STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155830	A. BUILDING -- B. WING	03/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARRISON'S CROSSING HEALTH CAMPUS	395 8TH AVENUE TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/10/25 Facility Number: 013335 Provider Number: 155830 AIM Number: 201290670 At this Emergency Preparedness survey, Harrison's Crossing Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 72 certified beds and had a census of 50 at the time of this visit. Quality Review completed on 03/14/25	E 0000	The submission of this plan of correction does not indicate an admission by Harrison's Crossing Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Harrison's Crossing Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by 4/4/2025	
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: 03/10/25	K 0000	The submission of this plan of correction does not indicate an admission by Harrison's Crossing Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sean Medsker	Executive Director	03/28/2025

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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	Facility Number: 013335 Provider Number: 155830 AIM Number: 201290670 At this Life Safety Code survey, Harrison's Crossing Health Campus was found not in compliance with Requirements for Participation in Medicare, 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 facility was located on the first floor of a two story building 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, spaces open to the corridors, and all resident rooms. The entire first floor of the facility, including the Legacy Lane-Assisted Living unit was surveyed due to the lack of a 2 hour fire-rated separation. The facility has a capacity of 72 certified beds and had a census of 50 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except a detached maintenance garage used for the storage of maintenance equipment. Quality Review completed on 03/14/25		the living environment provided to the residents of Harrison's Crossing Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. Corrections to be completed by 4/4/2025	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of 9 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1.1	K 0222	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice could have	04/04/2025

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	Delayed-Egress Locking Systems allows approved, listed, delayed-egress locks shall be permitted to be installed on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (1) The door leaves shall unlock in the direction of egress upon activation of one of the following: (a) Approved, supervised automatic sprinkler system installed in accordance with Section 9.7 (b) Not more than one heat detector of an approved, supervised automatic fire detections system in accordance with section 9.6 (c) Not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6 (2) The door leaves shall unlock in the direction of egress upon loss of power controlling the lock or locking mechanism. (3) An irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.		affected 5 Residents and staff in the Therapy gym. **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No Residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not reoccur:** The Director of Plant Operations has contacted the vendor to repair the audible signal on the Therapy Room egress door. **4 Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly egress door inspection audit. The Director of Plant Operations and/or Designee will perform the observation audits	

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	(4) A readily visible, durable sign in letters not less than 1 in. (25mm) high and at least 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". (5) The egress side of the doors equipped with delayed-egress locks shall be provided with emergency lighting in accordance with 7.9. This deficient practice could affect five residents and staff in the Physical Therapy. Findings include: Based on observations made on 03/10/25 with the Executive Director, Facilities Management Support and Director of Plant Operations during a tour of the facility at 1:55 p.m., the physical therapy exit door was provided with a delayed egress lock with the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. When the delayed egress was tested, there was not an audible signal in the vicinity of the door, however the irreversible process to release the lock did work properly. Based on interview at the time of observation, the Executive Director confirmed an audible signal was not heard when the delayed egress was initiated at the exit door in therapy. This finding was discussed with the Executive Director, Facilities Management Support and Director of Plant Operations at the exit conference. 3.1-19(b)		three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	
K 0225 SS=E	NFPA 101 Stairways and Smokeproof Enclosures			

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Bldg. 01	Based on observation and interview, the facility failed to ensure items stored in 1 of 3 interior fire escape stairways would not interfere with egress. LSC 7.2.2.5.3.1 states open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect second floor assisted living residents, staff and visitors using the center exit stairwell. Findings include: Based on observations and interview during a tour of the facility with the Executive Director, Facilities Management Support and Director of Plant Operations on 03/10/25 at 2:20 p.m., the center exit stairwell was marked as a facility exit. A plastic fold up table and 10 decorative cushions were being stored in the exit stairwell. This finding was confirmed by the Executive Director and Director of Plant Operations at the time of observation and again at the exit conference with the Executive Director, Facilities Management Support and Director of Plant Operations present. 3.1-19(b)	K 0225	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice could have affected second floor AL Residents and staff using the center stairwell. **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No Residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice does not recur:** The Executive Director immediately removed the tables and cushions. ED and DPO checked all other stairwells to ensure no other items were stored in exit stairwells. **4 Corrective Actions that will be monitored to ensure the**	04/04/2025

