STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155616	A. BUILDING -- B. WING	02/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEW ALBANY NURSING AND REHABILITATION CENTER	201 E ELM ST NEW ALBANY, IN 47150

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73 which included Complaint Number IN00348293. Complaint Number IN00348293 was substantiated. No deficiencies related to Emergency Preparedness were cited. Survey Date: 02/24/21 Facility Number: 001145 Provider Number: 155616 AIM Number: 200120200 At this Emergency Preparedness survey, New Albany Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a total of 143 licensed beds with 122 certified beds. At the time of the survey, the total census was 59. Quality Review completed on 03/02/21	E 0000		
K 0000 Bldg. 01	An investigation of Complaint Number IN00348293 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Complaint Number IN00348293 was substantiated.	K 0000		

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 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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	Federal/State deficiencies related to the allegation were cited K511, K914, and K920. Federal/State deficiencies unrelated to the allegation were cited at K321, K353, K362, and K363. Survey Date: 02/24/21 Facility Number: 001145 Provider Number: 155616 AIM Number: 200120200 At this complaint investigation, New Albany 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 two story facility with a partial basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus, the facility has smoke detectors hard wired to the nurses call system with battery backup in all resident sleeping rooms. The facility has a total capacity of 143 licensed beds with 122 certified beds and had a total census of 59 at the time of this visit. The entire facility was surveyed due to the lack of a 2 hour fire-rated separation. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/02/21			

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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 hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 4 shower room doors, a hazardous area room door due to the storage of soiled linen and trash carts, was provided with a properly working self closing device on the door.	K 0321	K321 The Self-Closing devise was repaired/replaced. All areas that require Self-Closing	03/26/2021

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	This deficient practice could affect at least 10 residents and staff. Findings include: Based on observation on 02/24/21 between 11:45 a.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the 200 hall (Harbor Unit) shower room contained a double cart of soiled linen and trash each with at least 32 gallon capacity, plus a large yellow soiled linen barrel with at least 32 gallon capacity. The door to this shower room was provided with a self-closing device, however, it was not connected at the time of observation and the door was standing open at least six inches. Based on interview at the time of observation, the Maintenance Director agreed the self closing device attached to the door was not connected at the time of observation and was standing open at least six inches. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		devises will be inspected to ensure there are no other Self-Closing devises that are not working properly. The Maintenance Staff was In-Serviced on 3/4/2021 regarding Hazardous Areas. Maintenance will inspect the facility monthly to ensure all Self-Closing doors are working properly. To ensure compliance, the maintenance person will monitor and document weekly rounds for 2 months and monthly for 4 months. Self-closing devises will be repaired or replaced immediately. Results will be reviewed at the monthly QAPI meeting overseen by the Administrator. If the threshold of 95% is not achieved, action plans will be revised to ensure compliance.	
K 0353 SS=F 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. a) Date sprinkler system last checked _____ b) Who provided system test			

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	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 1. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler systems during 35 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review on 02/24/21 at 3:15 p.m. with the Administrator and Maintenance Director present, there was no documentation available to show the facility's sprinkler system gauges were inspected weekly between 07/01/20 and 02/24/21. In addition, monthly inspection documentation for the sprinkler system control valves for 8 of the most recent 12 month period was also not	K 0353	K353 The Sprinkler system inspection will be documented. Ceiling tiles will be replaced for room 212, 105, and the area outside the elevator on the 2nd floor. Escutcheon ring will be replaced for 13. All Sprinkler Gauge and valve inspections will be completed throughout the entire facility. In addition, all areas of the facility will be inspected for missing or stained ceiling tiles. The Maintenance Staff was In-Serviced on 3/4/2021 regarding sprinkler system inspections. Results of the weekly inspection of the dry system gauges, monthly inspections of the wet system, and monthly inspections of the ceiling tiles and escutcheon rings will be documented on the QAPI a To ensure compliance, the maintenance person will provide gauge and valve inspection ceiling tile replacement, and Escutcheon Rings. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and	03/26/2021

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	available for review. Based on interview at the time of record review, this was acknowledged by the Administrator and Maintenance Director. Based on observation with the Maintenance Director during a tour of the facility at 2:30 p.m. the facility had four gauges at the sprinkler riser. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the ceiling in 3 of 8 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 20 residents and staff. Findings include: Based on observations on 02/24/21 between 11:45 a.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There was a ceiling tile missing in the bathroom of resident room 212. b. There was a ceiling tile missing in the bathroom of resident room 105. c. There was an attic access panel missing in the corridor outside the elevator on the second floor. d. There was an escutcheon ring missing from a sprinkler head in the bathroom of resident room 13. This was acknowledged by the Maintenance Director at the time of observations. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		reported to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised to ensure compliance.	

