STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155221	A. BUILDING -- B. WING	01/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE HEALTH & REHAB	1120 E DAVIS DR TERRE HAUTE, IN 47802

(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: 01/23/23 Facility Number: 000126 Provider Number: 155221 AIM Number: 100266400 At this Emergency Preparedness survey, Westminster Village Health & Rehab was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 78 certified beds. At the time of the survey, the census was 54. Quality Review completed on 01/25/23	E 0000	***Westminster Village Terre Haute wishes to have this submitted plan of correction (POC) stand as its allegation of compliance. Preparation and/or execution of this POC does not constitute admission to, nor agreement with either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.***	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Williams	Administrator	02/09/2023

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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	§491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural			

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	or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that			

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	requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,			

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	facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2			

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	years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

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	the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based	E 0039	Element #1 The Administrator conducted a Severe Weather Table Top in-service to all staff on 2/7/23 **Element #2** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. A team participated in a Severe Weather Tabletop Training on 2/7/23. **Element #3** The policy on Emergency Preparedness Plan exercises was reviewed by the Administrator and found to meet professional standards of practice. A schedule of yearly Emergency Preparedness Exercises was developed by the Administrator, Plant Operations Director and approved by QAPI committee on	02/10/2023

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	functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review on 01/23/23 at 1:20 p.m. with the Director of Plant Operations, the emergency preparedness book entitled "Disaster Plan" that was last reviewed on 05/04/22: a second full-scale exercise that is community-based or a second individual, facility-based functional exercise, a mock disaster drill, a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan was not available for review. Based on an interview at the time of record review, the Director of Plant Operations confirmed that documentation for a second exercise of choice was not available for review at the time of this survey. This finding was reviewed with the Administrator and Director of Plant Operations at the exit conference.		2/7/23. All staff received education on the requirement of Emergency Preparedness Exercises on 2/7/23. Emergency Preparedness Exercises/Plan will be presented to new employees during orientation. **Element #4** The Administrator will audit the completion of the Emergency Preparedness Exercises annually with Plant Operations Director. Additional audits will be completed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Plant Operations Director will be responsible for sustained compliance. **Element #5** The facility will be in and remain in compliance by 2/10/23.	

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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: 01/23/23 Facility Number: 000126 Provider Number: 155221 AIM Number: 100266400 At this Life Safety Code survey, Westminster Village Health & Rehab 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 and 410 IAC 16.2. This two story facility was determined to be Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 78 and had a census of 54 at the time of this visit. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/25/23	K 0000	***Westminster Village Terre Haute wishes to have this submitted plan of correction (POC) stand as its allegation of compliance. Preparation and/or execution of this POC does not constitute admission to, nor agreement with either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.***	
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure			

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Bldg. 01	Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 1 hazardous areas such as Activities Closet was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 10 residents and staff in the	K 0321	**Element #1** Activity Closet self-closing door located in the activity room was repaired by maintenance on **1/23/23.** **Element #2** All residents have the potential of	02/10/2023

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	vicinity of the Activities Closet in the Activities room. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 1:28 p.m. to 2:45 p.m. on 01/23/23, the door to the Activities Closet located in the Activities room that is open to the corridor was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. When swinging to self-close, the door appeared to be rubbing on the frame, preventing it from latching. Based on interview at the time of observation, the Director of Plant Operations agreed the door to the aforementioned hazardous area failed to self-close and latch into the door frame. This finding was reviewed with the Administrator and Director of Plant Operations at the exit conference. 3.1-19(b)		being affected by the alleged deficient practice. All combustible storage rooms/spaces self-closing were inspected by Director of Maintenance or designee for functioning self-closure latching on 2/9/23 and were repaired as applicable. Self-closing doors will be placed on a preventative maintenance inspection monthly. **Element #3** Maintenance Preventative Plan for inspection of self-closing doors was reviewed and updated as applicable. Director of Plant Operations provided education of the Preventative Maintenance Plan for combustible storage rooms/spaces self-closing doors to the maintenance and housekeeping employees on 1/24/23. All employees were educated on how to put in a work order for self-closing doors that do not close and latch. **Element #4** Plant Operations Director will randomly inspect 5 combustible storage rooms/spaces doors for functioning self-closures to ensure door latches weekly times 4 weeks then monthly times 6 months. Additional audits will be completed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such	

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			time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Plant Operations Director will be responsible for sustained compliance. **Element #5** The facility will be in and remain in compliance by 2/10/23.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 3 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all residents, staff, and visitors.	K 0712	**Element #1** Fire Drills are planned to be held on 1st shift 7am-3pm on 3/6/23, 2nd shift 3pm-11pm on 4/3/23 and 3rd shift 11pm-7am on 2/13/23. Administrator educated Plant Operations Director on the Fire Drill policy and procedure on 1/23/23. **Element #2** All residents, staff and visitors have the potential to be affected by the alleged deficient practice. Fire Drills are planned to held on	02/10/2023

