STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155022	A. BUILDING -- B. WING	10/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOWS OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

(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: 10/21/24 Facility Number: 000009 Provider Number: 155022 AIM Number: 100274760 At this Emergency Preparedness survey, The Willows of Shelbyville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 141 certified beds. At the time of the survey, the census was 60. Quality Review completed on 10/23/24	E 0000	**Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because is required by the provisions of Federal and State Law.** /b> /b>	
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: 10/21/24 Facility Number: 000009 Provider Number: 155022 AIM Number: 100274760 At this Life Safety Code survey, The Willows of Shelbyville was found not in compliance with	K 0000	**Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because is required by the provisions of Federal and State Law.** /b>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mandi Paul	HFA	11/01/2024

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 surveyed as one building of Type V(000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 141 and had a census of 60 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 10/23/24		/b>	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of over 4 corridor means of egresses were continuously maintained free of obstructions. LSC 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 in.(1525 mm). (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 0211	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 15 residents had the potential to be affected, none were. The PPE cart was removed and replaced with a wheeled cart. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	11/08/2024

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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 affects 15 residents in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., in all resident hall corridor near RR# 110 a Personal Protective Equipment (PPE) cart was in use but not equipped with wheels allowing the cart to be moved out of the hall during an emergency. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)		action(s) will be taken? While all residents have the potential to be affected none were. Facility reviewed all egress to assure no obstructions and/or wheeled equipment was appropriate. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance Director and Medical Records was educated on facility requirement. The PPE cart was removed and replaced with a wheeled cart. Facility reviewed all egress to assure no obstructions and/or wheeled equipment was appropriate. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor or designee will monitor ways of egress for obstructions and/or wheeled equipment are appropriate weekly for 4 weeks then monthly x 6months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6	

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			months. At the end of the 6-month period the QA team may opt to discontinue the review of data during the meeting if compliance is evident	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure 1 of over 8 exterior exit doors were readily accessible, not blocked and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., the double exit doors on Station 2 east hall would not open due to 8 large sandbags being stacked up against and outside the doors. The sandbags were removed during the survey, and it was verified the doors would open. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)	K 0222	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All occupants had the potential to be affected, none were. The sandbags were 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? While all occupants have the potential to be affected none were. Facility reviewed all exit doors to assure no obstructions or locks were in use. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur?	11/08/2024

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			Maintenance Director was educated on facility requirement. The sandbags were removed, facility reviewed all exit doors to assure no obstructions or locks were in use. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor or designee will monitor exit doors for obstructions and/or locks weekly for 4 weeks then monthly x 6months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6 months. At the end of the 6-month period the QA team may opt to discontinue the review of data during the meeting if compliance is evident	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure 1 of over 8 exit discharges was	K 0271	What corrective action(s) will be accomplished for those residents	11/08/2024

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	free of obstructions. This deficient practice could affect 6 kitchen staff and any residents being evacuated through this door. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., outside the kitchen exit, marked a facility exit, an employee had parked a truck on the exit discharge obstructing clear width of travel to the public way. The MD agreed and stated he was sure it was an employee vehicle stating they would need to install a no parking sign. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)		found to have been affected by the deficient practice? 8 dietary employees had the potential to be affected, none were. The vehicle was immediately 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? While all occupants have the potential to be affected none were. The vehicle was immediately removed, and all other exit pathways were reviewed. Sign was purchased and installed to note NO PARKING. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director educated all staff on parking locations. Sign was purchased and installed to note NO PARKING. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor or designee will monitor all exit	

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			pathways for clear accessibility weekly x 4 weeks and monthly x 6 months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6 months. At the end of the 6-month period the QA team may opt to discontinue the review of data during the meeting if compliance is evident	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of over 8 doors to the outside of the facility 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 13 residents. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director	K 0293	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 13 residents had the potential to be affected, none were. The exit sign chevron was updated to adhere to the correct exit passageway. 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? While all occupants have the	11/08/2024

