STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING -- B. WING	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 01/19/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/01/23 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this PSR survey to the Emergency Preparedness survey, Hooverwood was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 155 certified beds. At the time of the survey, the census was 138. Quality Review completed on 03/02/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 3/27/2023	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Administrator	03/18/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in			

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	155001	A. BUILDING -- B. WING	03/01/2023

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	this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012.			

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	155001	A. BUILDING -- B. WING	03/01/2023

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	(x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator under load" documentation dated 01/31/23 with the Director of Operations, the Director of Nursing (DON) and the Director of Maintenance (DOM) during record review from 9:10 a.m. to 10:00 a.m. on 03/01/23, the following was noted: a. monthly load testing documentation for the facility's diesel fuel fired emergency generator was incomplete. The "cool down" time for monthly load testing was not recorded and was not available for review. In addition, the amperage and volts achieved for the 01/31/23 monthly load test was also not recorded and was not available for review. Based on interview at the time of record review, the DOM stated the cool down time is 10 minutes, the emergency generator is a three-phase generator, the amperage and voltage during the test are used to calculate the load percent achieved for monthly load testing and	E 0041	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · On 3/2/23 The emergency generator was been inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Evapar, completed the emergency generator load test on 3/2/23 according to the Health Care Facilities Code, NFPA 110, and Life Safety Code	03/27/2023

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	155001	A. BUILDING -- B. WING	03/01/2023

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	agreed documentation of the cool down time, amperage and voltage for monthly load testing was not available for review. b. emergency generator testing documentation indicated emergency generator load testing does not achieve 30% of the name plate rating. Based on interview at the time of record review, the DOM agreed emergency generator load testing does not achieve a minimum load of 30% of the name plate rating and provided documentation from the emergency generator inspection contractor stating the contractor "attempted to complete the required load bank...on 02/16/23 but was unable to complete it due to mechanical issues with our equipment" and "we will return to complete this requirement at our earliest opportunity upon equipment repair". c. thirty-six-month period emergency generator testing documentation for four continuous hours for the facility's diesel fired emergency generator was not available for review. Based on interview at the time of record review, the DOM agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review and provided documentation from the emergency generator inspection contractor stating the contractor "attempted to complete the required load bank...on 02/16/23 but was unable to complete it due to mechanical issues with our equipment" and "we will return to complete this requirement at our earliest opportunity upon equipment repair". These findings were reviewed with the Director of Operations, the DON, and the DOM. This deficiency was cited on 01/19/23. The facility failed to implement a systemic plan of correction		· The emergency power will be tested weekly and documented according to LSC standards · A Maintenance audit tool, ensuring emergency power, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the emergency power system has been tested according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, for The emergency power system, to ensure it has been tested according to LSC standards, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action.	

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	to prevent recurrence.			
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/19/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/01/23 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this PSR survey, Hooverwood 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). Building 01 was surveyed using Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 01 consists of the memory care wing which is one story, the former kitchen, the basement and the former dining room on the first floor which is now a special events room. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 155 and had a census of 138 at the time of this survey.	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 3/27/2023	

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	155001	A. BUILDING 01 B. WING	03/01/2023

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	All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 03/02/23			
K 0000 Bldg. 02	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 01/19/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/01/23 Facility Number: 000001 Provider Number: 155001 AIM Number: 100275310 At this PSR survey, Hooverwood 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). Building 02 and Building 03 were surveyed using Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This two story facility with a basement consists of three portions of one building which was determined to be of Type II (111) construction and was fully sprinklered. Building 02 consists of the 2017 general renovation of all first and second floor resident sleeping room areas not in the memory care wing and the addition of resident sleeping rooms 1238, 1239, 1240 and 1241 on the	K 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 3/27/2023	

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	155001	A. BUILDING 02 B. WING	03/01/2023

