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	08/18/2022

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

(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: 08/18/22 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 58. Quality Review completed on 08/23/22	E 0000	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 these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 2, 2022, to the Life Safety Recertification and Emergency Preparedness Survey completed on August 18, 2022. It is the practice of this facility to assure that resident needs are met, and a safe living environment. The correction action taken for all residents with the potential for harm, with no actual harm occurred to be affected by the deficient practice include:	
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: 08/18/22 Facility Number: 000143 Provider Number: 155238	K 0000	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 these responses pursuant to our regulatory obligations. The facility	

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

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

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	AIM Number: 100283890 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 battery-operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 100 and had a census of 58 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except detached a metal storage building. Quality Review completed on 08/23/22		requests that the plan of correction be considered our allegation of compliance effective September 2, 2022, to the Life Safety Recertification and Emergency Preparedness Survey completed on August 18, 2022. It is the practice of this facility to assure that resident needs are met, and a safe living environment. The correction action taken for all residents with the potential for harm, with no actual harm occurred to be affected by the deficient practice include:	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be			

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through the facilities exits was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect everyone if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., the following exit doors, marked as facility exits, were magnetically locked and could be opened by entering a four-digit code but the code was not posted at the exits. a) Main facility front door b) Employee Entrance/Exit c) 300 Hall Exit d) 400 Hall Exit	K 0222	K- 222 Egress Doors All doors observed during survey and additional facility doors were evaluated and 4-digit code was typed for clear display and posted to each control box located at exit. Maintenance has included weekly monitoring log to ensure code remains visible and in sight. Any concerns will be addressed immediately and reviewed with QA. See attachment A Main hall double exit doors, Maintenance completed full assessment of door, added grease to hinges and tightened door seal. Maintenance will monitor weekly to ensure grease and seal tighten continue to open door with ease. Concerns will be addressed immediately, and all action will be reviewed with QA. Quote and approval to replace and install door. Order has been placed. See Attachment A	09/02/2022

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	This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 2. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., the Main Hall Double Door exit doors near the staff lounge, would not open easily on the first try when tested. The Surveyor, then the Maintenance Director tried to open the door, and the Maintenance Director was able, after several tries and considerable effort to open the double exit doors. The Maintenance Director stated that other exit door in the facility had recently been replaced and that there was intention to soon replace the aforementioned double exit door set. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING			

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	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 1 courtyard doors to the outside of the facility in the activities area were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 10 residents in the activities. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., in the activities area the door to the outside courtyard was not an exit door and the door was not posted with a "NO EXIT" sign. Based on interview at the time of the observations, the Director of Maintenance stated the courtyard is not an exit to the public way and acknowledged the courtyard door did not have a "NO EXIT" sign posted. The Administrated commented that the door once had a sign and she was not sure what had happened to the required signage. This finding was acknowledged by the	K 0293	K- 293 Exit signage Activity door to courtyard was corrected with a NO EXIT signage. All other non-exit and exit areas were reviewed to ensure all proper signage was present with no further concerns noted. Maintenance with monitor monthly to ensure all proper signage is in place and visible. Any concerns will be addressed immediately, and all findings reviewed with QA. See Attachment B	09/02/2022

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	Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)			

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	g. Laboratories (if classified as Severe Hazard - see K322) 1. Based on observation and interview, the facility failed to ensure 1 of 1 Hazardous storage room corridor doors in the kitchen were not obstructed from closing. This deficient practice could affect 6 kitchen staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., the Dry storage room in the kitchen contained over 50 boxes and was greater than 50 square feet making this a hazardous area. The door to the dry storage room was self-closing but the door was propped open with a sugar bin. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, were larger than 50 square feet, and the corridor door to the room was propped open. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 2. Based on observation and interview, the facility failed to ensure 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 6 staff in the kitchen area and 3 staff and residents in the Consulting area. Findings include:	K 0321	K-321 Hazardous Areas – Enclosure Closure to kitchen dry storage area was changed and closing correctly. Consultant storage for PPE, closure was installed, and door is self-closing and latching secured. Maintenance will monitor monthly to ensure that doors are free from obstruction and closing as intended. Any concerns will be corrected immediately and reviewed during QA. Education for all staff to ensure double kitchen doors are closed correctly when entering/exiting kitchen. Staff education included knowledge that double door purpose is contain smoke/fire if an event should occur. Maintenance or designee complete daily checks after carts returned from meal service and periodically throughout scheduled shifts to ensure doors were closed and secured without gaps. Any concerns will be addressed immediately, and all findings reviewed with QA. See attachment C	09/02/2022

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	Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., the (1) Dry Storage room door in the kitchen, greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and cardboard boxes. The door to this storage room was provided with a self-closing device however the door did not self-close and latch into the door frame when tested several times. And (2) the Corridor door to the "Consults Room" and area greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and cardboard boxes, PPE and totes and was not provided with a self-closing device. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3. Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors in the kitchen were not obstructed from closing. This deficient practice could affect 6 kitchen staff and 8 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., the Double Door set leading out of the kitchen into the corridor, equipped with a door coordination system to allow the doors to close in proper sequence, was manually overridden and closed in the reverse order, leaving a 3 inch gap in the door. The Maintenance Director stated that the kitchen staff reverse the doors so that they don't lock and			

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	therefore making it easier for staff to enter and exit while transporting food. The Maintenance Director agreed the condition left a gap in the doors and the aforementioned doors would not be smoke tight and resist the passage of smoke. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3.1-19(b)			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility	K 0324	K- 324 Cooking Facilities	09/02/2022

