STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155241	A. BUILDING -- B. WING	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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: 02/27/24 Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110 At this Emergency Preparedness survey, Forest Creek Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 128 certified beds. At the time of the survey, the census was 83. Quality Review completed on 03/01/24	E 0000		
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: 02/27/24 Facility Number: 000145 Provider Number: 155241 AIM Number: 100275110 At this Life Safety Code survey, Forest Creek Village was found not in compliance with	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 March 22, 2024.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Burton	Executive Director	03/13/2024

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

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	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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridors. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 128 and had a census of 83 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached wooden storage sheds. Quality Review completed on 03/01/24			
K 0222 SS=E 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 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			

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	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 be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS			

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	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 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 9 exits were 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 over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 02/27/24, the exit door at the entrance to the Alzheimer's wing by the west nurse's station was marked as a facility exit with an exit sign. The exit door could be opened by entering a code into a keypad to release the door to open but the code to release the door to open was not posted at the exit door. In addition, the exit door to the outside of the facility by Room 221 by the west nurse's station was also marked as a facility exit with an exit sign. The exit door could be opened by entering a code into a keypad to release the door to open but the code to release the door to open was not posted at the exit door. Based on	K 0222	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Both exit doors on the Memory Care Unit now have the code posted at the exit to the unit. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Maintenance Director/designee will make at least weekly documented rounds to ensure that the code is posted at the exit doors. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The Maintenance Director/designee will make at least weekly documented rounds to ensure that the code is posted	03/22/2024

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	interview at the time of the observations, the Maintenance Director stated the keypad at the west exit by Room 221 was recently replaced, the code was not posted after the replacement and agreed the exit doors were each marked as a facility exit but the code to release the doors to open was not posted at the exit. These findings were reviewed with the Administrator, the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during the exit conference. 3.1-19(b)		at the exit doors. How will the corrective actions be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? Rounds will be done weekly X 4 weeks and then monthly thereafter for 6 months. The audit results will be presented to the QAPI committee overseen by the Executive Director.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on record review, observation and interview; the facility failed to meet the clear width requirement for 2 of 8 corridors or met an exception per 19.2.3.4(4). LSC Section 19.2.3.4(4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency.	K 0232	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? the ED/designee will provide staff education on wheeled equipment needing to be located out of the path of egress. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action	03/22/2024

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	(c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 8:15 a.m. to 8:30 a.m. on 02/27/24, Hoyer lifts and resident transport equipment was stored in the corridor outside resident sleeping Room 105, Room 110 and Room 224. Based on review of the "Fire/Explosion Emergency Action Plan" section of "Emergency Preparedness Program" documentation dated 01/18/24 with the Field Maintenance Supervisor and the Director of Property Management during record review from 8:30 a.m. to 11:00 a.m. on 02/27/24, the health care occupancy fire safety plan addressed the relocation of wheeled equipment during a fire or similar emergency. Page 50 of the aforementioned documentation stated "Wheeled equipment in the corridor should be located out of the path of egress: shower room or similar area" in a fire or similar emergency. Based on observations with the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 02/27/24, Hoyer lifts and resident transport equipment were still stored in the corridor outside resident sleeping Room 105, Room 110 and Room 224. The corridor outside the resident sleeping rooms measured six feet six inches in width as measured with the Maintenance Director's measuring tape. The		will be taken? The Maintenance Director/designee will make documented rounds at least 3X a week to ensure that wheeled equipment is located out of the path of egress. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The Maintenance Director/designee will make documented rounds 3X a week to ensure that wheeled equipment is located out of the path of egress. How will the corrective actions be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? The audit results will be presented to the QAPI committee overseen by the Executive Director.	