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HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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	first floor and resident sleeping rooms 2238, 2239, 2240 and 2241 on the second floor in 2018. Building 03 consists of the renovated first floor main entrance lobby, administrative support offices, conference room, gift shop and beauty shop. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 155 and had a census of 138 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. The facility has no detached buildings providing facility services. Quality Review completed on 03/02/23			
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review, observation, and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code.	K 0345	**What corrective action(s) will be accomplished for those residents found to have been** · The Fire alarm system is in working order according to LSC requirements. Parts have been ordered to repair the “trouble	03/27/2023

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	NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Director of Nursing (DON) and the Director of Maintenance (DOM) at 10:09 a.m. on 03/01/23, the fire alarm system remote control panel at the 1B nurse's station was in the trouble mode. Based on interview at the time of record review, the DOM said the main fire alarm system control panel has been in the trouble mode for at least a couple months. The DOM stated the problem is the control board for the main fire alarm system panel and thinks the battery charging system for the fire alarm system control panel batteries is not charging the batteries continuously. The DOM stated they had a service call in to a fire alarm system inspection contractor when the problem was initially noted and provided e-mail documentation to the surveyor from the contractor dated 01/12/23 stating "I wanted to follow up with you about the services we completed at Hooverwood. My tech's notes stated that you were going to install a UPS for both panels at your site. Once that is done, my tech said that we would be able to come in with 2 new perf boards for your panels. He said this should most likely fix it, but if not, it is a deeper issue. Please let me know if you have completed the UPS and if you would like to move forward with the 2 perf boards". The DOM stated the facility has ordered parts for repairs but is awaiting the parts to complete the repairs. The fire alarm system was activated at 10:14 a.m. on 03/01/23 by using a manual fire alarm box at the 1B nurse's station.		mode" light. Repairs are scheduled for 3/20/23 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · A Maintenance audit tool will be completed monthly, to ensure the fire alarm system is in working order according to LSC requirements · A Maintenance audit tool, ensuring the fire alarm system, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the emergency power system has been tested according to LSC standards · **How the corrective action(s)**	

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	This finding was reviewed with the Director of Operations, the DON, and the DOM. 3.1-19(b)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool will be completed monthly, to ensure the fire alarm system is in working order according to LSC requirements and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	
K 0918 SS=F Bldg. 02	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

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	automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5-minute cool down period after a load test for 1 of 12 months. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.4.5(4) requires a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator under load" documentation dated 01/31/23 with the Director of Operations, the Director of Nursing (DON) and the Director of Maintenance (DOM) during record review from 9:10 a.m. to 10:00 a.m. on 03/01/23, monthly load	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · On 3/2/23 The emergency generator was been inspected, tested according to maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · No residents were affected by the alleged deficient practice. · All residents, visitors, staff have the potential to be affected by the alleged deficient practice	03/27/2023

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	testing documentation for the facility's diesel fuel fired emergency generator was incomplete. The "cool down" time for monthly load testing was not recorded and was not available for review. In addition, the amperage and volts achieved for the 01/31/23 monthly load test was also not recorded and was not available for review. Based on interview at the time of record review, the DOM stated the cool down time is 10 minutes, the emergency generator is a three-phase generator, the amperage and voltage during the test are used to calculate the load percent achieved for monthly load testing and agreed documentation of the cool down time, amperage and voltage for monthly load testing was not available for review. This finding was reviewed with the Director of Operations, the DON, and the DOM. This deficiency was cited on 01/19/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Evapar, completed the emergency generator load test on 3/2/23 according to the Health Care Facilities Code, NFPA 110, and Life Safety Code · The emergency power will be tested weekly and documented according to LSC standards · A Maintenance audit tool, ensuring emergency power, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee · Administrator/designee to verify documentation is in TELS of the emergency power system has been tested according to LSC standards **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · A Maintenance audit tool, for The emergency power system, to ensure it has been tested according to LSC standards, will be completed monthly for one year with results reported to the Quality Assurance Performance Improvement (QAPI) Committee overseen by the Administrator. If	

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	155001	A. BUILDING 02 B. WING	03/01/2023

