STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155354	A. BUILDING -- B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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: 02/25/25 Facility Number: 000245 Provider Number: 155354 AIM Number: 1002890800 At this Emergency Preparedness survey, Newburgh Health Care was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds. At the time of the survey, the census was 55. Quality Review completed on 02/28/25 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include:	E 0004	No residents were affected by this tag. No other residents were affected, and the manual will be update appropriately. Inservice staff to ensure awareness of updated manuals at each nurse's station. Annual monitoring and updates	04/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Emily Diedrich	HFA	04/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Based on review of the Emergency Preparedness Manual on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review on the cover of the manual was 04/20/22. Based on interview at the time of review, the Administrator confirmed there was no evidence that the Emergency Preparedness Manual has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		will be placed in the manual as needed.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Manual on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review on the cover of the manual was 04/20/22.	E 0013	No residents were affected by this tag. No other residents were affected, and the manual will be update appropriately. Inservice staff to ensure awareness of updated manuals at each nurse's station. Annual monitoring and updates will be placed in the manual as needed.	04/17/2025

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	Based on interview at the time of review, the Administrator confirmed the policies and procedures within the Emergency Preparedness Manual have not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			
E 0025 SS=C Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to LTC residents in accordance with 42 CFR 483.73(b)(7). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, documentation of emergency preparedness policies and procedures including the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations was available for review, however, the dates on the LTC facilities and other provider was listed 2017 and 2018 for the various facilities. Based on interview at the time of record review, the Administrator agreed the documentation of arrangements with other facilities needs to be updated.	E 0025	No residents were affected by this tag. No other residents were affected, and the manual will be update appropriately. Inservice staff to ensure awareness of updated manuals at each nurse's station. Annual monitoring and updates will be placed in the manual as needed.	04/17/2025

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the facility's emergency preparedness plan did include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws; however, the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review on the cover of the manual was 04/20/22. Based on interview at the time of review, the Administrator confirmed the Communication Plan within the Emergency Preparedness Manual has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0029	No residents were affected by this tag. No other residents were affected, and the manual will be update appropriately. Inservice staff to ensure awareness of updated manuals at each nurse's station and communication plan. Annual monitoring and updates will be placed in the manual as needed.	04/17/2025

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E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review on the cover of the manual was 04/20/22. Based on interview at the time of review, the Administrator confirmed the training and testing policy and procedure within the Emergency Preparedness Manual has not been reviewed and updated within the past twelve month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0036	No residents were affected by this tag. No other residents were affected, and the manual will be update appropriately. Inservice staff to ensure awareness of updated manuals at each nurse's station and communication plan. Annual monitoring and updates will be placed in the manual as needed.	04/17/2025
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency	E 0039	No residents were affected by this tag. No other residents were affected by this tag.	04/17/2025

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	procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness Manual on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the facility was able to provide		Inservice with Maintenance Director will be completed to ensure proper protocol is followed. Will review in QA meetings. and staff interviews, **E 0039** **CORRECTIVE ACTION** No residents were affected by the alleged deficiency. **RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. **MEASURES PUT INTO PLACE/SYSTEMIC CHANGES** A table top exercise lead by a facilitator including a group discussion, using a narrated clinically – relevant emergency scenario and a set of problem statements, directed messages or prepared questions designed to challenge an emergency plan will be conducted for facility staff by the Maintenance Director, Facility Administrator or designee. The facility's response will be analyzed and documented including all drills, table top exercises and emergency events. The facility's Emergency Plan will be updated and or revised as needed. The drill will be repeated the following year unless there is an actual event, then the drill will be repeated and conducted every two	

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	documentation of an actual event, a fire in the facility on 02/03/25, however, there was no documentation of a second exercise conducted by the facility during the past 12 month period. This was confirmed by the Administrator and Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		years and documented according to the requirement. **MONITORING** The Maintenance Director and facility Administrator will monitor the event and proceed with the appropriate follow up as soon as practicable but not to exceed two weeks. The results of the Emergency Drills will be presented in the monthly Quality Assurance Performance Improvement Meeting. This monitor will be ongoing to reflect the various opportunities for action. **Completion Date 4/17/2025**	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within	E 0041	No residents were affected by this tag. No other residents were affected by this tag. Maintenance Director will have the system inspected as required. Proper documentation and logbook to be kept.	04/17/2025