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			alleged will not re occur: The Director of Plant Operations and/or Designee developed a weekly exit stairwell audit. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Based on observation and interview, the facility failed to ensure all battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect staff.	K 0291	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice could have affected staff. **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No Residents, staff or visitors	04/04/2025

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	Findings include: Based on observation with the Director of Plant Operations, Executive Director and Facilities Management Support at 1:40 p.m. on 03/10/25, the battery operated emergency light inside the generator housing failed to function when its respective test button was pushed five times. Based on interview at the time of observation, the Executive Director confirmed the battery operated light failed to function when its respective test button was pushed. This finding was reviewed with the Executive Director, Facilities Management Support and Director of Plant Operations at the exit conference. 3.1-19(b)		were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice does not recur:** The Director of Plant Operations replaced the battery – operated light and battery that was located on the inside of the generator housing. The Director of Plant Operations was educated by the Executive Director on Emergency Lighting, Emergency Lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 **4 Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly Emergency Lighting audit. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order	

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			to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	
K 0311 SS=F Bldg. 01	NFPA 101 Vertical Openings - Enclosure Based on observation and interview, the facility failed to ensure 1 of 1 window and frame met the proper requirements for window glazing and frame fire resistance in a vertical open space in accordance with LSC 8.3.3. Section 8.3.3.12 states new fire protection-rated glazing shall be marked in accordance with Table 8.3.3.12 and Table 8.3.4.2, and such marking shall be permanently affixed. 8.3.3.6 Glazing in fire window assemblies, other than in existing fire window installations of wired glass and other fire-rated glazing material, shall be of a design that has been tested to meet the conditions of acceptance of NFPA 257or ANSI/UL 9. Fire protection-rated glazing in fire door assemblies, other than in existing fire-rated door assemblies, shall be of a design that has been tested to meet the conditions of acceptance of NFPA252, ANSI/UL 10B, or 10C. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interview with the Executive Director, Facilities Management Support and Director of Plant Operations on 03/10/25 during a tour of the facility between 12:51	K 0311	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice could have affected all Residents, Staff and Visitors. **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No Residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice**	04/04/2025

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	p.m. and 3:00 p.m., the second floor contained a window in the assisted living seating area which overlooked the first-floor atrium entry area, which was consistent with other corridor windows in the facility that were aluminum frame construction. The window and frame lacked an identifier or marking other than 'Tempered', and it was unknown if the window was provided with a fire-rated glazing material or if the aluminum frame met the fire resistance requirements for a vertical opening. Based on interview at the time of observation, Facilities Management Support said he thought the frame was aluminum and the magnet on his iPad cover didn't magnetize to the frame when tested, and agreed the window and frame was not marked with a fire-rated identifier. This finding was reviewed with the Executive Director, Facilities Management Support and Director of Plant Operations at the exit conference. 3.1-19(b)		**does not recur:** Trilogy Support and the Director of Plant Operations have contacted the appropriate vendors to replace the window with a window and frame that meets the proper requirements for window glazing and frame fire resistance in a vertical open space in accordance with LSC 8.3.3. **4 Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee will ensure that the new assembly is compliant with Section 8.3.3.12 of the LSC which states that new fire protection-rated glazing shall be marked in accordance with Table 8.3.3.12 and Table 8.3.4.2, and such marking shall be permanently affixed.	
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 4 of over 10 hazardous areas such as fuel-fired heater rooms and laundry rooms were separated from other spaces by smoke resistant	K 0321	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:**	04/04/2025

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	partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Executive Director, Facilities Management Support and Director of Plant Operations during a tour of the facility from 12:51 p.m. to 3:00 p.m. on 03/10/25, the corridor door to the soiled side of the laundry room was equipped with a self closing device and latching hardware but the door failed to fully self close and latch into the door frame when tested to close multiple times. In addition, at 1:10 p.m. the corridor door labeled A138 across from resident room 206 was to a room containing a fuel fired furnace, which was equipped with a self closing device and latching hardware but the door failed to latch into the door frame when tested. The latch on the door was taped over to hold the latch in the door, as well as the receiving plate on the frame was completely taped over. The Director of Plant Operations removed the tape at the time of observation and the door positively latched into the frame when tested. The following rooms containing fuel fired furnaces had the door latches and receiving plates taped over as well: furnace room across from 100 Nurse station, furnace room across from resident room 103. Based on interview at the time of the observations, the Director of Plant Operations agreed the aforementioned hazardous areas were not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director, Facilities Management Support and Director of Plant Operations during the exit conference.		This deficient practice could have affected all Residents, Staff and Visitors. **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No Residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice does not recur:** The Director of Plant Operations removed the tape immediately on the three doors in the hallways. The Director of Plant Operations has fixed the door leading to soiled laundry so that the self-closing device latches properly. **4 Corrective Actions that will be monitored to ensure the alleged will not re occur:**	