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	(MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., the exit sign chevron near the therapy Entrance was pointing toward an exit door which was no longer accessible due to a recent remodel of the facility. The exit door still existed but due to a new permanent wall was no longer accessible from the area described above. The MD agreed the chevron arrow in the exit sign would need to be corrected. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)		potential to be affected none were. The exit sign chevron was updated to adhere to the correct exit passageway. All other exits were reviewed for deficient practice. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director was educated on exit and directional signs. The exit sign chevron was updated to adhere to the correct exit passageway. All other exits were reviewed for deficient practice. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor or designee will monitor all exit and directional signs monthly x 6months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6 months. At the end of the 6-month period the QA team may opt to discontinue the review of data during the meeting if compliance is evident	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 5 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. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., the following corridor doors failed to self-close and latch positively into their respective door frames, each were areas greater than 50 square feet containing a mixture of combustible items, such as paper, plastic, cardboard boxes, construction materials, chairs and furniture: a) Resident Room #57, equipped with a self-closing device, the room is being used for storage. b) Resident Room #46, the room is being used to store long construction pieces which prevent the door from closing. c) RR # 10B being used for storage and equipped with a self-closing device, did not self-close and latch positively into the door frame. d) RR # 9B being used for storage and equipped with a self-closing device, did not self-close and latch positively into the door frame. e) The Kitchen door into the dining room equipped with a self-closing device failed to self-close and latch. The Kitchen contained several large trash receptacles.	K 0321	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All occupants had the potential to be affected, none were. All hazardous material doors have been maintained with self-closing devices. These rooms include RR 57, 46,10B, 9B and the kitchen. 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? While all occupants have the potential to be affected none were. All hazardous material doors have been maintained with self-closing devices. All rooms were reviewed and none other were identified. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director was educated on hazardous room doors and deficient practice. Full	11/08/2024

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	This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)		facility tour completed, and no other areas identified. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor or designee will monitor all hazardous room doors weekly x4 weeks then monthly thereafter x6 months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6 months. At the end of the 6-month period the QA team may opt to discontinue the review of data during the meeting if compliance is evident	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1. Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified,	K 0324	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All occupants had the potential to be affected, none were. How other residents having the potential to be affected by the	11/08/2024

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	or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice affected 6, staff, and no residents. The findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., the electric wheeled two (6) burner range and flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the		same deficient practice will be identified and what corrective action(s) will be taken? While all occupants have the potential to be affected none were. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director and dietary manager was educated on returning appliances back to their original location. Maintenance director placed tape on the floor to identify appliance location following hood cleaning. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor or designee will monitor location of hood extinguishing equipment weekly x4 weeks then monthly x6 months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6 months. At the end of the 6-month period the QA team may opt to discontinue the review of data	

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	Maintenance Director present. 2. Based on observation and interview, the facility failed to install the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect up to 6 staff. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., the design of the kitchens' 2 hoods requires two drip trays, one on each side. Each side was missing the metal drip tray underneath the kitchen range hood system. Kitchen staff were unsure of the location of the drip trays. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)		during the meeting if compliance is evident	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation			

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	Based on observation and interview, the facility failed to maintain the ceiling construction in in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect 2 staff. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., 1 of 1 Sprinkler Heads in the HR Storage room was protruding into the room approximately 4 inches and created a gap around the sprinkler head and ceiling. Based on interviews at the time of observation, the Maintenance Director agreed the aforementioned area would need to be corrected. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)	K 0351	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 2 staff had the potential to be affected, none were. The sprinkler head and ceiling construction in the HR closet was repaired. 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? While all occupants have the potential to be affected none were. The sprinkler head and ceiling construction in HR closet was repaired. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director was educated on installation of sprinkler systems and ceiling construction. A facility tour was completed, and no other areas were identified. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place?	11/08/2024

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	155022	A. BUILDING 01 B. WING	10/21/2024

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			The maintenance supervisor or designee will monitor sprinkler system and ceiling construction weekly x4 weeks and then monthly x6 months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6 months. At the end of the 6-month period the QA team may opt to discontinue the review of data during the meeting if compliance is evident	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 3 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 8 staff. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., the following corridor doors failed to latch positively into their respective door frames or would not resist the passage of smoke: a) The Laundry Storage corridor door on the East hall had a self-closing device which the Maintenance Director stated was not "hooked up" and the door failed to self-close and latch.	K 0363	**K363** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? All occupants had the potential to be affected, none were. The 3 identified doors have been maintained and now close and latch into door frame. Holes have been repaired in the maintenance door. These rooms include the laundry room, maintenance room and medical supply room. How other residents having the potential to be affected by the	11/08/2024