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	padded wheelchair outside Room 105 projected 39 inches into the corridor. The Hoyer lifts outside Rooms 105, 110 and Room 224 projected 28 inches into the corridor. An additional Hoyer lift was also observed stored in the 100 Hall outside the entrance to the Therapy Room. The Hoyer lift projected 27 inches into the corridor. Each of the measurements were made with the measuring tape. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned wheeled equipment reduced the clear unobstructed corridor width of the two corridors to less than 60 inches. These findings were reviewed with the Administrator, the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during the exit conference. 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			

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	REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of over 14 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of resident sleeping Room 8. Findings include: Based on observations with the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 02/27/24, two separate 1/4th's inch in diameter holes were noted above and below the door handle for the corridor door to resident sleeping Room 8. Resident sleeping Room 8 had been converted to the Classroom, was greater than 50 square feet in size and was also being used as a storage room for combustible boxes and supplies. Based on interview at the time of the	K 0321	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Room 8 door handle has been repaired and the combustibles have been removed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Maintenance Director/designee will make at least weekly documented rounds to ensure that door handles are in good repair and that the classroom is not used to store large quantities of combustibles. What measures will be put into	03/22/2024

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	observations, the Maintenance Director and the Field Maintenance Supervisor agreed the aforementioned hazardous area was not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Administrator, the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during the exit conference. 3.1-19(b)		place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The Maintenance Director/designee will make at least weekly documented rounds to ensure the door handles are in good repair and that resident rooms are not used to store large quantities of combustibles. How will the corrective actions be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? Rounds will be done weekly X 4 weeks and then monthly thereafter for 6 months. The audit results will be presented to the QAPI committee overseen by the Executive Director.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test			

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	c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to ensure 1 of 1 private fire hydrant was continuously maintained in reliable operating condition. NFPA 25, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Table 7.1.1.2 requires wet and dry barrel hydrants to be inspected annually and after each operation. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of the fire hydrant inspection contractor's "Fire Hydrant Test Report" documentation dated 06/07/23 with the Field Maintenance Supervisor and the Director of Property Management during record review from 8:30 a.m. to 11:00 a.m. on 02/27/24, the facility has one fire hydrant which was impaired. The "Deficiency Summary" section of the 06/07/23 report stated "the hydrant expelled water but at a	K 0353	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The private fire hydrant has been repaired and is in good operating condition. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Maintenance Director/designee will make at least weekly documented rounds to ensure that the private fire hydrant is in good operating condition. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The Maintenance Director/designee will make at least weekly documented rounds to ensure that the private fire hydrant is in good operating	03/22/2024

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	rate so low it wouldn't register on the testing equipment". Based on interview at the time of record review, the Field Maintenance Supervisor and the Director of Property Management stated the facility has one fire hydrant and agreed fire hydrant repair documentation on or after 06/07/23 was not available for review. These findings were reviewed with the Administrator, the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during the exit conference. 3.1-19(b)		condition. How will the corrective actions be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? Rounds will be done weekly X 4 weeks and then monthly thereafter for 6 months. The audit results will be presented to the QAPI committee overseen by the Executive Director.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 4 of over 50 corridor doors to resident sleeping rooms would resist the passage of smoke. This deficient practice could affect over 40 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 02/27/24, two separate 1/4th's inch in diameter holes were noted above and below the door handle for the corridor door to resident sleeping Room 7, Room 8 and Room 236. In addition, a 1/2 inch in diameter hole was noted above the the door handle to resident sleeping Room 135. Based on interview at the time of the observations's, the Maintenance Director and the Field Maintenance Supervisor agreed the holes in the corridor doors to the aforementioned four	K 0363	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Room 7, 8, 135, 236 corridor doors have all been repaired. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Maintenance Director/designee will make at least weekly documented rounds to ensure that corridor doors are in good repair. What measures will be put into place or what systemic changes	03/22/2024

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FOREST CREEK VILLAGE	525 E THOMPSON RD INDIANAPOLIS, IN 46227

(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
	resident sleeping rooms would not resist the passage of smoke. These findings were reviewed with the Administrator, the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during the exit conference. 3.1-19(b)		will you make to ensure that the deficient practice does not reoccur? The Maintenance Director/designee will make at least weekly documented rounds to ensure that corridor doors are in good repair. How will the corrective actions be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? Rounds will be done weekly X 4 weeks and then monthly thereafter for 6 months. The audit results will be presented to the QAPI committee overseen by the Executive Director.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.			

