STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING -- B. WING	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/02/25 Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510 At this Emergency Preparedness survey, Envive of Lawrenceburg was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 50. Quality Review completed on 04/08/25	E 0000	**Plan of Correction FOR Envive of lawrenceburg** **INITIAL COMMENTS** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted April 2, 2025.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Director on 04/02/25 at 12:35 p.m., no documentation was available for review to show	E 0041	**E041 Hospital CAH and LTC Emergency Power** **1. What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *The Maintenance director now documents load each week.* .**2. How will other residents have the potential to be**	04/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Peninah Wood	Executive Director	04/25/2025

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	the available percentage of load placed upon the generator during monthly load tests. Based on an interview at 12:35 p.m. the Maintenance Director stated he did not record the percentage of load placed upon the generator during the monthly load tests. The category line on the Monthly Load Test forms was blank and the MD stated he didn't know he needed to record the percentage of load. The facility did complete an annual load bank test on 06/11/24. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present.		**affected by the same deficient practice be identified and what action will be taken?** *This deficient practice could affect all residents, staff and visitors.* *The maintenance director has been trained on how to calculate load, and documents load percentage each week,* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director Maintenance was educated by the Executive Director on* E041 Hospital CAH and LTC Emergency Power load must be documented each week to ensure transfer of power has taken place and transfer switch is working correctly. Documenting generator load task has been placed in the Tels building system for weekly reminders of generator documentation needed **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** *This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued*	

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			recommendations for process monitoring and improvement Until 100% compliance is achieved. **5. Date of Completion:** *4-30-25*	
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: 04/02/2025 Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510 At this Life Safety Code survey, Envive of Lawrenceburg 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 three story facility with a basement was determined to be of Type II(222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the basement, in the corridor, in all areas open to the corridor and in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 50 at the time of this visit. All areas where residents have customary access	K 0000	**Plan of Correction FOR Envive of lawrenceburg** **INITIAL COMMENTS** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted April 2, 2025.	

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	were sprinklered and all areas providing storage services were sprinklered, except the detached outdoor oxygen storage area. Quality Review completed on 04/08/25			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 3 of over 4 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: 1. Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 04/02/25 at 1:45 p.m., the exit discharge from the South Stair Tower was obstructed with a large wooden table and garden hose which combined obstructed the full width of the aforementioned exit discharge. The MD stated that the table and hose would need to be moved. 2. Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 04/02/25 at 2:12 p.m., 16 large boxes were obstructing the corridor near the exit by the Oxygen Transfilling Room. The MD agreed the boxes needed to be sorted and relocated. 3. Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 04/02/25 at 1:50 p.m., in the basement trash receptacles, several boxes, a lamp and furniture were obstructing the corridor. The MD stated the aforementioned material would need to be moved.	K 0211	**K211 Means of Egress- General** **1. What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *·(1) table, hose, and all other obstructions moved out of egress path* *·(2) boxes near 02 room were removed* *·(3) furniture, and all other obstructions in basement hall were removed.* . **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect Over 20 residents, staff and visitor* *All items obstructing egress pathways were removed* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient**	04/30/2025

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	This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**practice does not occur?** *The Director of Maintenance was educated by the Executive Director on K211 Means of Egress- General. Egress pathways must be clear of obstructions for emergency use when necessary. Weekly checking of egress pathways to ensure they are clear of obstructions has been added to the tails building system.* **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *4-30-25*	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of over 4 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	K 0271	**K271 Discharge from Exits** **1 What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient**	10/31/2025

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	Certification Letter 05-38. This deficient practice could affect 25 residents and staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 04/02/25 at 1:42 p.m., the exit discharge from the Therapy Exit had uneven grade where the section of concrete had sunk. The MD stated that there was at least a 2 inch rise in the concrete, across the width of the exit discharge which would create a trip hazard. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**practice?** *The maintenance director has reached out to obtain contractor quotes to repair the concrete egress pathway.* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect 25 residents, staff and visitors.* *The maintenance director has reached out to contractors to obtain quotes to repair uneven area* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director K271 Discharge from Exits. An exterior clear and safe path of egress must be maintained for emergency use purposes. Weekly checking of egress pathways to ensure they are clear of obstructions has been added to the tails building system.* **4. How the corrective action will be monitored to ensure the deficient practice will not recur**	

