STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155796	A. BUILDING -- B. WING	09/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARS THE	14409 SUNRISE CT LEO, IN 46765

(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: 09/24/24 Facility Number: 001215 Provider Number: 155796 AIM Number: 100450890 At this Emergency Preparedness survey, The Cedars was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 65 and had a census of 40 at the time of this survey. Quality Review completed on 09/25/24	E 0000	We respectfully request consideration for paper compliance. If you have any questions or concerns, please contact Amanda Duggan, HFA at 260-627-2191. Thank you and have a great day! Amanda Duggan, HFA	
K 0000 Bldg. 01	A Life Safety Code (LSC) Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/24/24 Facility Number: 001215 Provider Number: 155796 AIM Number: 100450890 At this LSC survey, The Cedars 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	K 0000	We respectfully request consideration for paper compliance. If you have any questions or concerns, please contact Amanda Duggan, HFA at 260-627-2191. Thank you and have a great day! Amanda Duggan, HFA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda Duggan	Health Facility Administrator	10/10/2024

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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	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with an Independent Living in the basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility is fully protected by a Type II EES 300 kW diesel generator. The facility has a capacity of 65 and had a census of 40 at the time of this survey. All areas where the residents have customary access are sprinklered. All areas which provided facility services were sprinklered. The facility does have a barn providing facility services that was not sprinklered. Quality Review completed on 09/25/24			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Based on observation and interview, the facility failed to ensure penetrations in 1 of 1 fire barrier walls that separated health care from assisted living was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed	K 0131	The facility failed to ensure 1 of 1 fire barrier walls that separated healthcare from assisted living was maintained to ensure the fire resistance barrier. This deficient practice could affect 25 residents. Facility will fill the hole and ensure that there are no penetrations in the separation which is the fire barrier. (Attachment A) Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly	10/10/2024

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	as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 25 residents on the 200-hall. Findings include: Based on observations with the Maintenance Director and Administrator on 09/24/24 at 2:05 p.m., above the drop ceiling of the separation fire barrier from the 200-hall had an unsealed 1/4-inch gap around wires. Based on interview at the time of observation, Maintenance Director agreed the separation fire barrier had an unsealed penetration. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		with the QAPI meetings. (Attachment B)	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to maintain the means of egress through 1 of 4 exits egresses in accordance with LSC section 7.2.1.14 Horizontal-Sliding Door Assemblies which states, horizontal-sliding door assemblies shall be permitted in means of egress, provided that all of the following criteria are met: (1) The door leaf is readily operable from either side without special knowledge or effort. (2) The force that, when applied to the operating device in the direction of egress, is required to	K 0211	The facility failed to ensure 1 of 4 means of egress were maintained free of all obstructions in case of fire or emergency. This deficient practice could affect 25 residents in the 200 hall. The Handrail will be adjusted to allow for the push function to work in case of emergency and the door will open. (Attachment C) Audits will be completed weekly for 4 weeks and	10/10/2024

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	operate the door leaf is not more than 15 lbf (67 N). (3) The force required to operate the door leaf in the direction of travel is not more than 30 lbf (133 N) to set the leaf in motion and is not more than 15 lbf (67 N) to close the leaf or open it to the minimum required width. (4) The door leaf is operable using a force of not more than 50 lbf (222 N) when a force of 250 lbf (1100 N) is applied perpendicularly to the leaf adjacent to the operating device, unless the door opening is an existing horizontal-sliding exit access door assembly (5) The door assembly complies with the fire protection rating, if required, and, where rated, is self-closing or automatic closing by means of smoke detection in accordance with 7.2.1.8 and is installed in accordance with NFPA80. This deficient practice could affect 25 residents in the 200-hall. Findings include: Based on observation with the Maintenance Director and the Administrator on 09/24/24 at 1:52 p.m., the exit horizontal-sliding door assembly for the 200-hall did open automatically but when the push breakaway feature was tested the door did not open due to a handrail blocking the swing path for the door. Based on interview at the time of observation, the Maintenance Director agreed the door would not swing open due to the handrail blocking the door. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	