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	failed to ensure 1 of 1 kitchen range hood extinguishing systems was maintained in proper working order. NFPA 96, 2011 edition, Section 10.1.2 requires cooking equipment that produces grease-laden vapors and that might be a source of ignition of grease in the hood, grease removal device, or duct shall be protected by fire-extinguishing equipment. Section 11.1.6 states cooking equipment shall not be operated while its fire-extinguishing system or exhaust system is nonoperational or impaired. This deficient practice was not in a resident area but could affect 6 kitchen staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., the kitchen range hood extinguishing system nozzles were not properly positioned over the cooking equipment under the hood. All nozzles were pointed upward and away from the cooking equipment. The Maintenance Director stated the hood was cleaned recently and perhaps the nozzles were likely not pointed back down. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3.1-19(b)		Kitchen hood extinguishing system nozzles were positioned correctly over cooking equipment. Maintenance will monitor equipment nozzles weekly to ensure proper placement over equipment and after cleaning of hood to ensure proper placement. Any concerns during round will be corrected immediately and discussed with QA. See Attachment D	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance			

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	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 observation and interview, the facility failed to maintain the fire alarm system batteries in accordance with the requirements of NFPA 101-2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review of the "Logbook Documentation regarding Fire Drills" and interview with the Maintenance Director on 08/18/22 between 10:00 a.m. and 12:30 p.m., the inspection report from the facilities contractor of the fire alarm system dated 06/01/22 indicated that the batteries in the fire alarm panel "failed" the test done by the contractor and needed to be replaced. The note in the aforementioned report indicated that "maintenance" would replace the batteries. No documentation was available for review to show that the failed batteries had been replaced. The Maintenance Director stated that he was unaware of the failed batteries and would see that they were replaced immediately. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m.	K 0345	K – 345 Fire Alarm Systems Maintenance to review all safety inspection reports from contracting companies to ensure all recommendations and been reviewed and corrected immediately. Maintenance will monitor system monthly to ensure system working correctly and batteries current with proper voltage. See Attachment E	09/02/2022

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K 0511 SS=E Bldg. 01	3.1-19(b) NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance	K 0511	K- 511 Gas and Electric Receptacle used to power water machine in service hall has been changed and new GFCI circuit. All other receptacles checked with no further concerns. Maintenance will monitor all receptacles located within 3 feet of water supply to ensure all receptacles are GFCI and in proper working. Any concerns will be corrected immediately, and all concerns reviewed during QA. See Attachment F	09/02/2022

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	155238	A. BUILDING 01 B. WING	08/18/2022

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	with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff and up to 2 residents while at the water machine. Findings include:			

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	Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., the water machine in the service hall was connected to an electric receptacle which was being used to power the freestanding water machine, with it's own water supply. The water machine was located within 3 feet of the electric receptacle, and not provided with ground fault circuit interruption (GFCI). The Maintenance Director at the time of observation stated he did not believe the receptacle was on a GFCI circuit. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills on unexpected days and at unexpected times under varying conditions. This deficient practice could	K 0712	K-712 Fire Drills Maintenance to host unannounced fire drill with unannounced days of week and times with alternating	09/02/2022

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	affect all residents, staff and visitors in the facility. Findings include: Based on records review of the "Logbook Documentation regarding Fire Drills" and interview with the Maintenance Director on 08/18/22 between 10:00 a.m. and 12:30 p.m., 9 of 12 quarterly fire drills were conducted near the end of the month, between the 28th and 31st days of the month. These conditions do not allow fire drills to be conducted at unexpected times. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3.1-19(b)		shifts. Each month should alternate with days, evening, and nights. Not only differ in shifts but allow difference in day and altering times per each shift. Drills should cover the beginning of the month through the end of month. Maintenance will immediately initiate change with next drill and keep recorded in Life Safety Fire Drill log.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet			

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	other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 1. Based on observation and interview, the facility failed to ensure power strips in the some resident rooms were of UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet 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 feet 6 inches above the floor. This deficient practice affects 3 residents and 2 staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., the power strips being used in Resident Rooms 409 and 304 lacked a UL rating of 1363A or 60601-1 label. Two power strips were in use in RR 409, a white one and a black one. The black one did not appear to have the proper UL listed rating for a patient care area. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m.	K 0920	K- 920 Electrical Equipment – Power Cords Power strips were removed from rooms 409 and 304 and replaced with approved UL approved. Power strip in room 409 was mounted. All other resident rooms checked with no further concerns. Maintenance will ensure weekly rounds to all residents' rooms to ensure that all power strips in use and approved UL and are mounted in a secure location. Any concerns will be addressed immediately and reviewed during QA. See Attachment G	09/02/2022

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., in Resident Room 409 a power strip was in use and was powering a dorm style refrigerator (high power draw equipment). This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3. Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as and as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 3 residents. Findings include: Based on observations and interview during a			

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	tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., in resident room 107 two power strips were connected, one with a green cord was plugged into and supplied power by another power strip. Based on interview at the time of observation, the Maintenance Director and agreed 2 power strip were daisy chained together and in use. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 4. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect 3 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director on 08/18/22 between 12:30 p.m. and 2:15 p.m., in Resident Room 409 a power strip used to power equipment was not secured and dangling from the wall connecting a cell phone charging device. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the			

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	Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was acknowledged by the Maintenance Director at the time of observation and again at the exit conference with the Maintenance Director and Administrator present at 3:00 p.m. 3.1-19(b)			