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			i.e., what quality assurance program will be put into place? *This TeIs task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *10-31-25* *Waiver filed*	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any	K 0324	**K324 Cooking Facilities** **1. What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *The maintenance director has marked the floor, and a picture has been posted to ensure the cooking equipment is in the proper position under the hood suppression system.* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect 5 staff.*	04/30/2025

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	disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 5 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 04/02/25 at 2:05 p.m., the (4) burner gas range and flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, at 2:05 p.m., the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. The MD agreed that it appeared the aforementioned range had been moved as much as a foot from its original location and the suppression nozzles were not currently aligned properly over the cooking surfaces. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		*The floor has been marked, and a picture has been posted for proper placement when items are moved from the suppression system.* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on* K324 Cooking Facilities*. Proper placement of cooking items task has been placed in the Tels building system or monthly reminders and documentation* **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieve*d. **5. Date of Completion:** *4/30/25*	

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K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 04/02/25 the following corridor doors failed to latch positively into their respective door frames: a) At 1:20 p.m. Resident Room #104 b) At 1:46 p.m. Resident Room #108 c) At 2:25 p.m. Resident Room #208 d) At 2:50 p.m. Resident Room #308 This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)	K 0363	***K363 Corridor doors*** ***1. What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?*** *The maintenance director has reached out to a contractor to repair or replace the doors on rooms 104,108,208 and 308* ***2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?*** *This deficient practice could affect 6 staff and residents* *A contractor has been called to fix or replace the doors on rooms 104, 108, 208 and 308.* ***3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?*** *The Director of Maintenance was educated by the Executive Director on K363 Corridor doors. All doors must close and latch freely to prevent the spread of smoke and fire and emergency cases a weekly door latching test task has been added to the tells building system.*	10/31/2025

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			4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? *This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* ***5. Date of Completion:*** *Waiver filed 10-31-25*	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire, pipe and/or conduit through 2 of 3 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a	K 0372	**K372 Subdivision of Building Spaces** **1. What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *The maintenance director has fire caulked the penetrations in the stairwell and the ceiling in the pump room.* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could*	04/30/2025

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	smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 25 residents on 2 floors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director (MD) on 04/02/25 at 1:36 p.m., (1) the north stair tower had missing fire caulk where wire penetrated near the sprinkler pipe. And (2) at 1:51 p.m. in the Sewage Pump Room, there were large gaps in the ceiling where the ceiling material had come apart around where the pipes penetrated from the basement to the 1st floor. The MD agreed that the aforementioned penetrations would need to be addressed. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		*affect 25 residents, staff and visitors on the 2nd floor* *All penetrations in the stairwell and pump room have been fire caulked* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director* K372 Subdivision of Building Spaces. Firewalls are required to prevent smoke and flame transfer. Any penetration must be fire caulked or repaired to meet CMS code. A monthly task to inspect firewalls for penetrations has been added to Tels building system. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.*	

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			5. Date of Completion: *4-30-25*	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to 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 Section 19.2.3.4(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment	K 0711	**K711 Evaluation and Relocation Plan** **1. What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** The VP of facilities maintenance has updated the company policy on evacuation and relocation to include assigned personnel to move wheeled medical equipment out of egress pathways during an emergency. **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect all residents, staff and visitors. The company policy on evacuation and relocation to include assigned personnel to move wheeled medical equipment out of egress pathways during an emergency.* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient**	04/30/2025

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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
	This deficient practice could affect all occupants. Findings include: Based upon record review and interview with the Maintenance Director (MD) and Executive Director (ED) on 04/02/25 at 1:05 p.m., the written fire safety plan provided did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observation with the Maintenance Director throughout the afternoon during a tour of the facility patient lifts and med-carts were in the corridors throughout the building. Based on interview during records review at 1:05 p.m., the ED acknowledged there was patient wheeled equipment in the halls but the documentation could not be found. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**practice does not occur?** *The Director of Maintenance was educated by the Executive Director* K711 Evaluation and Relocation Plan. Medical equipment must be moved out of egress pathways during an emergency. This job will be assigned to the charge nurse on each hall. The maintenance director will review this requirement with all nurses on duty during each fire drill. This will ensure all nurses on all shifts receive this training quarterly. This task has been added to the fire drill requirement and tails for monthly documentation. **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee Lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *4-30-25*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 01 B. WING	04/02/2025