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	installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator under load" documentation dated 01/31/23 with the Director of Operations, the Director of Nursing (DON) and the Director of Maintenance (DOM) during record review from 9:10 a.m. to 10:00 a.m. on 03/01/23, emergency generator testing documentation indicated emergency generator load testing does not achieve 30% of the name plate rating. Based on interview at the time of record review, the DOM agreed emergency generator load testing does not achieve a minimum load of 30% of the name plate rating and provided documentation from the emergency generator inspection contractor stating the contractor "attempted to complete the required load bank...on 02/16/23 but was unable to complete it due to mechanical issues with our equipment" and "we will return to complete this requirement at our earliest opportunity upon equipment repair". This finding was reviewed with the Director of Operations, the DON, and the DOM. This deficiency was cited on 01/19/23. The facility		a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. Any non compliance with staff will result in staff education and up to disciplinary action.	

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	failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b) 3. Based on record review and interview, the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Director of Operations, the Director of Nursing (DON) and the Director of Maintenance (DOM) from 9:10 a.m. to 10:00 a.m. on 03/01/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the facility's diesel fired emergency generator was not available for review. Based on interview at the time of record review, the DOM agreed documentation of supplemental			

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	load testing for four hours within the most recent three year period was not available for review and provided documentation from the emergency generator inspection contractor stating the contractor "attempted to complete the required load bank...on 02/16/23 but was unable to complete it due to mechanical issues with our equipment" and "we will return to complete this requirement at our earliest opportunity upon equipment repair". . This finding was reviewed with the Director of Operations, the DON, and the DOM. This deficiency was cited on 01/19/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)			
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used			

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	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 all lamps containing electrical receptacles in the facility in the patient care vicinity in resident sleeping rooms 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 over	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The CPAP in Room 2131 has been plugged into an appropriate receptacle · Plug covers have been super glued over the outlet plugs of the lamps with receptacles in them **How other residents having the potential to be affected by the same deficient practice will be identified and who corrective action(s) will be taken?** · All residents, visitors, staff have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · The Maintenance Director/designee will monitor the facility to ensure medical equipment is plugged into an appropriate receptacle and plug	03/27/2023

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	90 residents, staff, and visitors. Findings include: Based on observations with the Director of Nursing (DON) and the Director of Maintenance (DOM) at 10:26 a.m. on 03/01/23, the portable lamp on the lamp stand by the resident bed in the patient care vicinity in Room 2131 had two electrical receptacles installed in the base of the lamp stand. A CPAP machine was on the lamp stand but it was not plugged into a receptacle on the lamp stand. The electrical cord for the CPAP machine did not have enough length to plug into a wall mounted receptacle. Based on interview at the time of the observations, the DON and the DOM stated about 60% of the resident sleeping rooms in the facility have the same type of lamp with receptacles installed in the base of the lamp which are used in the resident sleeping rooms. The estimate of 60% of the resident sleeping rooms would affect about 93 residents per the DON. The UL listing of the receptacles in the lamp stands could not be determined. Based on interview at the time of the observations, the DON and the DOM agreed the lamp stand receptacles were being used as a substitute for fixed wiring including in the patient care vicinity. This finding was reviewed with the Director of Operations, the DON, and the DOM. This deficiency was cited on 01/19/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		covers are glued over the outlet plugs of the lamps · A visual inspection by the Maintenance Director/designee has been completed to ensure medical equipment is plugged into an appropriate receptacle and plug covers are glued over the outlet plugs of the lamps · Staff will be inserviced by the Clinical Educator/designee on medical equipment being plugged into appropriate receptacles, per LSC requirements · The Maintenance Supervisor/designee will make environmental rounds daily to ensure medical equipment is being plugged into appropriate receptacles and plug covers are glued over the outlet plugs of the lamps **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** · A Maintenance audit tool will be completed monthly, to ensure medical equipment being plugged into appropriate receptacles and the Administrator will monitor the facility to ensure continued compliance with power cords and extension cord requirements, for 6 months with results reported to the Quality	

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			Assurance Performance Improvement (QAPI) Committee overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action	