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K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of 4 exit discharges were provided with an unobstructed level walking surface in accordance with NFPA 101 (2012 edition) section 7.7. This deficient practice could affect 20 residents that would use exit door #7. Findings include: Based on observation with the Maintenance Director and the Administrator on 09/24/24 at 1:42 p.m., the exit discharge from door #7 had a wood ramp leading to an asphalt walkway and to the common way. There was a 1-1/2-inch drop at the transition point from the ramp to the walkway. Also, on the walkway there were 2 skids of construction materials, loose dirt and gravel, and the access from the walkway to the parking lot was partly blocked by a flat trailer. Based on interview at the time of observation, the Maintenance Director agreed the walkway was obstructed, did not have a level walking surface from the ramp to the asphalt, and did remove all items blocking the exit discharge. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0271	The facility failed to ensure 1 of 4 exit discharges were provided with an unobstructed level walking surface in accordance with NFPA101 section 7.7.Ramp was adjusted to make level transition in accordance with NFPA section7.7. (Attachment D) This deficient practice could affect 20 residents that would use exit door 7. Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	10/01/2024
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Based on observation and interview, the facility failed to ensure 1 of 4 stairway doors were self-closing and latching to keep the door in the	K 0311	The facility failed to ensure 1 of 4 stairway doors were self-closing and latching to keep the door in	10/10/2024

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	closed position. LSC 19.3.1.7 states a door in a stair enclosure shall be self-closing and shall normally be kept in the closed position, unless otherwise permitted by 19.3.1.8. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and Administrator on 09/24/24 at 1:23 p.m., the top door to the activity's stairwell was self-closing but did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the door was not held in the closed position due to the door was not latching into the door frame. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		the closed position. This deficient practice could affect up to 20 residents. The door has been adjusted to latch into the frame and therefore keeps the door in the closed position.(Attachment E) Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	
K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to properly install and maintain equipment protected by 1 of 1 kitchen hood extinguishing systems and provided a shut off for 1 of 1 cooktops in the cooking area in the activities room. (#1,) LSC 9.2.3 states cooking equipment shall be in accordance with NFPA 96 section 12.1.2.2 states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer	K 0324	The facility failed to properly install and maintain equipment protected by 1 of 1 kitchen hood extinguishing systems and provide a shut of for 1 of 1 cook tops in the cooking area in the activities room. This deficient practice could affect staff in the kitchen and all residents. Markers have been placed in the kitchen so that staff and maintenance know where to return equipment to so that it would be under the hood.	10/10/2024

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	or servicing agent, unless otherwise allowed by the design of the fire extinguishing system, unless such installations are approved existing installations, which shall be permitted to be continued in service, and have an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Section 10.1.2 states cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. (#2) LSC 19.3.2.5.3(3) states the requirements of (3) through (10) and (13) are met. Section 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 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 The deficient practice affects staff in the kitchen and all residents. Findings include: (#1.) Based on observation with the Maintenance Director and Administrator on 09/24/24 at 1:15 p.m., the cooking equipment in the main kitchen was covered by the fire suppression system, but the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview during observation, the Maintenance Director and Administrator		(Attachment F) A shut off switch had been installed in the cooking area which will cut the power to the cooktop when not in use. (Attachment G & G.1) Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	

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	agreed the kitchen was not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. (#2.) Based on observation with the Maintenance Director and Administrator on 09/24/24 at 1:49 p.m., there was a cooktop in the activities room that was separated from the corridor, but staff were unable to deactivate the cooktop from power by a shutoff in the cooking area. Based on interview at the time of observation, the Maintenance Director was asked if staff were able to deactivate the cooktop and lock the switch. The Maintenance director stated the shut off switch is in a braker box in the basement and agree the shut off was not in the cooking area. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation, and interview, the facility failed to maintain 1 of 1 sprinkler system storage tanks and maintain 1 of 1 spare sprinkler boxes in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. (#1.) Section 9.2.4.1 states the temperature of water tanks shall not be less than 40°F. Section 9.2.4.2 states the temperature of water in tanks with low temperature alarms connected to a	K 0353	The facility failed to maintain 1 of 1 sprinkler system storage tanks and maintain 1 of 1 spare sprinkler boxes in accordance with NFPA 25. This deficient practice could affect all residents and staff in the building. The storage tank supplies water to the facility sprinkler system will have temperature checked weekly, monthly water level checks will be completed as well as will be	10/10/2024

