STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155428	A. BUILDING -- B. WING	08/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERIDIAN NURSING AND REHABILITATION CENTER	2102 S MERIDIAN ST INDIANAPOLIS, IN 46225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/10/20 Facility Number: 000386 Provider Number: 155428 AIM Number: 100286820 At this Emergency Preparedness survey, Meridian Nursing and Rehabilitation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 44 certified beds. At the time of the survey, the census was 20. Quality Review completed on 08/12/20 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	Please accept the following plan of correction for Meridian Nursing and Rehab.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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	program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.			
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.	E 0004	E004 1. What corrective Action will be accomplished for those residents	08/25/2020

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	Findings include: Based on review of "Emergency Preparedness Planning & Resource Manual" documentation dated February 2014 and "Comprehensive Emergency Management Plan" documentation dated 01/14/19 with the Regional Director during record review from 9:40 a.m. to 11:00 a.m. on 08/10/20, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned plans were not dated as reviewed within the most recent twelve month period. Based on interview at the time of record review, the Regional Director stated she thought the facility has had its emergency preparedness program reviewed and updated within the last year but agreed the emergency program documentation was not dated as reviewed within the most recent twelve month period.		found to have been affected by the alleged deficient practice? The EP Plan was updated and reviewed at the 8/25/2020 QAPI meeting. The updated plan was added to the EP Plan Binder. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by the alleged deficient practice. All residents had the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The update and review of the EP Plan has been added to the QAPI Calendar for January of every year. 4. How will the corrective action be monitored to ensure the	

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			alleged deficient practice will not occur? QAPI calendars are reviewed monthly the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5. By what date will systemic changes be completed? 8/25/2020	

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E 0006 SS=C Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.			

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	*[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR	E 0006	E006 1.What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The Facility Annual Hazard Assessment was updated and	08/25/2020

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	483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Planning & Resource Manual" documentation dated February 2014 and "Comprehensive Emergency Management Plan" documentation dated 01/14/19 with the Regional Director during record review from 9:40 a.m. to 11:00 a.m. on 08/10/20, a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, reviewed within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Regional Director agreed a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, reviewed within the most recent twelve month period was not available for review at the time of the survey.		reviewed at the 8/25/2020 QAPI meeting. The updated assessment was added to the EP Plan Binder. 1.How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by the alleged deficient practice. All residents had the potential to be affected. 1.What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The update and review of the Facility Hazard Assessment has been added to the QAPI Calendar for January of every year. 1.How will the corrective action be monitored to ensure the alleged deficient practice will not occur? QAPI calendars are reviewed monthly the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance.	

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			1.By what date will systemic changes be completed? 8/25/2020	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis			

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	facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Planning & Resource Manual" documentation dated February 2014 and "Comprehensive Emergency Management Plan" documentation dated 01/14/19 with the Regional Director during record review from 9:40 a.m. to 11:00 a.m. on 08/10/20, a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, reviewed within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Regional Director agreed policies and procedures based on a documented facility-based and community-based risk assessment, utilizing an all-hazards approach, reviewed within the most recent twelve month	E 0013	E013 1.What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The EP Plan with policies and procedures were updated and reviewed at the 8/25/2020 QAPI meeting. The updated plan was added to the EP Plan Binder. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by the alleged deficient practice. All residents had the potential to be affected. 3. What measures will be put into place or systemic changes will be	08/25/2020

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	period was not available for review at the time of the survey.		made to ensure that the alleged deficient practice does not occur? The update and review of the EP Plan with policies and procedures has been added to the QAPI Calendar for January of every year. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? QAPI calendars are reviewed monthly the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5. By what date will systemic changes be completed? 8/25/2020	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).			

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	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Planning & Resource Manual" documentation dated February 2014 and "Comprehensive Emergency Management Plan" documentation dated 01/14/19 with the Regional Director during record review from 9:40 a.m. to 11:00 a.m. on 08/10/20, documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Regional Director agreed the facility has not had an emergency preparedness program reviewed within the most recent twelve month period which includes a communication plan.	E 0029	E029 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? The EP & Plan was updated and reviewed at the 8/25/2020 QAPI meeting. The updated plan was added to the EP Plan Binder. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by the alleged deficient practice. All residents had the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The update and review of the EP Plan has been added to the QAPI Calendar for January of every year. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? QAPI calendars are reviewed monthly the QAPI committee	08/25/2020

