STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155238	A. BUILDING -- B. WING	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
YORKTOWN MANOR	2000 S ANDREWS RD YORKTOWN, IN 47396

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 10/21/24 Facility Number: 000143 Provider Number: 155238 AIM Number: 100283890 At this Emergency Preparedness survey, Yorktown Manor was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 68. Quality Review completed on 10/22/24	E 0000	K000 - By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit this response pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 3, 2024, to the Recertification and State Licensure Life Safety and Emergency Preparedness Survey completed on October 21, 2024. The facility also respectfully requests that our plan of correction be considered for paper review compliance. The facility will submit any evidence as requested to validate compliance.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 10/21/24 Facility Number: 000143 Provider Number: 155238 AIM Number: 100283890	K 0000	K000 - By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit this response pursuant to our regulatory obligations. The facility requests that the plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Bailey	Administrator	11/04/2024

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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	At this Life Safety Code survey, Yorktown Manor 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 V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and has battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 68 at the time of this visit. All areas where residents have customary access were sprinkled except for an open air smoking shed and all areas providing facility services were sprinkled except a detached a metal storage building. Quality Review completed on 10/22/24		correction be considered our allegation of compliance effective November 3, 2024, to the Recertification and State Licensure Life Safety and Emergency Preparedness Survey completed on October 21, 2024. The facility also respectfully requests that our plan of correction be considered for paper review compliance. The facility will submit any evidence as requested to validate compliance.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 43 of 46 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.2.1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published	K 0300	K- 300 Protection Facility conducted audits with all battery-operated smoke detectors to ensure all battery-operated detectors were in accordance with manufacturers' guidance. All smoke detectors not meeting manufacturers' guidance were replaced with new battery-operated smoke detectors.	11/03/2024

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	instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 2:50 p.m. on 10/21/24, manufacturer's documentation affixed to the Kidde Model i9040 battery operated smoke alarm installed on the wall above the corridor door in resident sleeping Room 101, 102, 207, 402 and 412 indicated it was manufactured 05/26/14. Manufacturer's documentation affixed to the Kidde Model i9040 battery operated smoke alarm installed on the wall above the corridor door in resident sleeping Room 311 indicated it was manufactured 07/23/14. The manufacturer's documentation also stated "replacement date is 10 years after installation". Based on interview at the time of the observations, the Maintenance Director stated the facility has the same type of smoke alarm installed in each sleeping room except for three resident sleeping rooms in the 400 Hall which have a newly installed 10 year battery operated smoke detector installed in the room. The Maintenance Director stated all other smoke alarms not installed in those three rooms would have the same or similar manufacture date in 2014. Based on interview at the time of the observations, the Maintenance Director agreed the manufacture date for most all resident sleeping room battery operated smoke alarms installed in the facility was more than ten years old. These findings were reviewed with the		All residents have the potential to be affected from alleged deficient practice, with no actual harm noted. Outdated smoke detectors were removed and replaced with new battery-operated detectors. Maintenance was educated on manufacturers' guidance of battery-operated detectors. IDT team reviewed policy for battery operated smoke detectors. Maintenance educated on policy and manufacturers recommendations. Audit tool in place to assist with monthly tracking. Maintenance will audit monthly to ensure battery operated smoke detectors are in proper working order and dated according to manufacturers' recommendations. All audits will be reviewed, and corrections will be made immediately if required. Audits will be present quarterly with the Quality Assurance Meeting. Monitoring will remain as a continuous going process and added to preventative maintenance program.	

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	Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to maintain electrical receptacles in wall mounted outlet boxes in 1 of 46 resident sleeping rooms in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, at Article 110.12 (B) Integrity of Electrical Equipment and Connections states internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners, abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating. This deficient practice could affect two residents, staff and visitors in resident sleeping Room 104. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 2:50 p.m. on 10/21/24, the wall mounted outlet box for four electrical receptacles where the head of the resident bed nearest the corridor door would be in resident sleeping Room 104 was loose and was not affixed securely to the wall. In addition, the wall mounted outlet box for four electrical receptacles where the head of the resident bed would be nearest the window in resident sleeping Room 104 was caved in and	K 0511	K- 511 Utilities – Gas and Electric Both receptacles in room 104 near the head of bed by window and near head of bed by door were replaced, mounted and secured. A facility audit was conducted for each resident room to ensure all receptacles are mounted, secured, and no cracks noted with proper working. IDT reviewed alleged deficient practice. All residents had potential to be affected with no actual harm. An audit performance tool was created to ensure deficient act does not recur. Maintenance will complete weekly rounds to ensure all receptacles in facility are mounted, secured and without cracks/damage noted. All areas of concern will be corrected immediately. Audits will be reviewed during the Quality Assurance Meeting and all results reviewed. Monitoring will remain as a continuous going process and added to preventative maintenance program.	11/03/2024