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	3.1-19(b)		The Director of Plant Operations and/or Designee developed a weekly door latching audit. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. The Director of Plant Operations and/or Designee will educate all visiting vendors on our policy on self-closing and latching doors. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to ensure 1 of 1 kitchen range hood fire suppression systems was maintained in accordance with NFPA 96. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 Edition, Section 10.2.6 states automatic fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and the following standards where applicable: (1) NFPA 12 (2) NFPA 13 (3) NFPA 17	K 0324	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice could have affected 5 kitchen staff. **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:**	04/04/2025

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	(4) NFPA 17A NFPA 17A, Section 4.3.1.5 states all discharge nozzles shall be provided with caps or other suitable devices to prevent the entrance of grease vapors, moisture, or other foreign materials. Section 4.3.1.6 states the protection device shall blow out upon agent discharge. This deficient practice could affect over five staff in the kitchen. Findings include: Based on observations with the Executive Director, Facilities Management Support and Director of Plant Operations during a tour of the facility from 12:51 p.m. to 3:00 p.m. on 03/10/25, one of six discharge nozzle caps for the facility's kitchen hood fire suppression systems were not in place as it was dangling. Based on interview at the time of the observation, the Director of Plant Operations agreed the nozzle cap was not in place for the kitchen range hood fire suppression system. This finding was reviewed with the Executive Director, Facilities Management Support and Director of Plant Operations during the exit conference. 3.1-19(b)		No Residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice does not recur:** The Director of Plant Operations replaced nozzle cap on the one nozzle that was not in place correctly. **4 Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly Kitchen Range Hood audit. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	

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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 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Physical Therapy rooms. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and causes the sprinkler to operate at a specified temperature. Section 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 Physical Therapy room by the dining room. Findings include: Based on observation with the Executive Director, Facilities Management Support and Director of Plant Operations during a tour of the facility at 1:47 p.m. on 03/10/25, two suspended ceiling tiles were missing in the Physical Therapy room, which exposed the ceiling above. The room was equipped with pendant sprinklers installed on the suspended ceiling. Based on interview at the time of the observation, the Executive Director confirmed the missing ceiling tiles in Physical Therapy, adding there was a recent ceiling leak is why the tiles are missing. This finding was reviewed with the Executive	K 0353	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice could have affected 10 Residents, Staff and Visitors in the Therapy Gym and two Staff in Laundry. **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No Residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice does not recur:** The Director of Plant Operations	04/04/2025

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	155830	A. BUILDING 01 B. WING	03/10/2025

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	Director, Facilities Management Support and Director of Plant Operations at the exit conference. 2. Based on observation, and interview; the facility failed to ensure all sprinkler heads in the Laundry room covered with lint were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect two staff in the Laundry room. Findings include: Based on observation with the Executive Director, Facilities Management Support and Director of Plant Operations during a tour of the facility at 1:32 p.m. on 03/10/25, the sprinkler located above the washers in the Laundry room was covered with lint. Based on interview at the time of		replaced the two ceiling tiles in the Therapy gym. The Director of Plant Ops cleaned the sprinkler head in laundry in accordance with the code using a vacuum that did not touch the sprinkler. Director of Plant operations was educated on the following: 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. **4 Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly Sprinkler System audit. The Director of Plant Operations and/or Designee will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance	