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	3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Based on observation and interview, the facility failed to ensure corridor walls were constructed with at least a 1/2 hour fire resistance rating in 1 of 9 smoke compartments. This deficient practice could affect at least 6 residents and staff in the Assisted Living unit. Findings include: Based on observations on 02/24/21 between 11:45 p.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, there was a one foot by two foot opening in the drywall below the handrail	K 0362	K362 The opening in the wall between rooms 228 and 230 will be replaced and painted. All areas in the facility have the potential to be affected by openings in the drywall. The Maintenance Staff was In-Serviced on 3/4/2021 regarding opening in the drywall. Maintenance person will inspect	03/26/2021

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	in the AL unit corridor between rooms 228 and 230. The opening exposed wood studs and water lines. Based on interview at the time of observation, the Maintenance Director said the opening in the corridor drywall had been there for as long as he had worked at the facility which was about two months. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		corridor halls for any openings in the drywall. To ensure compliance, the maintenance person will inspect corridor halls weekly for 4 weeks and 1 time monthly for 2 months. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised to ensure compliance.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 4 of 14 resident room corridor doors in the Assisted Living unit were not provided with padlocks on the corridor side of the door to ensure that the doors could be unlocked from inside the resident room. This deficient practice could affect up to 4 residents on the AL unit. Findings include: Based on observations on 02/24/21 between 11:45 a.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. AL unit resident room 225 corridor door had a padlock with hasp equipped on the outside of the door. The padlock was locked independently and not locking the hasp closed. The room was occupied at the time of observation. b. AL unit resident room 226 corridor door had a padlock with hasp equipped on the outside of the	K 0363	K363 The padlocks for rooms 222, 225, 226, and 231 will be removed. All rooms were rooms in Assisted Living, therefor 14 rooms have the potential to be affected. The Maintenance Staff was In-Serviced on 3/4/2021 regarding no padlocks can be installed on the resident room doors. New door locks will be installed on all occupied Assisted Living rooms if residents are out overnight or longer. To ensure compliance, the maintenance person will inspect Assisted Living room doors weekly for 4 weeks and 1 time monthly for 2 months. Will do annual	03/26/2021

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	door. The padlock was locked independently and not locking the hasp closed. The room was occupied at the time of observation. c. AL unit resident room 222 corridor door had a padlock with hasp equipped on the outside of the door. The padlock was locked independently and not locking the hasp closed. The room was unoccupied at the time of observation. d. AL unit resident room 231 corridor door had a padlock with hasp equipped on the outside of the door. The padlock was locked independently and not locking the hasp closed. The room was unoccupied at the time of observation. Based on interview at the time of observations, the Maintenance Director said the padlocks and hasps were provided so the residents could lock their doors when they left their rooms. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		monitoring there after. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported to corporate compliance. If the threshold of 100% is not achieved, action plans will be revised to ensure compliance.	
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 receptacle in 21 of 89 resident rooms, plus 2 resident common areas were protected. 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	K 0511	K511 Cable outlet in room 101 will be replaced, control knob in room 104 and 119 will be replaced, electrical receptacles in rooms 102, 107, 108, 111, 123, 129, 214, 206, 209, 234, 228, 11, 13, 16, and 22 will	03/26/2021

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	against the mounting surface. This deficient practice could affect at least 20 residents. Findings include: Based on observations on 02/24/21 between 11:45 a.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. Room 101 had the cable outlet housing cracked, the electrical receptacle housing by the bed detached and hanging by a cord with the cover cracked and wires exposed. b. Room 104 had the control knob missing from the thermostat. c. Room 102 had a cracked electrical receptacle cover by bed B. d. Room 107 had a cracked electrical receptacle cover exposing loose wires. e. Room 108 had a missing electrical receptacle cover by bed B TV. f. Room 111 had a cracked receptacle cover by the bed. g. Room 119 had a thermostat knob missing. h. Room 123 had an electrical receptacle missing a cover at the entrance right side wall. i. Room 129 had an electrical receptacle broken at the top plug near the bed. j. Harbor Dining Room had a wall AC unit electrical receptacle scorched/burnt as well as one of the plug-in prongs. The AC unit was not plugged in at the time of observation. At the time of observation, the Maintenance Director did cut off a portion of the cord to ensure it could not be plugged back into the scorched/burnt electrical receptacle. The AC unit vent was stuffed with food, paper trash, and other debris. Furthermore, on the other side of the Harbor Dining Room there was a portable AC unit which was not plugged in; however, the AC unit vent was stuffed with food,		be replaced. AC in Harbor Dining Room will be cleaned. AC Electrical receptacle will be repaired/replaced. All outlets in the entire facility will be inspected to ensure that there are none that are missing or cracked. All thermostat control knobs will also be inspected to ensure that they are not damaged or missing. All Cable outlets will be inspected to ensure that there are none that are cracked or missing. The Maintenance Staff was In-Serviced on 3/4/2021 regarding outlet covers and thermostat control knobs. Maintenance person will inspect all electrical outlets and thermostat control knobs to ensure they are not broken/cracked and to makes sure none are missing. Maintenance person will also inspect all AC units to ensure there is no debris inside units. To ensure compliance, the maintenance person will monitor by checking all electrical receptacles and thermostat control knobs monthly for 6 months. Maintenance person will also monitor by checking all AC Units for debris for 6 months. Results will be reviewed at the monthly QAPI meeting overseen by the administrator and reported	