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K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, Chapter 8. NFPA 110 Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include:	K 0918	**K918 Electrical Systems - Essential electrical systems** **1.What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?** *The Maintenance director now documents load each week.* ***.2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?*** *This deficient practice could affect all residents, staff and visitors.* *The maintenance director has been trained on how to calculate load, and documents load percentage each week,* **3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive Director on K*918 Electrical Systems - Essential electrical systems. Documentation of load is required to show transfer of	04/18/2025

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	Based on records review and interview with the Maintenance Director on 04/02/25 at 12:35 p.m., no documentation was available for review to show the available percentage of load placed upon the generator during monthly load tests. Based on an interview at 12:35 p.m. the Maintenance Director stated he did not record the percentage of load placed upon the generator during the monthly load tests. The category line on the Monthly Load Test forms was blank and the MD stated he didn't know he needed to record the percentage of load. The facility did complete an annual load bank test on 06/11/24. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		power is functioning correctly. Load percentage documentation has been added to the Tels building systems for weekly documentation requirements **4. How will the corrective action be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *4/18/25*	
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 flexible cord power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 5 residents in the therapy gym. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director	K 0920	***K920 electrical equipment dash power cords and extension cords*** ***1.What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice?*** The maintenance director has	04/30/2025

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	155061	A. BUILDING 01 B. WING	04/02/2025

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	(MD) on 04/02/25 at 1:40 p.m., a power strip was in use in the therapy gym where resident care was provided that did not meet 1363A or 60601-1. Based on interview at the time of observation, the MD agreed a power strip was in use in a resident care area and did not meet 1363A or 60601-1. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		removed the nonrated power strip from the therapy department. .***2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be take*** *This deficient practice could affect 5 residents, staff and visitors.* *Non-UL rated power strips have been removed from the therapy department,* ***3. What measures will be putting place or what systemic changes will be made to ensure that the deficient practice does not occur?*** *The Director of Maintenance was educated by the Executive Director on K920 electrical equipment - power cords and extension cords. A monthly task to audit for unapproved UL rated surge protectors has been added to the Tels building system* ***4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?*** *This Tels task will be reviewed by the Safety/QAPI committee lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued*	

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			recommendations for process monitoring and improvement Until 100% compliance is achieved. ***5. Date of Completion:*** *4-30-25*	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances	K 0921	**K921 Electrical Equipment - Testing and Maintenance** **What corrective action(s) Will be accomplished for those Residents found to have been affected by the deficient practice** *Testing and documentation will be performed on all Patient Care Related Electrical Equipment (PCREE).* **2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** *This deficient practice could affect all residents, staff and visitors. Testing and documentation will be performed* **3. What measures will be putting place or what systemic changes will be made to**	10/31/2025

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	receive continuous training. This deficient practice affects all residents. Findings include: Based on records review, interview and tour with the Maintenance Director (MD) on 04/02/25 at 11:58 a.m. and facility tour throughout the afternoon, no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour throughout the afternoon revealed that the facility provided electric beds for all residents. The MD stated that PCREE such as nebulizers, oxygen concentrators, and other electrical medical equipment was present and in use at the facility. This finding was acknowledged by the MD at the time of discovery and again at the exit conference with the MD and Executive Director present. 3.1-19(b)		**ensure that the deficient practice does not occur?** *The Director of Maintenance was educated by the Executive* Director on K921 PCREE testing requirements annual free PCREE testing reminder has been added to the Tels building systems **4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** *This Tels task will be reviewed by the Safety/QAPI committee lead by the Executive Director and/or Maintenance Director. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement Until 100% compliance is achieved.* **5. Date of Completion:** *10-31-25* *Waiver filed*	