STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155254	A. BUILDING -- B. WING	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	5430 W US 40 GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/28/23 Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720 At this Emergency Preparedness survey, Sugar Creek Rehabilitation and Convalescent Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 60 certified beds. At the time of the survey, the census was 40. Quality Review completed on 07/31/23	E 0000	This plan of correction is to serve as Sugar Creek Nursing and Rehabilitation Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Sugar Creek or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations.	
K 0000 Bldg. 01	A Life Safety Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/28/23 Facility Number: 000157 Provider Number: 155254 AIM Number: 100274720 At this Life Safety Code survey, Sugar Creek Rehabilitation and Convalescent Center was	K 0000	This plan of correction is to serve as Sugar Creek Nursing and Rehabilitation Center's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Sugar Creek or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Roger Brannan	Administrator	08/11/2023

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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	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 one-story facility was determined to be of Type II (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery-operated smoke detection in all resident sleeping rooms. The facility has a capacity of 60 and had a census of 40 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility had two detached storage buildings and a detached maintenance shop which were not sprinklered. Quality Review completed on 07/31/23		facility, nor does this submission constitute an agreement or admission of the survey allegations.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

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	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through all exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/28/23 between 11:30 a.m. and 1:00 p.m., the exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four-digit code but there were two sets of codes posted at each door; except for door #1 which did not have a working code posted. The Maintenance Director stated that he would remove the set of codes which were no longer in use. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance	K 0222	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this deficient practice. Posted inactive codes were removed from all exit doors and current codes were posted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No other residents were affected by this deficient practice. Posted inactive codes were removed from all exit doors and current codes were posted. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** All posted inactive codes were removed from all exit doors and current codes were posted. Maintenance Director will be in-serviced over regulation for	08/27/2023

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	Director and Administrator present. 3.1-19(b)		egress doors. **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.** The Maintenance Director/Designee will monitor all exit doors to ensure current exit door codes are posted weekly times 4 weeks, then every two weeks times 8 weeks, then monthly on-going. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure 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			

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	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 the corridor doors to 4 of 4 hazardous rooms were provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect 6 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/28/23 between 11:30 a.m. and 1:00 p.m., the corridor doors to the following hazardous areas did not meet the requirements for protection of a hazardous area: a) The activities area storage room/office, which was larger than 50 square feet and contained over 30 cardboard and paper boxes of supplies was not self-closing and did not self-close and latch into the door frame. b) The janitor's closet, which was larger than 50 square feet contained hazardous materials, was equipped with a self-closing device but did not	K 0321	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this deficient practice. A proper self-closing device has been added to the activity storage room/office. The self-closing device to the janitor's closet has been fixed to self-close and latch properly. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No other residents were affected by this deficient practice. A proper self-closing device has been added to the activity storage room/office. The self-closing	08/27/2023

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	self-close and latch when tested. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		device to the janitor's closet has been fixed to self-close and latch properly. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** A proper self-closing device has been added to the activity storage room/office. The self-closing device to the janitor's closet has been fixed to self-close and latch properly. The Maintenance Director will be in-serviced over regulation for hazardous areas enclosures. **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.** The Maintenance Director/Designee will monitor storage areas/offices to ensure self-closing devices are present (if appropriate) and that the self-closing device is functioning properly weekly times 4 weeks, then every 2 weeks times 8 weeks, then monthly times 3 months, then quarterly on-going. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	

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K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Maintenance Director on 07/28/23 between 9:40 a.m. and 11:30 a.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. During the survey the	K 0345	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this deficient practice. A visual fire alarm inspection has been completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No other residents were affected by this deficient practice. A visual fire alarm inspection has been completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** A visual fire alarm inspection has been completed. The Maintenance Director will maintain a log of the semi-annual visual fire alarm	08/27/2023

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	Maintenance Director stated that a visual inspection of the Fire Alarm system had not been done. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		system inspection, documenting the results The Maintenance Director will be in-serviced over regulation for fire alarm system testing and Maintenance. **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.** The Maintenance Director/Designee will monitor the visual fire alarm monitoring log every 6 months on-going. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical outlets were protected according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient	K 0511	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this deficient practice. The electrical	08/27/2023

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	practice could affect 10 residents, staff and visitors. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/28/23 between 11:30 a.m. and 1:00 p.m., in: (1) The break room a microwave was plugged into an electrical outlet which was not attached to the box, partly dangling inside the outer box. When the surveyor attempted to unplug the microwave, the entire receptacle moved like it was coming out of the wall. (2) An outlet cover was missing in the rear of the DON office, near the floor, exposing electrical wires. (3) In the copy room, an outlet cover was broken and only partially covering the outlet. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		outlet in the employee breakroom was fixed. The outlet cover in the rear of the DON office has been replaced. The outlet cover outside the copy room has been replaced. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No other residents were affected by this deficient practice. The electrical outlet in the employee breakroom was fixed. The outlet cover in the rear of the DON office has been replaced. The outlet cover outside the copy room has been replaced. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The electrical outlet in the employee breakroom was fixed. The outlet cover in the rear of the DON office has been replaced. The outlet cover outside the copy room has been replaced. The Maintenance Director will be in-serviced over the regulation for utilities-gas and electric specifically pertaining to outlets. **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.**	