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	constantly attended location shall be inspected and recorded monthly during the heating season when the mean temperature is less than 40°F. Section 9.2.4.3 states the temperature of water in tanks without low temperature alarms connected to a constantly attended location shall be inspected and recorded weekly during the heating season when the mean temperature is less than 40°F. (#2.) Section 9.2.1.1 states tanks equipped with supervised water level alarms that are connected to a constantly attended location shall be inspected quarterly. Section 9.2.1.2 states tanks not equipped with supervised water level alarms connected to a constantly attended location shall be inspected monthly. (#3.) Section 9.2.6.1.1 states the interior of steel tanks without corrosion protection shall be inspected every 3 years. Section 9.2.6.1.2 states the interior of all other types of tanks shall be inspected every 5 years. Section 9.2.6.3 states the tank interior shall be inspected for signs of pitting, corrosion, spalling, rot, other forms of deterioration, waste materials and debris, aquatic growth, and local or general failure of interior coating. (#4.) Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any 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		inspected once every three years for evidence of corrosion. (Attachment H) The spare sprinkler heads were adjusted to fit into the sprinkler box provided. (Attachment I & I.1) Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	

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	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 records review of the facility's sprinkler inspection reports with the Maintenance Director and Administrator on 09/24/24 at 10:50 a.m., (#1.) There was no documentation to indicate the storage tank that supplied water to the facility sprinkler system was inspected and recorded for temperatures weekly. Based on observation at 12:20 p.m., there was an in-ground water storage tank that was connected to the fire sprinkler system and was not monitored for temperatures. Based on interview at the time of the observation and records review, the Maintenance director stated the tank did supply water to the sprinkler system, was not monitored for temperatures, and was not checked or recorded for temperatures weekly. (#2.) There was no documentation of monthly water level checks for tanks not equipped with supervised water level alarms. Based on observation at 12:20 p.m., there was an in-ground water storage tank that was connected to the fire sprinkler system and was not equipped with a low-level alarm. Based on interview at the time of the observation and records review, the Maintenance director stated the tank did supply water to the sprinkler system, was not equipped with a low-level alarm, and was not checked or recorded for water level monthly. (#3.) There was no documentation to indicate that			

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	the interior of the storage tank that supplied water to the facility sprinkler system was inspected once every three years. Based on observation at 12:20 p.m., there was an in-ground water storage tank that was connected to the fire sprinkler system with unknown corrosion protection. Based on interview at the time of the observation and records review, the Maintenance director stated the tank did supply water to the sprinkler systems, was unknown if the tank had corrosion protection, and was not inspected once every three years. (#4) Based on observation at 12:21 p.m., the spare sprinkler cabinet in the riser room was not designed for the facility's sprinkler heads and to prevent damage to the sprinkler heads. When the cabinet in the riser room was opened, there were sprinkler heads that were not in the provided slots due to the sprinkler heads were too large for the slots. Based on interview at the time of the observations, the Maintenance Director agreed the sprinkler heads were too large for the designed slots. The findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Based on observation and interview, the facility failed to ensure 1 of 1 sunrooms open to the corridor were provide with electrically supervised automatic smoke detection system. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area,	K 0361	The facility failed to ensure 1 of 1 sunrooms open to the corridor were provided with electrically supervised automatic smoke detection system. This deficient practice could affect up to 25 residents. Two electrically	10/10/2024