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	paper trash, and other debris. k. Room 216 had a bathroom ceiling light fixture with water and water stains. l. Room 214 had an electrical receptacle missing a cover by bed A. m. Room 206 had two electrical receptacles with cracks by bed A and bed B. n. Room 204 had a thermostat cover displaced and hanging loose. o. Room 203 had a cracked thermostat cover. p. Room 209 had a cracked electrical receptacle by the bed. q. Room 234 had two cracked electrical receptacles near the dressers and the desk. r. Room 228 had a missing electrical receptacle cover near the kitchenette. s. Room 11 had a cracked electrical receptacle cover near bed A. Also, the thermostat cover was missing. t. Room 13 had a cracked electrical receptacle cover between the beds. u. Room 16 had a missing electrical receptacle cover near the bed. v. Room 22 had a cracked electrical receptacle cover near the bed. Based on interview at the time of each observation, the Maintenance Director acknowledged the cracked, damaged, and missing covers for the electrical receptacles and thermostats. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) This federal tag relates to Complaint Number IN00348293		to corporate compliance. If the threshold of 95% is not achieved, action plans will be revised to ensure compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 interview; the facility failed to ensure all nonhospital-grade electrical receptacles in 89 of 89 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	K 0914	K914 The electrical receptacles in the 89 of 89 resident room locations will be inspected visually for physical integrity and tested for correct polarity and retention force and results documented. The deficient practice affects all resident room locations. The Maintenance Staff was	03/26/2021

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	155616	A. BUILDING 01 B. WING	02/24/2021

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	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 02/24/21 at 3:15 p.m. with the Administrator and Maintenance Director present, 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 Maintenance Director said all of the electrical receptacles in resident rooms were not hospital-grade receptacles as far as he knew. The Administrator said there was no record or documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met. Based on observations between 11:45 a.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director there were at least four to six electrical receptacles in each resident room. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) This federal tag relates to Complaint Number IN00348293		In-Serviced on 3/4/2021 on the procedure for inspecting and testing non-hospital grade receptacles at intervals not to exceed 12 months. The electrical receptacle inspection and testing were added to the maintenance schedule. Electrical receptacle inspection ad testing log was obtained. The maintenance person will check the electrical receptacles for physical integrity and note any receptacle replacements/upgrades and ad them to the schedule, and document findings on the inspection testing log, weekly for one month and monthly for 6 months. The audit logs will be reviewed monthly by the QAPI committee. If threshold if 95% is not achieved an action plan will be developed to ensure compliance.	
K 0920 SS=D	NFPA 101 Electrical Equipment - Power Cords and			

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Bldg. 01	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 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 strip was not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, 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 could affect one resident in room 203. Findings include:	K 0920	K920 The Power Strip in room 203 was removed. All resident rooms and common areas were checked for power strips. Power strips in resident rooms that did not meet the requirements if UL 1363 were removed. The Maintenance Staff was In-Serviced on 3/4/2021 on the use of unauthorized power strips in	03/26/2021

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	Based on observation on 02/24/21 between 11:45 a.m. and 3:00 p.m. during a tour of the facility with the Maintenance Director, a TV was plugged into a power strip in Room 203, furthermore, the power strip was hanging and unsupported below the TV. Based on interview at the time of observation, the Maintenance Director agreed a power strip was being used as a substitute for fixed wiring in Room 203. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) This federal tag relates to Complaint Number IN00348293		common areas and resident care rooms. All staff in-serviced on the use of power strips in resident care rooms and common areas. Maintenance person or designee will track the results of weekly inspections and provide results for review at the monthly QAPI committee meeting. If threshold if 95% is not achieved an action plan will be developed to ensure compliance.	