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	Findings include: Based on record review with the Director of Plant Operations on 01/23/23 from 10:00 a.m. to 1:28 p.m., complete documentation of the following fire drills or complete documentation of orientation training could not be provided: a) fire drills conducted in the first quarter (January, February, March) of 2022/2023 on the first, second or third shifts. b) fire drills conducted in the third quarter (July, August, or September) of 2022 on the second and third shifts. c) fire drills conducted in the fourth quarter (October, November, December) 2022 on the second and third shifts. There were documented orientation trainings conducted with staff in lieu of a fire drill during the waiver period, however, the documents stated '1st & 3rd shifts' with no times of when the training occurred. The staff sign in sheets provided indicated a time range of several orientation hours. Based on interview at the time of record review, the Director of Plant Operations stated they have restarted fire drills since the waiver is over, and there were no further fire drill or orientation training documents for review as of the time of this survey. This finding was discussed with the Administrator and Director of Plant Operations during the exit conference. 3.1-19(b) 3.1-51(c)		1st shift 7am-3pm on 3/6/23, 2nd shift 3pm-11pm on 4/3/23 and 3rd shift 11pm-7am on 2/13/23. Administrator educated Plant Operations Director on the Fire Drill policy and procedure on 1/23/23. **Element #3** The Fire Drill Policy and Procedure was reviewed by the Administrator and Plant Operations Director and meets professional standards. The fire drill schedule was reviewed and updated which includes the date and shift time frames of the fire drills. All Staff were educated on the Fire Drill Policy and Procedure on 1/23/23 with on-going education. **Element #4** **Plant Operations Director will audit Fire Drills on all shifts monthly with the Administrator for compliance.** Additional audits will be completed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. **Element #5** The facility will be in and remain in compliance by 2/10/23.	

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K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation, records review, and interview; the facility failure to ensure 1 of 1 portable space heaters was not used in the facility and enforce the space heater policy. This deficient practice could affect up to 8 residents and staff in the lounge by the scheduler office. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations on 01/23/23 at 2:30 p.m., a portable space heater was sitting on the floor in the Scheduler/Medical Supplies office plugged into a wall outlet. The space heater's manufacture documentation indicated 120 V and 1500 W on the base, but did not state the maximum temperature achieved by the unit. Based on records review at 2:50 p.m., the Space Heater Policy dated 10/14/20 stated 'The use of portable space heaters is prohibited in all areas of the health center of Westminster Village Terre Haute. If a portable space heater is discovered, it shall be removed immediately by Director of Plant Operations.' Based on interview at the time of the observation, the Director of Plant Operations agreed a space heater was in the health center, removed the space heater and stated space heaters are not allowed in the facility. This finding was reviewed with the Administrator	K 0781	**K 781 Portable Space Heaters** Element #1 The space Heater located in the Scheduler/Medical Supply office was removed immediately from room during survey. The Scheduler received education on the Space Heater Policy from the Administrator on 1/23/23. **Element #2** All residents have the potential to be affected by the alleged deficient practice. All offices were inspected for space heaters. No additional space heaters were observed. **Element #3** The Space Heater Policy was reviewed and met professional standard of practice of “the use of portable space heaters is prohibited in all areas of the Health Center”. All staff received education from the Administrator, maintenance, and Environmental Service Director on the Space Heater policy on 1/23/23. **Element #4** The Plant Operations Director or Designee will conduct inspections	02/10/2023

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	and Director of Plant Operations during the exit conference. 3.1-19(b)		of 5 offices monthly times 6 months then quarterly thereafter. Additional audits will be completed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Plant Operations Director will be responsible for sustained compliance. Element #5 The facility will be in and remain in compliance by	
K 0920 SS=D 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			

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	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 Based on observation and interview, the facility failed to ensure 1 of 1 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 1 or 2 staff. Findings include: Based on observation during a facility tour with the Director of Plant Operations on 01/23/23 between 1:28 p.m. and 2:45 p.m., in the Scheduler/Medical Supplies office a power strip was plugged into and supplied power to another power strip and computer equipment. Based on interview at the time of observation, the Director of Plant Operations agreed that power strips were daisy chained together and would make sure it is corrected. This finding was reviewed with the Administrator and Director of Plant Operations at the exit conference. 3.1-19(b)	K 0920	**K920 Electrical Equipment-Power Cords and Extension Cords** **Element #1** **The "daisy chain power cord" were immediately removed from the Scheduler/Medical Supply office. The Scheduler received education on the Power Strip Policy from the Administrator on 1/23/23.** **Element #2** All residents have the potential to be affected by the alleged deficient practice of use of "daisy chain power cord use". Plant Operations Director and designee completed an inspection of all areas in the Health Center for "daily chain power cord use", no other daisy chain power cords were found to be in use. **Element #3** The Power Cord Use Policy was reviewed and met professional standard of practice. All staff received education from the maintenance director on the Power Cord Strip Policy on 2/10/23. **Element #4** The Plant Operations Director or	02/10/2023

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			Designee will conduct inspections of 5 random rooms for daisy chain power cord use monthly times 6 months then quarterly thereafter. Additional audits will be completed based upon the level of compliance. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Plant Operations Director will be responsible for sustained compliance **Element #5** 1. The facility will be in and remain in compliance by 2/10/23.	