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	observation, the Director of Plant Operations agreed the aforementioned automatic sprinkler was loaded with lint. This finding was reviewed with the Executive Director, Facilities Management Support and Director of Plant Operations at the exit conference. 3.1-19(b)		may result in cessation of the monitoring plan based on review.	
K 0781 SS=F Bldg. 01	NFPA 101 Portable Space Heaters Based on record review and interview, the facility's policy addressing the use of portable space heaters in the facility did not prohibit the use of portable space heaters in resident areas in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.7.8. Section 19.7.8 states Portable space heating devices shall be prohibited in all health care occupancies, unless both of the following criteria are met: (1) Such devices are only used in nonsleeping staff and employee areas (2) The heating elements of such devices do not exceed 212F (100C). This deficiency could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director and Facilities Management Support on 03/10/25 at 12:50 p.m., review of the document titled "Portable Heaters Policy Life Safety" with a revised date of 08/28/2019, revealed that the wording was not clear that portable space heaters were only allowed in non-sleeping employee areas. The policy stated that portable space heaters are permitted in non-patient care or non-patient treatment areas. The policy stated patient care areas were loosely defined as a smoke	K 0781	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice could have affected all Resident, Staff and Visitors. **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No Residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice**	04/04/2025

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	compartment which contains patient care or treatment activities. This wording could be misinterpreted and portable space heaters could be used in areas other than non-sleeping staff and employee areas. Based on interview at the time of record review, the Executive Director agreed the space heater policy did not clearly state that portable space heaters were only allowed in non-sleeping employee areas. This finding was confirmed by the Executive Director and the Director of Plant Services at the time of discovery. 3.1-19(b)		**does not recur:** The Portable Space Heater policy has been updated to reflect that space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit. **4 Corrective Actions that will be monitored to ensure the alleged will not reoccur:** The new Portable Space Heater policy will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure a multi plug adapter was not used as a substitute for fixed wiring in the facility. 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,	K 0920	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice had the	04/04/2025

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	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 at least 10 residents and five staff in one smoke compartment. Findings include: Based on observation on 03/10/25 at 1:04 p.m. during a tour of the facility with the Executive Director, Facilities Management Support and Director of Plant Operations, there was an electronic picture frame and other personal electrical equipment plugged into a multi plug adapter in resident room 218. Based on interview at the time of observation, the Executive Director confirmed the use of the multi plug adapter in resident room 218. This finding was reviewed with the Executive Director, Facilities Management Support and Director of Plant Operations during the exit conference. 3.1-19(b)		potential to affect 10 Residents and five staff in one smoke compartment **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice. **3 Corrective Actions including Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur:** The Director of Plant Operations immediately removed the multi-plug adapter from room 218. The Executive Director and/or designee provided re-education to the Director of Plant Operations on Electrical Equipment - Power Cords and Extension CFR(s): NFPA 101 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	

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			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 **4 Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly audit that includes monitoring the usage of any power strips or multi plug adapters in Resident rooms. The Director of Plant Operations and/or Designee	

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			will perform the observation audits three times a week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels	K 0921	**1 Corrective Action for the resident(s) affected by the alleged deficient practice:** This deficient practice could have affected all Residents **2 Corrective Actions taken for those resident(s) having the potential to be affected by the alleged deficient practice:** No Residents, staff or visitors were identified or reported any findings suggestive of having been affected by the deficient practice.	04/04/2025

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	and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. Findings include: Based on records review with Facilities Management Support (FMS) and Director of Plant Operations on 03/10/25 between 9:30 a.m. and 12:51 p.m., incomplete documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Facilities Management Support stated he was recently trained on the requirement and started the testing on 03/05/25 and got one wing completed. The remainder of the facility has not been tested as of this survey. Observation during the building tour revealed that the facility provided electric beds for all residents. This finding was reviewed with the Executive Director, Facilities Management Support and Director of Plant Operations at the exit conference. 3.1-19(b)		**3 Corrective Actions including Measures/Systemic changes put in place to ensure the alleged deficient practice does not recur:** The Director of Plant Operations has completed inspections for all Patient Care Related Electrical Equipment (PCREE) in accordance with 10.3.5.4 or 10.3.6, which states that all PCREE is tested prior to service or after any repair or modification. **4 Corrective Actions that will be monitored to ensure the alleged will not re occur:** The Director of Plant Operations and/or Designee developed a weekly PCREE audit of PCREE documentation. The Director of Plant Operations and/or Designee will perform the observation audits one time per week, for three months. Findings will be reviewed during the quarterly QA Committee in order to determine the frequency for ongoing monitoring. Findings suggestive of 100% compliance may result in cessation of the monitoring plan based on review.	

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