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	provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect staff and up to 25 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Administrator on 09/24/24 at 12:47 p.m., the sunroom had a door between the corridor and the room, the door did not contain a latching device making the room open to the corridor, and the room did not contain electrically supervised automatic smoke detection. Based on interview at the time of observation, the Maintenance Director agreed the sunroom was open to the corridor and did not contain electrically supervised automatic smoke detection. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		supervised smoke detectors have been installed in the sunroom. (Attachment J) Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on observation, interview, and record review, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans in accordance with 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms	K 0711	The facility failed to ensure a clear plan as to where the locations of the smoke/fire barriers or cross corridor doors that could be mistaken as a smoke or fire barrier. This deficient practice could affect all occupants of the	10/10/2024

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	(2) Transmission of alarm to the fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and Administrator on 09/24/24 at 11:25 a.m., the facility provided information on evacuation of smoke compartments in the fire safety plan, but the plan did not address the locations of smoke/fire barriers or cross corridor doors that could be mistaken as a smoke or fire barrier. Based on interview during records review, the Maintenance Director stated no documentation was available to show the location of the smoke/fire barriers. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		building. The facility map was zoned off to show smoke compartments and fire doors. (Attachment K) Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 1 of 17 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be	K 0761	The facility failed to ensure a 1 of 17 fire door assemblies were completed in accordance with the regulation. This deficient practice could affect up to 20 residents. The fire door to the oxygen room	10/10/2024

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	155796	A. BUILDING 01 B. WING	09/24/2024

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	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. (9) Auxiliary hardware items that interfere or		will be inspected initially and then added to the annual list to inspect with the other fire doors. (Attachment L) Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	

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	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 20 residents in one smoke compartment. Findings include: Based on records review with the Maintenance Director and Administrator on 09/24/24 at 10:28 a.m., the fire door annual inspection form listed the stairwell fire doors and cross corridor fire doors but fail to include the fire door to the oxygen storage and transfilling room. Based on observation at 1:20 p.m., the label on the door indicated the door was a 45-minute rated fire door. Based on interview at the time of records review and observation, the Maintenance Director agreed the oxygen room door was a 45-minute rated fire door and was not inspected within the past 12 months. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0781 SS=C Bldg. 01	NFPA 101 Portable Space Heaters Based on record review and interview, the facility failed to develop 1 of 1 portable space heater policies. This deficient practice could affect all residents, staff, and visitors. Findings include:	K 0781	The facility failed to develop 1 of 1 portable space heater policy. This deficient practice could affect all residents, staff and visitors in the building. The facility does not allow space heaters and a policy	10/10/2024

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	Based on records review with the Maintenance Director and Administrator on 09/24/24 at 11:55 a.m., no documentation of a space heater policy was available for review. Based on interview at the time of records review, the Administrator stated space heaters are not allowed in the facility but could not find a policy stating such. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		has been written. All staff will be educated on the policy. (Attachment M) Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords and 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw or met the UL rating of 1363A or 60601-1 in patient care locations according to LSC/2012 chapter 19 and NFPA-70/2011, 400.8. This deficient practice could affect 25 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director and Administrator on 09/24/24 between 12:00 a.m. and 2:00 p.m., the following areas had improper use of power strips and extension cords: A.) In the dietary office an extension cord was used to power a refrigerator. B.) In room 313 a power-strip that did not meet 1363A or 60601-1 was used to power the resident's electronics. Based on interview at the time of observation, the	K 0920	The facility failed to ensure 1 of 1 extension cords and 1 of 1 power strips were not used as a substitute for fixed wiring. This deficient practice could affect up to 25 residents. The extension cord and power strips were removed from the room and if needed replaced with an appropriate medical grade power strip. Audits will be completed weekly for 4 weeks and then monthly until 100% compliance is met for 6 months. Results will be reviewed monthly with the QAPI meetings. (Attachment B)	10/10/2024

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	Maintenance Director agreed an extension cord was powering a refrigerator and a power-strip not meeting 1363A or 60601-1 was used in a patient care area. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			