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	19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 7 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 02/27/24, each door in the cross corridor door set by resident sleeping Room 116 swings to close in the same direction. The door set was equipped with a door closing coordinator but the coordinator did not function properly which caused the door in the door set with the astragal to remain propped open against the coordinator and caused a gap of greater than 1/8 inch at the meeting edges of the doors when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director stated the bottom hinge on the door without the astragal was loose which caused the door to not swing to close correctly and had maintenance staff adjust the door to close. Based on observations with the Maintenance Director at 12:46 p.m. after maintenance staff adjustments, the door set still did not fully close when tested to close multiple times. These findings were reviewed with the	K 0374	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The smoke barrier door by room 116 has been repaired. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Maintenance Director/designee will make at least weekly documented rounds to ensure that smoke barrier doors are functioning properly. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The Maintenance Director/designee will make at least weekly documented rounds to ensure that smoke barrier doors are functioning properly. How will the corrective actions be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? Rounds will be done weekly X 4	03/22/2024

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	Administrator, the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during the exit conference. 3.1-19(b)		weeks and then monthly thereafter for 6 months. The audit results will be presented to the QAPI committee overseen by the Executive Director.	
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 other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with	K 0920	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The power strip was removed from	03/22/2024

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	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 5 residents, staff and visitors in the Therapy Room near the main entrance. Findings include: Based on observations with the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 02/27/24, an electrically powered massage table for residents, a clock radio, computer equipment and a cell phone charging cable were plugged into a power strip placed on the floor near the massage table in the Therapy Room by the main entrance for the facility. The UL listing of the power strip could not be determined. Based on interview at		the therapy gym area. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Maintenance Director/designee will make at least weekly documented rounds to ensure that their are no unauthorized power strips in the therapy gym. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The Maintenance Director/designee will make at least weekly documented rounds to ensure their are no unauthorized power strips in the facility. How will the corrective actions be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? Rounds will be done weekly X 4 weeks and then monthly thereafter for 6 months. The audit results will be presented to the QAPI committee overseen by the Executive Director.	

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	the time of the observations, the Maintenance Director agreed a power strip was being used in the patient care vicinity for PCREE and non-PCREE and as a substitute for fixed wiring in the Therapy Room. These findings were reviewed with the Administrator, the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during the exit conference. 3.1-19(b)			
K 0930 SS=A Bldg. 01	NFPA 101 Gas Equipment - Liguid Oxygen Equipment Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) Based on observation and interview, the facility failed to protect 1 of over 50 resident sleeping rooms from the use of liquid oxygen containers stored in a patient bed location or patient care room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.7.4 states the maximum total quantity of liquid oxygen permitted in storage and in use in a patient bed location or patient care room shall be 120 L (31.6 gallons), provided that the patient bed location or patient care room, or both, are separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour in accordance with the adopted building code. Per Centers for Medicare & Medicaid Services (CMS), this practice is deficient according to NFPA 99, 2012 Edition, Section 11.7.4. LSC Section 7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or	K 0930	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The liquid oxygen container in room 123 was removed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Maintenance Director/designee will make at least weekly documented rounds to ensure that there are not liquid oxygen containers in resident	03/22/2024

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	automatic-closing. This deficient practice could affect one resident, staff and visitors. Findings include: Based on observations with the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during a tour of the facility from 11:00 a.m. to 12:55 p.m. on 02/27/24, one liquid oxygen container was stored in resident sleeping Room 123 and available for use. One resident was observed in the sleeping room at the time of the observation . Room 123 was not separated from the remainder of the facility by fire barriers and horizontal assemblies having a minimum fire resistance rating of 1 hour. The corridor door to the room was not self-closing or automatic closing and was equipped with a 20-minute fire resistance rating label affixed to the hinge side of the door. Based on interview at the time of the observations, the Maintenance Director agreed a liquid oxygen container was stored in resident sleeping Room 123 and the room was not maintained with a minimum fire resistance rating of 1 hour. These findings were reviewed with the Administrator, the Maintenance Director, the Field Maintenance Supervisor and the Director of Property Management during the exit conference. 3.1-19(b)		rooms. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not reoccur? The Maintenance Director/designee will make at least weekly documented rounds to ensure that there are not liquid oxygen containers in resident rooms. How will the corrective actions be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place? Rounds will be done weekly X 4 weeks and then monthly thereafter for 6 months. The audit results will be presented to the QAPI committee overseen by the Executive Director.	