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			overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5. By what date will systemic changes be completed? 8/25/2020	
E 0039 SS=C 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 *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, 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			

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	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. *[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			

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	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 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			

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	155428	A. BUILDING -- B. WING	08/10/2020

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	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 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			

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	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 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 requires activation of the			

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	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			

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	requires activation of the emergency plan, the ICF/IID 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 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 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			

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	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 the [RNHCI's and OPO'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 in a 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 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	E 0039	E039 EP Testing Requirements 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. The EP Plan Testing exercise has been scheduled for 8/25/2020 and 12/08/2020. The EP Plan Testing exercise schedule will be reviewed and updated at the 8/25/2020 QAPI meeting. Updated testing schedule was added to the EP Plan Binder. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by the alleged deficient practice. All residents had the potential to be affected. 3. What measures will be put into	08/25/2020

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	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 review of "Emergency Preparedness Planning & Resource Manual" documentation dated February 2014 and "Comprehensive Emergency Management Plan" documentation dated 01/14/19 with the Regional Director during record review from 9:40 a.m. to 11:00 a.m. on 08/10/20, documentation of a community based disaster drill or table top exercise conducted within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Regional Director agreed the facility has not conducted a community based disaster drill, a table top exercise or experienced and documented an additional actual natural or man-made emergency within the most recent twelve month period and agreed testing documentation was not available for review at the time of the survey.		place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The update and review of the EP Plan Testing Exercise schedule has been added to the QAPI Calendar for January and July every year to ensure compliance. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? QAPI calendars are reviewed monthly the QAPI committee overseen by the administrator and reviewed by corporate risk management. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5. By what date will systemic changes be completed? 8/25/2020	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a).	K 0000	Please accept the following plan of correction for Meridian Nursing and Rehab.	

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	Survey Date: 08/10/20 Facility Number: 000386 Provider Number: 155428 AIM Number: 100286820 At this Life Safety Code survey, Meridian Nursing and Rehabilitation Center 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 one story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 44 and had a census of 20 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached buildings which were each not sprinklered. Quality Review completed on 08/12/20			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This			

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	information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of 20 of 20 battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors within the facility. Findings include: Based on review of the Battery-operated Smoke Detectors Maintenance documentation (resident rooms) on 08/10/20 at 9:52 a.m. with the Maintenance Director, there was no itemized list of resident room battery operated smoke alarms tested for functionality on a monthly basis for June, July or August of 2020. Based on interview at the time of review, the Maintenance Director acknowledged the battery-operated smoke detector manufacturer recommendations called for monthly testing. Based on observations between 11:05 a.m. and 11:45 a.m. during a tour of the facility with the Maintenance Director, battery operated smoke alarms were observed in resident sleeping rooms.	K 0300	K 300 – Protection-Other 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. All battery-operated smoke alarms in resident rooms had batteries replaced, alarms tested, and documentation put in place. Testing of battery-operated smoke alarms in resident rooms was put on the monthly Preventative Maintenance log for each month. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Maintenance Supervisor or designee will inspect and conduct audit rooms during monthly deep	08/25/2020

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	This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		cleaning schedule to ensure batteries have been changed out and test battery-operated smoke alarms to ensure they are functioning properly. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur. Maintenance Supervisor or designee will review the results of inspections monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% is not achieved an action plan will be developed to ensure compliance 5. By what date will systemic changes be completed? 8/25/2020	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.			

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	a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 kitchen. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 10 residents, staff and visitors in the vicinity of the kitchen by resident room #1 and Therapy. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:05 a.m. to 11:45 a.m. on 08/10/20, one suspended ceiling tile was missing in the kitchen entryway by janitor's closet 2. The entryway was equipped with one pendant sprinkler installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Director acknowledged the missing ceiling tiles in the aforementioned area. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0353	K 353 – Sprinkler Systems-Maintenance and Testing 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. The missing ceiling tile in the kitchen entryway has been replaced. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur?	08/25/2020

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			Maintenance Supervisor or designee will inspect and conduct an audit of all ceiling tiles with the facility to ensure they are in place and functioning properly. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? 1. Maintenance Supervisor or designee will review the results of inspections monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% is not achieved an action plan will be developed to ensure compliance 5. By what date will systemic changes be completed? 8/25/2020	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 8 portable fire extinguishers was inspected at least monthly and	K 0355	K 355 Portable Fire Extinguishers	08/25/2020

