6/2023. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** · All occupants have the potential to be affected. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental walk through was completed by maintenance department and plan has been put into place to address 6 month post annual inspection of Fire Alarm System. · The Maintenance Director and/or designee will include identified areas in the current preventative maintenance program and conduct routine rounds according to facility protocol. · The Director of Maintenance was educated by the Executive Director on requirement for annual and 6 month post annual inspection of fire alarm system on 3/20/2024.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur: · The Maintenance Director and/or designee will conduct observations in facility monthly for next 6 months to ensure the completion of all required inspections are complete and up to date, and will be ongoing. Any concerns identified will be addressed immediately. · The results of these will be discussed at the monthly facility Quality Assurance Committee meeting and reviewed for a total of 3 months and then quarterly thereafter once compliance.¿ QAPI will determine the need for further audits. Compliance date: April 17, 2024. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
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			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 3 of 3 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 03/19/24 between 9:48 a.m. and 12:35 p.m., the internal pipe inspection documentation titled "Sprinkler: Five Year Internal Pipe Inspection" dated 08/25/21 indicated the following: a) System #1: Some slight sediment in crossmain and clear branch line b) System #2: Pipe had some scaling with no loose rust, branch line clear c) System #3: Crossmain had scaling and branch line found with rust. Main clear but crossmain had had slight rust. Furthermore, a "work performed" document dated 08/25/21 indicated "Further work Required: Send quote to Flush the 2-4" Dry Pipe Systems. Based on interview at the time of record review, the Maintenance Director acknowledged the sprinkler	K 0353	**K 353 Sprinkler System-Maintenance and Testing** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · Documentation was unable to be provided regarding requested flush post internal 5 year internal pipe inspection on 8/25/21, flush to be completed 4/5/2024. · During walk through the sprinkler riser in both the dry kitchen storage area and dock area were observed to be blocked, both dry storage and dock area were cleared on 3/19/2024. · During walk through one sprinkler head above laundry dryer was loaded with dirt and one head in the shower room on 400 (west) hall showed sign of corrosion, will be replaced 4/4/2024, sprinkler head in laundry room was cleaned on 3/25/2023. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** · All occupants have the potential to be affected.	04/17/2024

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	inspection and he stated that the systems have been flushed a couple of times due to repairs being made, but he had no documentation during the survey to confirm it was completed. 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 2 of 3 automatic sprinkler system risers were easily accessible and properly protected. NFPA 13, 2010 Edition, 9.3.4.1, Clearance shall be provided around all piping extending through walls, floors, platforms and foundations, including drains, fire department connections and other auxiliary piping. This deficient practice could affect approximately all residents, staff and visitors. Findings include: Based on observation on 03/19/24 between 12:40 p.m. and 3:34 p.m. with the Maintenance Director present, the sprinkler riser within the dry kitchen storage had a food card, boxes, and numerous food products that blocked access to the sprinkler riser. Furthermore, the sprinkler riser within the dock area was also blocked with numerous tools, storage, and equipment that blocked access towards the riser. Based on interview at the time of record review, the Maintenance Director confirmed the risers were blocked from access and would rearrange the rooms. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put into place to address internal pipe inspection requests, sprinkler risers are not blocked, and sprinkler heads are clean and not corroded. · The Maintenance Director and/or designee will include identified areas in the current preventative maintenance program and conduct routine rounds according to facility protocol. · The Director of Maintenance was educated by the Executive Director on requirement for thorough review of internal pipe inspections reports, ensuring sprinkler risers are not blocked, and sprinkler heads are clean and not corroded 3/20/2024. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur:*** · The Maintenance Director and/or designee will conduct observations in facility monthly for next 6 months to ensure that all inspection requested, and recommendations are completed. · The Maintenance Director and/or designee will conduct observations throughout facility 5x weekly for 2 months, and then	

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	3. Based on observation and interview, the facility failed to ensure 1 of 3 sprinkler heads in the laundry room and 1 of 3 sprinkler heads in 400 shower room 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 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. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/19/24 between 12:40 p.m. and 3:34 p.m. the following sprinkler heads were coved in dust or showed signs of corrosion: a) One sprinkler head above the laundry dryers was loaded with dirt and lint which made the fuse barely visible. b) One sprinkler head in the shower room within 400 hall had excessive signs of corrosion and had green/bluish foreign material. Based on interview at the time of record review, the Maintenance Director confirmed the sprinkler heads were corroded or loaded and would make sure they were addressed. Findings were discussed with the Maintenance Director and Executive Director at exit conference.		weekly for 4 months to ensure that all sprinkler risers are not blocked and sprinkler heads are clean and not corroded. · The results of these will be discussed at the monthly facility Quality Assurance Committee meeting and reviewed for a total of 3 months and then quarterly thereafter once compliance.¿ QAPI will determine the need for further audits. Compliance date: April 17, 2024. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	

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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 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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(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
	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 8 of 91 resident room corridor doors and 1 of 1 central storage rooms in 300-Hall 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 25 residents and staff. Findings include: Based on observation with the Maintenance Director on 03/19/24 between 12:40 p.m. and 3:34 p.m., the following resident room doors did not latch into the frame after testing three times: Resident room 005, 105, 111, 104, 301, 309, 312. Furthermore, the central supply storage room next to room 301 could not latch when pushed shut after three times. Based on interview, the Maintenance Director confirmed that the aforementioned doors would not latch into the frame and indicated the doors will have to be repaired/maintenanced. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**K 363 Corridor - Doors** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · During walk through resident room doors 005, 105, 111, 104, 301, 309, 312 and central supply storage on 300 (south) hall did not latch, all doors fixed and latched appropriately on 3/21/2024. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** · Approximately 25 residents and staff have the potential to be affected. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put into place to address any issues with doors not latching. · The Maintenance Director and/or designee will include identified areas in the current	04/17/2024