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	b The Maintenance Room corridor door on station 1 east hall had a hole in the door which penetrated completely through. The MD agreed that the door would not resist the passage of smoke. c) The Medical Supply Corridor door equipped with a self-closing device failed to self-close and latch. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)		same deficient practice will be identified and what corrective action(s) will be taken? While all occupants have the potential to be affected none were. A facility tour was completed and none other were identified. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance director was educated on doors having no impediments of closing, latching, and/or holes in door or frame. Full facility tour completed, and no other areas identified. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor or designee will monitor all corridors weekly x4 weeks then monthly thereafter x6 months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6 months. At the end of the 6-month period the QA team may opt to discontinue the review of data during the meeting if	

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			compliance is evident ="" p="">="" p="">="" a the="" maintenance="" director="" added="" new="" parts,="" replaced="" worn="" parts="" and="" or="" made="" adjustments="" to="" closing="" latching="" mechanism="" ensure="" proper="" of="" doors="" that="" identified.<="" p="">="" p="">="" p="">="" p="">="" a="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="">="" p="" <="">="" p="">="" span="">="" span="">="" span="">="" span="">="" span="">="" span="">="" span="">="" span="">="" span="">="" span=""	

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K 0521 SS=E Bldg. 01	NFPA 101 HVAC Based on observation and interview, the facility failed to ensure 5 of 14 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 4.3.12.1.1 states egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect over 30 residents, staff and visitors. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., all rooms in Station 1 (west wing), Station 2 (east and west wing) and Station 3 were using the	K 0521	The Willows of Shelbyville respectfully requests a waiver for this finding. Smoke detectors are located in the areas identified in this finding. Activation of the fire alarm system will trigger relays that shut down the air handlers in these portions of the building. Once the air handler is closed, smoke will be prevented from transferring from one smoke zone to another. Modification to the existing air handling system will pose a hardship for residents during installation process. The facility received an estimate for over $100,000 to fix the deficiency.	11/08/2024

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	egress corridor as a return air system. Based on interview at the time of the observations, the Maintenance Director stated the facility has in the past had a waiver from IDOH for using the corridor as a portion of the HVAC return air system and agreed the aforementioned egress corridors were being using as a return air system. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 1. Based on observation and interview, the facility failed to ensure 1 of over 60 resident rooms did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 resident. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., room 100 contained a multi-plug adaptor powering equipment. Based on interview at the time of observation, the Maintenance Director agreed a mulita-plug adaptor was in use in room	K 0920	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 2 residents and the kitchen staff had the potential to be affected, none were. The muti plug adapter in room 100 was removed and the extension cord in the kitchen was 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? While all residents have the potential to be affected none were. The muti plug adapter in	11/08/2024

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	100. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords in the kitchen were not used 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. This deficient practice could affect up to 6 staff in the kitchen. Findings include: Based on observations and interviews during a tour of the facility with the Maintenance Director (MD) on 10/21/24 between 11:30 a.m. and 2:45 p.m., in the kitchen an orange extension cord was plugged in and powering a grease fryer which was sitting on the range. Based on interview at the time of observation, the MD acknowledged an extension cord was in use as described above and was unsure how long this had been occurring. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Administrator, Reginal Representative and the Maintenance Director present. 3.1-19(b)		room 100 was removed and the extension cord in the kitchen was removed. Facility tour completed to ensure no power strips were used in patient care vicinity and no extension cords being used. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? Maintenance Director and all staff were educated on use multiplug adapters and extension cords in facility. Facility tour completed to ensure no power strips were used in patient care vicinity and no extension cords being used. How the corrective action(s) will be monitored to ensure that the deficient practice will not recur. I.e., what Quality Assurance program will be put into place? The maintenance supervisor or designee will monitor all areas of the building in relation to electrical equipment weekly x4 weeks then monthly x 6 months. The Quality Assurance and Performance Improvement committee will review results of the findings during the monthly facility QA meeting for at least 6 months. At the end of the 6 month period the QA team may opt to discontinue the review of data during the meeting if compliance is evident	

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