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	the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 6 residents, and staff in the vicinity of the boiler room across from resident room #14. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:05 a.m. to 11:45 a.m. on 08/10/20, the portable fire extinguisher located in the boiler room across from resident room #14 had an affixed maintenance tag which did not document a monthly inspection after May 2020. The affixed maintenance stated documented the annual fire extinguisher inspection was conducted by a contractor in May 2020. Based on interview at the time of the observations, the Maintenance Director agreed monthly inspection documentation after May 2020 for the portable		1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. The portable fire extinguisher located in the boiler room across from resident room #14 has been inspected and updated. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Maintenance Supervisor or designee will inspect all portable fire extinguishers on the first Monday of the month. Administrator or designee will audit all portable fire extinguishers by the 10th of each month to ensure they have been inspected and are up to date. 4. How will the corrective action	

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	fire extinguisher was not available for review. 2. Based on observation and interview, the facility failed to ensure 1 of 8 portable fire extinguishers were given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect over 5 staff. Findings include: Based on observations with the Maintenance Director during a tour of the facility on 08/10/20 between 11:05 a.m. and 11:45 a.m., the portable fire extinguisher located in Mechanical Room 1 had a tag on it that was used for over a year. The tag had an annual testing date of May 2019 on it and was last checked monthly on February 2020. Based on interview at the times of observations, the Maintenance Director acknowledged the portable fire extinguisher listed above as being in		be monitored to ensure the alleged deficient practice will not occur Maintenance Supervisor or designee will review the results of audits monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% is not achieved an action plan will be developed to ensure compliance 5. By what date will systemic changes be completed? 8/25/2020	

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	155428	A. BUILDING 01 B. WING	08/10/2020

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	use for approximately 15 months without being subjected to maintenance at intervals of not more than 1 year. These findings were reviewed with the Administrator at the exit conference. 3.1-19(b)			
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 provide documentation of second quarter fire drills and third quarter first shift fire drill in the last 12 months. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents and staff within the facility. Findings include: Based on record review of the "Chosen Healthcare Fire Drill Report" report form with the Maintenance Director & Regional Director on 08/10/20 at 9:48 a.m., documentation of fire drills conducted on the first, second and third	K 0712	K 712 Fire Drills 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. An Annual Fire Drill Schedule was created that shows the month, shift and timeframe fire drills will be conducted in. The Annual Fire Drill Schedule will not be shared outside of the Administrator and Maintenance Director so it will still	08/25/2020

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	shift in the second quarter (April, May, June) 2020 were not available for review. Documentation of a fire drill conducted on the first shift in the third quarter (July, August, September) 2020 was not available for review. Based on interview at the time of record review, the Regional Director acknowledged that documentation of a fire drill conducted on the aforementioned shifts within the most recent twelve month period was not available for review at the time of the survey. She indicated that the facility has had Maintenance staffing issues and turnover. This deficiency was discussed and acknowledged by the facility Administrator at the exit conference. 3.1-19(b) 3.1-51(c)		be random and unannounced to staff. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? An Annual Fire Drill Schedule was created that shows the month, shift and timeframe fire drills will be conducted in. The Annual Fire Drill Schedule will not be shared outside of the Administrator and Maintenance Director so it will still be random and unannounced to staff. Maintenance Supervisor or designee will conduct an audit of all fire drills conducted. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur Maintenance Supervisor or designee will review the results of	

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			inspections monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% is not achieved an action plan will be developed to ensure compliance 5. By what date will systemic changes be completed? 8/25/2020	
K 0911 SS=F Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 mechanical rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts	K 0911	K 911 Electrical Systems – Others 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? No residents were affected by alleged deficient practice. All items have been removed from in front of electrical panel in the Mechanical Room located on the	08/25/2020

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	if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect at least one to ten staff travelling by the mechanical rooms. Findings include: Based on observations on 08/10/20 during tour between 11:05 a.m. to 11:45 a.m. with the Maintenance Director at 11:44 a.m. the Mechanical Room 1 located on the south side of the building by an exit door had flat screen televisions, and table stacked in front of the electrical panels. Based on interview at the time of the observations, Maintenance Director acknowledged the stored items were present and would have to be removed. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		south side of the building. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected by alleged deficient practice. All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? Maintenance Supervisor or designee will conduct an audit of Mechanical Rooms weekly to ensure electrical panel is not blocked. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? 1. Maintenance Supervisor or designee will review the audits monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% is not achieved an action plan will be developed to ensure compliance	