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	155287	A. BUILDING 01 B. WING	03/19/2024

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			preventative maintenance program and conduct routine rounds according to facility protocol. · The Director of Maintenance was educated by the Executive Director on requirement for all doors to securely latch on 3/20/2024. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur:*** · The Maintenance Director and/or designee will conduct observations in facility weekly for next 6 months to ensure the completion of all doors securely latch. Any concerns identified will be addressed immediately. · The results of these will be discussed at the monthly facility Quality Assurance Committee meeting and reviewed for a total of 3 months and then quarterly thereafter once compliance.¿ QAPI will determine the need for further audits. Compliance date: April 17, 2024. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview; the facility failed to ensure annual inspection and testing of 2 of 2 oxygen room fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in	K 0761	**K 761 Maintenance, Inspection & Testing- Doors** ***What corrective action(s) will be accomplished for those residents found to have been***	04/17/2024

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	dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 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. (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.		***affected by the deficient practice?*** · No annual inspection for the 2 Oxygen fire door assemblies were available for review, inspection was completed on 3/20/2024. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** · Approximately 30 residents and staff have the potential to be affected. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put into place to address annual inspection of Fire door assemblies. · The Maintenance Director and/or designee will include identified areas in the current preventative maintenance program and conduct routine rounds according to facility protocol. · The Director of Maintenance was educated by the Executive Director on requirement for annual inspection of Fire door assemblies on 3/20/2024. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur:***	

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	(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 approximately 30 residents and staff. Findings include: Based on record review with the Maintenance Director on 03/19/24 between 9:48 a.m. and 12:38 p.m., annual fire door inspection documentation was accessible during the survey and conducted on 01/10/24. However, fire door inspections for the "Skilled oxygen room" and "Core oxygen room" were not available during the survey. Based on observation during a tour of the facility between 12:40 p.m. and 3:34 p.m., both oxygen room doors had a tagged fire resistance rating of 1-1/2 hours. Based on interview at the time of record review and observation, the Maintenance Director stated that the oxygen storage/filling rooms have not had fire door inspections and would start if needed. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		· The Maintenance Director and/or designee will conduct observations in facility monthly for next 6 months to ensure the completion of all required inspections are complete and up to date, and will be ongoing. Any concerns identified will be addressed immediately. · The results of these will be discussed at the monthly facility Quality Assurance Committee meeting and reviewed for a total of 3 months and then quarterly thereafter once compliance.¿ QAPI will determine the need for further audits. Compliance date: April 17, 2024. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	
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			

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	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. 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 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 approximately 4 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Executive Director on 03/19/24 between 12:40 p.m. and 3:34 p.m., A power strip located in the business office contained a power strip that was used to power a refrigerator (high draw power). Furthermore, a power strip was used to power a refrigerator (high	K 0920	**K 920 Electrical Equipment – Power Cords and Extension Cords** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** · During walk through use of power strips were observed powering high draw power appliances, power strip plugged into another power strip, and use of extension cords, to be corrected by date of compliance. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective***	04/17/2024

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	draw power) and a coffee maker (high draw power) in the medical records office. Based on interview at the time of observation, the Maintenance Director confirmed that the power strips were in use to power the high draw appliances. The medical records fridge and coffee maker was changed out during the survey. 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 2 of 2 power cord daisy chains were not used as and 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. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect approximately 12 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 03/19/24 between 12:40 p.m. and 3:34 p.m., in the CNA station next to room 101, a power strip was plugged into and supplied power by another power strip which was used to power electrical equipment. Furthermore, a power strip was located in the employee breakroom that was powering a fridge and an extension cord. That extension cord was plugged into a microwave (high draw power). Based on interview at the time of observation, the Maintenance Director agreed that both locations had daisy chained power		***action(s) will be taken:*** · All occupants have the potential to be affected. ***What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:*** · Environmental rounds have been completed by maintenance department and plan has been put into place to address any use of extension cords or inappropriate use of power strips. · The Maintenance Director and/or designee will include identified areas in the current preventative maintenance program and conduct routine rounds according to facility protocol. · The Director of Maintenance was educated by the Executive Director on not using extension cords and appropriate use power strips on 3/20/2024. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur:*** · The Maintenance Director and/or designee will conduct observations in facility weekly for next 6 months to ensure the completion of all required inspections are complete and up to date, and will be ongoing. Any concerns identified will be addressed immediately. · The results of these will be discussed at the monthly facility Quality Assurance Committee	

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	strips and would have to be fixed. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 2 of 2 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 approximately 4 residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 03/19/24 between 12:40 p.m. and 3:34 p.m., resident room 412 had an extension cord used to power electrical/computer equipment. That extension cord was then plugged into a power strip. Furthermore, resident room 301 had an extension cord used to power a lamp within the room. Based on interview at the time of record review, the Maintenance Director confirmed that the extension cords were in use and would have to resolve the issues. Finding were reviewed with the Maintenance Director and the Executive Director during the exit conference. 3.1-19(b)		meeting and reviewed for a total of 3 months and then quarterly thereafter once compliance.¿ QAPI will determine the need for further audits. Compliance date: April 17, 2024. The Administrator at Rensselaer Care Center is responsible in ensuring compliance in this Plan of Correction.	