STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155381	A. BUILDING -- B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOUR MANOR HEALTH & LIVING COMMUNITY	1667 SHERIDAN RD NOBLESVILLE, IN 46060

(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: 09/01/22 Facility Number: 000551 Provider Number: 155381 AIM Number: 100267400 At this Emergency Preparedness survey, Harbour Manor Health & Living Community was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 129 certified beds. At the time of the survey, the census was 117. Quality Review completed on 09/06/22	E 0000	**Submission of this plan of correction in no way constitutes an admission by Harbour Manor Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.** **This plan of correction is also Harbour Manor Health & Living Community's credible allegation of compliance.** **We allege substantial compliance on September 9th 2022.** **We are respectfully request paper compliance for this survey.**	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c),			

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

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	§441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an complete emergency preparedness communication plan that complies with Federal, State, and local laws in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on records review of the facility's Emergency Preparedness Manual and interview with the Director of Maintenance on 09/01/22 between 9:30 a.m. and 12:15 p.m., the two provided EPP manuals did not match. The contact list with names and phone numbers to contact in an emergency from the EPP kept at the Nurses Station contained outdated names and phone numbers which were not updated during the review process. The Director of Maintenance stated that the contact for the Executive Director was from a few directors ago. This finding was acknowledged by the Director of Maintenance at the time of observation and discovery and again at the exit conference with the Director of Maintenance and Executive Director present at 3:00 p.m.	E 0029	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Contact sheet in Emergency Preparedness Binder have been updated **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by the deficient practice. Contact sheet updated and reviewed (Attachment A). **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance	09/09/2022

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			team educated on contact sheet for Emergency Preparedness Manual. (Attachment 2) **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit emergency preparedness binder. Audits will occur Weekly x 4 weeks, Monthly x 6 months (Attachment 1). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of Compliance: September 9, 2022.	
K 0000 Bldg. 01	rA 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: 09/01/22 Facility Number: 000551	K 0000	**Submission of this plan of correction in no way constitutes an admission by Harbour Manor Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal**	

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	Provider Number: 155381 AIM Number: 100267400 At this Life Safety Code survey, Harbour Manor Health & Living Community 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 (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, hard wired smoke detectors in all resident rooms in the building. The facility has a capacity of 129 and had a census of 117 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for one detached garage and Maintenance office which were not sprinklered. Quality Review completed on 09/06/22		**of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law.** **This plan of correction is also Harbour Manor Health & Living Community's credible allegation of compliance.** **We allege substantial compliance on September 9th 2022.** **We are respectfully request paper compliance for this survey.**	
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			

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	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) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 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 3 staff and visitors in the Business Office. Findings include: Based on a facility tour and interview with the Director of Maintenance and Executive Director on 09/01/22 between 12:15 p.m. and 2:30 p.m., the Business Office, a Room greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and 10-12 large cardboard boxes containing paper. The corridor door to this	K 0321	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Boxes located in the business office have been removed. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**	09/09/2022

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	office did not self-close and latch into the door frame when tested. This finding was acknowledged by the Director of Maintenance at the time of observation and discovery and again at the exit conference with the Director of Maintenance and Executive Director present at 3:00 p.m. 3.1-19(b)		3 staff and visitors could be affected by the deficient practice. Boxes removed from office (Attachment B). **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator, Maintenance team and business office manager educated on self-closing doors related to combustible items (Attachment 2) . **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit 5 hazardous areas. Audits will occur Weekly x 4 weeks, Monthly x 6 months (Attachment 1). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of Compliance: September 9, 2022.	

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K 0353 SS=E 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 _____ 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 observation and interview, the facility failed to maintain the ceiling construction throughout the facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 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 4 residents and 3 staff. Findings include: Based on a facility tour and interview with the Director of Maintenance and Executive Director on 09/01/22 between 12:15 p.m. and 2:30 p.m., in	K 0353	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Sprinkler Head gap has been closed. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** 3 staff and 4 residents could be affected by the deficient practice.	09/09/2022

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	the (1) Medical Room at the Rehab Nurses Station and (2) Resident Room 111, sprinkler heads had dropped approximately 1-2 inches from the ceiling tile and created a gap around the sprinkler head which would allow smoke and or heat to escape. The Director of Maintenance stated that this part of the building is on the dry sprinkler system and when the air compressor engages it shakes the pipes causing the sprinkler heads to sometimes sag. This finding was acknowledged by the Director of Maintenance at the time of observation and discovery and again at the exit conference with the Director of Maintenance and Executive Director present at 3:00 p.m. 3.1-19(b)		Sprinkler head gap has been closed (Attachment B). **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance team educated on sprinkler head gap. (Attachment 2) **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit 5 sprinkler heads. Audits will occur Weekly x 4 weeks, Monthly x 6 months (Attachment 1). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of Compliance: September 9, 2022.	