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			The Maintenance Director/Designee will monitor the outlets throughout the facility quarterly ongoing to ensure they are properly covered, and the receptacles are intact and functioning properly. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure egress corridors were not used as a portion of a return air system serving adjoining resident rooms. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, Section 4.3.12.1.1 states egress corridors in nursing and long-term care facilities shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect as many as 40 residents, as well as staff and visitors. Findings include:	K 0521	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** No residents were affected by this alleged deficient practice. A Life Safety Code waiver has been requested (Attachment A). **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:**	08/27/2023

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	Based on observations and interview during a tour of the facility with the Maintenance Director on 07/28/23 between 11:30 a.m. and 1:00 p.m., resident rooms were using the egress corridor as a return air system. Based on interview at the time of the observations, the Maintenance Director acknowledged that resident rooms were using the egress corridor as a return air system. The MD stated he was aware of this from the previous survey and had already applied to renew the facility's waiver. No copy of an current approved waiver was available for review during the survey. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		No other residents were affected by this alleged deficient practice. A Life Safety Code waiver has been requested (Attachment A). **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** A Life Safety Code waiver has been requested (Attachment A). The Maintenance Director will be educated over requirements for return air systems and the life safety code waiver to be requested. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** Maintenance Director/Designee will monitor the life safety code waiver to ensure annual update occurs ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire			

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	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 on unexpected days and at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on records review and interview with the Maintenance Director on 07/28/23 between 9:40 a.m. and 11:30 a.m., 7 of 12 quarterly fire drills were conducted near the end of the month, around the 30th day of the month. These conditions do not allow fire drills to be conducted at on unexpected and unpredictable days. Additionally, the 4 quarterly fire drills for the first shift were conducted at the following times - 10:45 a.m., 10:00 a.m., 10:00 a.m. and 10:01 a.m. These conditions do not allow fire drills to be conducted at varying times. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)	K 0712	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this deficient practice. Fire drills will be completed on varying shifts on varying days at varying times. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No other residents were affected by this deficient practice. Fire drills will be completed on varying shifts on varying days at varying times. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Fire drills will be completed on varying shifts on varying days at varying times. The Maintenance Director will be in-serviced over the facility fire drill policy and	08/27/2023

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SUGAR CREEK REHABILITATION AND CONVALESCENT CENT	5430 W US 40 GREENFIELD, IN 46140

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			procedure and the regulations for fire drills. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Administrator will monitor the fire drill log quarterly on-going to ensure drills are occurring per regulations. Any negative findings will be corrected immediately and forwarded to the Regional Director of Operations. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0761 SS=E Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of at least 1 fire door assembly was 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 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	K 0761	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this deficient practice. An annual inspection for the fire assembly at the oxygen transfilling room has been completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No other residents were affected by this deficient practice. An annual inspection for the fire	08/27/2023

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	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 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 10 residents. Findings include: Based on records review and interview with the Maintenance Director on 07/28/23 between 9:40		assembly at the oxygen transfilling room has been completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** An annual inspection for the fire assembly at the oxygen transfilling room has been completed. The Maintenance Director will be in-serviced over the regulation for Maintenance, Inspection and Testing-Doors as it relates to the oxygen transfilling room. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director will monitor the inspection log for the fire assembly at the oxygen transfilling room annually on-going to ensure proper completion of inspection. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	

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	a.m. and 11:30 a.m., no documentation of an annual inspection for the fire door assembly at the Oxygen Transfilling room was available for review. Based on observation during the tour the Oxygen Transfilling room has one 90-minute fire door assembly. Based on interview at the time of records review, the Maintenance Director stated the annual fire door inspection was not completed within the last year and he was previously unaware a fire door inspection was needed on the Transfilling Room door. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are			

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	tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure documentation of electrical outlet receptacle testing at all resident rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include:	K 0914	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this deficient practice. An inspection and testing of electrical outlet receptacles has been completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No other residents were affected by this deficient practice. An inspection and testing of electrical outlet receptacles has been completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** An inspection and testing of electrical outlet receptacles has been completed. The Maintenance Director will be in-serviced over the regulation Electrical Systems-Maintenance and Testing as it relates to outlet receptacles. **How The Corrective Action(s)**	08/27/2023

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	Based on records review and interview with the Maintenance Director on 07/28/23 between 9:40 a.m. and 11:30 a.m., an itemized listing of inspection and testing electrical outlet receptacles for the most recent twelve-month period was not available for review. Based on interview at the time of record review, the Maintenance Director stated electrical receptacle testing documentation was not available because he had not yet gotten around to doing it this year. No documentation was available for the previous year either. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)		**Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor the log for inspection and testing of receptacle outlets monthly ongoing to ensure all outlet receptacles in the facility are inspected and tested annually. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension			

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	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 strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 2 staff in the Social Services office. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 07/28/23 between 11:30 a.m. and 1:00 p.m., in the Social Services/Dietary Office area a power strip was being used to power a dorm style refrigerator (high power draw equipment). This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Administrator present. 3.1-19(b)	K 0920	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No residents were affected by this deficient practice. The refrigerator in SSD/Dietary office has been unplugged from the power cord strip and is plugged directly into the wall outlet. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** No other residents were affected by this deficient practice. The refrigerator in SSD/Dietary office has been unplugged from the power cord strip and is plugged directly into the wall outlet. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The refrigerator in SSD/Dietary office has been unplugged from the power cord strip and is plugged directly into the wall outlet. The Maintenance Director will be in-serviced over the	08/27/2023

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			regulation for Electrical Equipment-Power cords and Extension Cords specifically for power cord strips. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** The Maintenance Director/Designee will monitor all areas of the facility to ensure power cords are not being utilized in an inappropriate way monthly times 6 months, then quarterly ongoing. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly.	