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	cracked. Both outlet boxes had electrical power when tested with an Ideal Industries GFCI receptacle testing device. Based on interview at the time of the observations, the Maintenance Director stated staff have submitted a work order for electrical receptacle replacement or repair, he has not yet been able to replace or repair the receptacles and agreed the receptacles needed replacement or repair. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator and the Maintenance Director during record review from 9:40 a.m. to 12:55 p.m. on 10/21/24, first shift fire drills conducted within the most recent twelve month period on 01/29/24, 04/26/24 and 07/26/34 period were conducted at, respectively, 12:40 p.m., 1:22 p.m. and 1:00 p.m. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and agreed the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions.	K 0712	K- 712 Fire Drills Fire Drills will be conducted at unexpected times under varied conditions. During review it was alleged that the day shift fire drills did not meet this specification. Audit was completed for continued shift drills with no further concerns noted. Additional drills were conducted with unexpected times and varied conditions. All residents had potential to be affected with no harm occurrence. IDT team meet and performance expectation reviewed. Maintenance educated on varying fire drills with unexpected times and conditions.	11/03/2024

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	These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Fire drills will be conducted monthly according to K-712 with expected and unexpected times under varying conditions. Maintenance will review previous months' time and conduct drill according to varying time per recommendation of K-712. Fire drill logs will be reviewed with Quality Assurance to make sure all drills are conducted with varying times and conditions. The concerns will be addressed immediately. Monitoring will remain as a continuous going process and added to preventative maintenance program	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review, observation and interview; the facility failed to maintain a complete written record of monthly generator load testing for 5 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 states spark-ignited (Natural Gas) generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all	K 0918	K – 918 Electrical Systems Audit for generator load test was reviewed and noted to have 5 of 12 test was not conducted for 30 minutes for load test. A new performance tool was initiated to ensure each load test will run for 30 minutes and have 15-minute cool down. IDT reviewed policy, education for maintenance and performance tool initiated to ensure deficient practice does not recur. Maintenance will conduct and record 30-minute load test monthly with 15-minute cool down	11/03/2024

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	residents, staff and visitors. Findings include: Based on review of "Weekly/Monthly Generator Log" documentation, Direct Supply TELS Logbook documentation and "Emergency Generator-Monthly Test Log" documentation with the Administrator and the Maintenance Director during record review from 9:40 a.m. to 12:55 p.m. on 10/21/24, monthly load testing documentation for the most recent twelve month period on 10/31/23, 12/30/23 02/14/24, 07/09/24 and 08/29/24 did not indicate the emergency generator was run under load for a minimum of 30 minutes. The "Load Run Time" for each of the five aforementioned monthly load tests, except for the 02/14/24 load test, were documented as "20 minutes". The "Load Run Time" for the 02/14/24 load test was documented as "15 minutes". Based on interview at the time of record review, the Maintenance Director stated he also runs the generator weekly for 30 minutes but agreed the weekly generator run does not transfer load to the emergency generator and agreed documentation for the aforementioned five monthly load tests did not indicate the emergency generator was run under load for a minimum of 30 minutes. Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 2:50 p.m. on 10/21/24, the facility has one natural gas fired emergency generator located outside the building on the east side of the property. Manufacturer's documentation affixed to the generator indicated it was rated at 30 kW. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference.		according to regulations. Audits will be reviewed with concerns corrected immediately. Performance tool will be reviewed with Quality Assurance. Monitoring will remain as a continuous going process and added to preventative maintenance program	

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K 0920 SS=E Bldg. 01	3.1-19(b) NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 3 of 3 extension cords including power strips were 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 6 residents, staff and visitors. Findings include: Based on observations with the Maintenance	K 0920	K-920 Electrical Equipment – Power Cords and Extension Cords Maintenance conducted an audit of all room to ensure code approved power strips were secured, and no medical equipment was plugged into unit. Power strip in room 305 was removed and resident bed was directly plugged into wall unit. Room 110 and 207 power strips were adjusted to 7 ft in patient care vicinity. Facility placed order for new Tripp-Lite medical grade UL rated power strips and will replace immediately upon arrival. See Attached IDT reviewed code; maintenance educated. Performance tool initiated to ensure deficient practice does not recur. Maintenance will use performance audit tool to conduct monthly audits to ensure all power strips are approved medical grade and no medical equipment is connected to power strip. Concerns will be corrected immediately. All findings will be presented with the Quality Assurance meeting. Monitoring will remain as a continuous going	11/04/2024

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	Director during a tour of the facility from 1:10 p.m. to 2:50 p.m. on 10/21/24, the following was noted: a. a television, a toy aquarium and a cell phone charging cable were plugged into a power strip affixed to a chest of drawers six feet from the resident bed nearest the window in resident sleeping Room 110. b. a clock and two televisions were plugged into a power strip affixed to a chest of drawers five feet from the resident bed nearest the window in resident sleeping room 207. c. the resident bed, a lamp, a radio and a plug in light were plugged into a power strip affixed to a chest of drawers two feet from the resident bed nearest the corridor door in resident sleeping Room 305. Each of the three power strips had labeling identifying it as a "Yellow Jacket" power strip but the UL listing of each of the three power strips could not be determined. Packaging for the power strips in the maintenance office did not identify the UL listing of the "Yellow Jacket" power strips. Based on interview at the time of the observations, the Maintenance Director agreed power strips were being used in the patient care vicinity for PCREE and non-PCREE and were also being used as a substitute for fixed in the aforementioned three resident sleeping rooms. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		process and added to preventative maintenance program.	