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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 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			

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	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 1 of over 30 resident room corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents. Findings include: Based on a facility tour and interview with the Director of Maintenance and Executive Director on 09/01/22 between 12:15 p.m. and 2:30 p.m., the corridor door to resident room 11 did not latch into the frame when tested. Based on interview at the time of observation, the Director of Maintenance stated the corridor door would latch into the door frame because the door was not adjusted correctly, and he was surprised because the doors were recently checked. The condition was corrected during the survey. This finding was acknowledged by the Director of Maintenance at the time of observation and discovery and again at the exit conference with the Director of Maintenance and Executive Director present at 3:00 p.m. 3.1-19(b)	K 0363	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident room 11 door was fixed prior to exit of survey. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** 2 residents could be affected by the deficient practice. Resident room door was fixed. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance team resident door latching properly. (Attachment 2) **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will	09/09/2022

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			audit 5 resident doors to make sure they are latching properly. Audits will occur Weekly x 4 weeks, Monthly x 6 months (Attachment 1). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of Compliance: September 9, 2022.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through barriers walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed	K 0372	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	09/09/2022

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	in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 16 residents and staff near room 16. Findings include: Based on a facility tour and interview with the Director of Maintenance and Executive Director on 09/01/22 between 12:15 p.m. and 2:30 p.m., an unsealed penetration was discovered in the smoke barrier wall above the drop ceiling near Resident Room 16. Three wires were running along a pipe and created a hole/gap approximately 1/2inch around the pipe. The Director of Maintenance stated that he believed this was done by telephone contractors. This finding was acknowledged by the Director of Maintenance at the time of observation and discovery and again at the exit conference with the Director of Maintenance and Executive Director present at 3:00 p.m. 3.1-19(b)		Smoke barrier in wall above drop ceiling has been properly sealed with fire caulk **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** 16 residents and staff could be affected by the deficient practice. Smoke barrier filled with fire caulk. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance team educated on smoke barrier requirements. (Attachment 2) **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit 5 smoke barriers. Audits will occur Weekly x 4 weeks, Monthly x 6 months (Attachment 1). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as	

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			needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of Compliance: September 9, 2022.	
K 0511 SS=E Bldg. 01	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, the facility failed to ensure 1 of 1 electrical junction boxes in the attic were maintained in a safe operating condition. 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, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect staff and 28 residents in the memory care area. Findings include: Based on a facility tour and interview with the Director of Maintenance and Executive Director on 09/01/22 between 12:15 p.m. and 2:30 p.m., an electrical junction box in the attic near the entrance to the memory care unit did not contain a cover and had exposed electrical wiring hanging out of the box. The box was approximately	K 0511	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Cover plate added to electrical junction box. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** 28 residents and staff could be affected by the deficient practice. Junction box cover added. **what measures will be put into place and what systemic changes will be made to ensure that the deficient**	09/09/2022

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	155381	A. BUILDING 01 B. WING	09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOUR MANOR HEALTH & LIVING COMMUNITY	1667 SHERIDAN RD NOBLESVILLE, IN 46060

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	12"X12" and contained heavy wire which appeared to connect the facility to the generator. Based on interview at the time of the observations, the Director of Maintenance acknowledged the electrical junction box was not provided with a cover and had exposed wires. This finding was acknowledged by the Director of Maintenance at the time of observation and discovery and again at the exit conference with the Director of Maintenance and Executive Director present at 3:00 p.m. 3.1-19(b)		**practice does not recur.** Administrator and Maintenance team educated on requirements of electrical code related to junction box covers. (Attachment 2) **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit 5 attic spaces for proper junction box coverings. Audits will occur Weekly x 4 weeks, Monthly x 6 months (Attachment 1). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of Compliance: September 9, 2022.	
K 0712 SS=C 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			

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	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 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 Director of Maintenance on 09/01/22 between 9:30 a.m. and 12:15 p.m., 9 of 12 quarterly fire drills were conducted between the 28th and 31st day of the month. These conditions do not allow fire drills to be conducted at unexpected times. This finding was acknowledged by the Director of Maintenance at the time of observation and discovery and again at the exit conference with the Director of Maintenance and Executive Director present at 3:00 p.m. 3.1-19(b)	K 0712	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Quarterly fire drills will be scheduled at unexpected dates and times. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** The deficient practice could affect all residents, staff and visitors. Corrective actions include monthly fire drills at unexpected date and time **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance team educated on fire drill process and procedure. (Attachment 2) **how the corrective action(s) will be monitored to ensure the**	09/09/2022

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			deficient practice will not recur, i.e., what quality assurance program will be put into place; and Administrator or designee will audit Fire Drills. Audits will occur quarterly (Attachment 1). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of Compliance: September 9, 2022.	
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 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 1 resident and 2 staff in the MDS office. Findings include: Based on a facility tour and interview with the Director of Maintenance and Executive Director on 09/01/22 between 12:15 p.m. and 2:30 p.m., in the MDS office a power strip was being used to power computer equipment and was not secured, dangling from the walls underneath the desk. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Director of Maintenance 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 Director of Maintenance at the time of observation and	K 0920	**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Power Cord adapter has been secured to wall. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** The deficient practice could affect 1 resident and 2 staff. Corrective actions include mounting the power cord adapter. **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Administrator and Maintenance team educated on cord adapter and extension cord procedure. (Attachment 2)	09/09/2022

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	discovery and again at the exit conference with the Director of Maintenance and Executive Director present at 3:00 p.m. 3.1-19(b)		**how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Administrator or designee will audit staff offices for proper cord adapters. Audits will occur Weekly x 4 weeks, Monthly x 6 months (Attachment 1). The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting. Frequency and duration of reviews will be adjusted as needed if compliance is below 100%. Ongoing frequency and duration will be determined by the Quality Assurance Committee Date of Compliance: September 9, 2022.	