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			5. By what date will systemic changes be completed? 8/25/2020	
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 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 observation, record review and	K 0914	K914 – Electrical Systems –	08/25/2020

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	interview, the facility failed to ensure all nonhospital-grade electrical receptacles in 20 of 20 resident room locations were tested at least annually. 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 is administered, shall be tested at intervals not exceeding 12 months. Additionally, 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). This deficient practice could affect all residents. Findings include: Based on record review on 08/10/20 between 9:30 a.m. and 11:00 a.m. with the Maintenance Director & Regional Director, there was no record of an annual test for each resident room electrical receptacle that was not a hospital-grade receptacle. Based on interview at the time of record review, the Regional Director said she had the inspection form, but it had not been completed, so there was no record or documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met. Based on observations between 11:05 a.m. and 11:45 a.m. during a tour of the facility with the Maintenance Director, there were at least four to six electrical receptacles in each of the		Maintenance & Testing 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? All electrical receptacles will be tested by 8/25/2020 for correct polarity and retention force and results will be documented. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No residents were affected. All outlet receptacles have been tested. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur? The Maintenance Supervisor or designee will inspect plugs monthly and replace accordingly. Maintenance Supervisor will complete inspection form with his findings. Once a new maintenance director has been obtained, will be educated on proper procedure and documentation of preventative maintenance.	

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	resident rooms. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? Maintenance Supervisor or designee will review the results of inspections monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% is not achieved an action plan will be developed to ensure compliance. 5. By what date will systemic changes be completed 8/25/2020	
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			

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	other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure a power strip was not used as a substitute for fixed wiring in 1 of 1 kitchen. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all staff in the kitchen. Findings include: Based on observation on 08/10/20 at 11:06 a.m. during a tour of the facility with the Maintenance Director, there was an ice machine plugged into a power strip in the kitchen next to Janitor's Closet 2. Furthermore, the power strip was laying on a shelving bracket. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the use of the power strip and said he would plug the ice machine into a wall outlet. 2. Based on observation and interview, the facility failed to ensure in 1 of 1 therapy area, flexible cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless	K 0920	K920 – Electrical Equipment – Power Cords & Extensions 1. What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice? Power strips that meet the Medical Grade UL 1363A replaced previously used power strips, where applicable. Residents were educated not to plug anything into the power strips except medical equipment. 2. How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken? No other residents were affected by this practice. Medical Grade UL 1363A power strips have been placed into each resident room. 3. What measures will be put into place or systemic changes will be made to ensure that the alleged	08/25/2020

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	specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 5 residents and staff in therapy area. Findings include: Based on observation with the Maintenance Director on 08/10/20 at 11:11 a.m. one orange 100 foot extension cord was found to be plugged into a power strip in therapy. Also plugged into the power strip were two fans, an air purifier and a lamp. This cord was used to provide power to fans that could not be plugged into fixed wiring outlets. Based on interview at the time of the observation, the Maintenance Director acknowledged the use of the orange extension cord. 3. Based on observation and interview, the facility failed to ensure 1 of 1 mechanical room did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects up to 1 staff only. Findings include: Based on observation with the Maintenance Director on 08/10/20 at 11:44 a.m. Mechanical room 1 had a multi-plug adapter plugged into a wall outlet. This multi-plug adapter was powering a portable drill charger in the vicinity of fuel fired water heaters within the room. Based on		deficient practice does not occur? Maintenance Supervisor or designee will inspect rooms during monthly deep clean to ensure any power strips being utilized are of the appropriate grade and that items were not plugged in that shouldn't be. 4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur Maintenance Supervisor or designee will review the results of inspections monthly by the QAPI committee overseen by the administrator and reviewed by corporate risk management, monthly times six months and annually. If threshold of 100% is not achieved an action plan will be developed to ensure compliance 5. By what date will systemic changes be completed? 8/25/2020	

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	interview at the time of the observation, the Maintenance Director acknowledged the use of the multi-plug adapter, stated that it had been there since before he had started working at the facility, and that he did not know that multi-plug adapters were not allowed to be in use. These deficiencies were discussed and acknowledged by the facility Administrator at the exit conference. 3.1-19(b)			