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	every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 2. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available for review. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any			

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	repair for the time as recommended by the manufacturer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine maintenance report for the emergency generator was dated 01/09/24, which was over a month past due. Based on interview at the time of record review, the Maintenance Director said there is currently no scheduled date for the generator vendor to come to the facility to perform routine maintenance service on the emergency generator. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			
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: 02/25/25 Facility Number: 000245 Provider Number: 155354 AIM Number: 100290800 At this Life Safety Code survey, Newburgh Health Care was found not compliance with	K 0000		

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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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 55 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services, including a detached garage used for a maintenance shop and maintenance and facility storage, were sprinklered, except a small detached wood framed shed used for furniture storage and a walk in cooler outside the kitchen service hall exit. Quality Review completed on 02/28/25			
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Based on record review and interview, the facility failed to ensure documentation was provided for the testing of 1 of 1 battery powered emergency light unit that was tested monthly for 30 seconds during 3 of the past 12 months, and annually for 90 minutes during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires	K 0291	No residents were affected by this tag. No other residents were affected. Maintenance Director has begun logbook and proof of testing. M**CORRECTIVE ACTION** No residents were affected by the alleged deficiency. **RESIDENTS HAVING THE**	04/17/2025

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	functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility did have a line item on the emergency generator monthly load testing form indicating emergency lighting was tested monthly. There was no documentation on the form for November and December of 2024 and January of 2025 that the emergency light was tested for 30 seconds. Furthermore, there was no documentation available to show the battery powered emergency light unit was tested annually for 90 minutes during the past 12 month period. Based on interview at the time of record review, the Maintenance Director said he does test the battery powered emergency light unit at the generator during each monthly load test, but must have forgotten to document the 30 second tests for November and December of 2024 and January of 2025. He further said there is no documentation of a 90 minute test of the battery powered emergency light unit available for review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**POTENTIAL TO BE AFFECTED** Residents may have the potential to be affected but are not identified. **MEASURES PUT INTO PLACE / SYSTEMIC CHANGES** The Maintenance Director or designee will perform the 30 second monthly test has been completed. The 90 minute annual test by 4/17/2025 utilizing the current logging tool including the time frame for the month as scheduled. **MONITORING** The Maintenance Director will monitor the competition of the testing and document on the monitoring tool. The Maintenance Director will follow up on it's completion before the end of the month it is scheduled to ensure completion of the check and the documentation. A report or copy of the results will be given to the facility Administrator. Any area or areas of concern will be reviewed and addressed as necessary at this time. The results will be reviewed monthly at the Quality Assurance Performance Committee Meeting for 6 month . Afterwards it will be reviewed for patterns requiring changes. **Completion Date 4/17/2025**	

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K 0300 SS=F Bldg. 01	3.1-19(b) NFPA 101 Protection - Other 1. Based on record review and interview, the facility failed to ensure the preventative maintenance for all battery operated smoke alarms in resident rooms was conducted according to manufacturer's published instructions. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and the Maintenance Director present, the "Maintenance Log for Resident Room Smoke Detector Test" showed monthly testing of the battery operated smoke alarms. The manufacturer's published instructions on the back side of each smoke alarm stated the alarms require weekly testing. Based on interview at the time of record review, the Maintenance Director stated the smoke alarms are tested monthly, and agreed the alarms should be tested weekly according to manufacturer's published instructions.	K 0300	No residents were affected by this tag. No other residents were affected by this tag. Maintenance Director will have the smoke detectors inspected as required. Prop **K 0300** **CORRECTIVE ACTION** No residents were affected by the alleged deficiency. **RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. **MEASURES PUT INTO PLACE / SYSTEMIC CHANGES** The Maintenance Director and or Designee has begun the battery checks for residents rooms . A smoke detector battery test check will be performed weekly thereafter according to the devices manufacturers guidelines. Corrections will be made as soon as possible. The testing dates and results will be documented in the log book.	04/17/2025

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in all resident rooms was complete. NFPA 72 14.2.1.1.1 states that to ensure operations integrity, the system shall have an inspection, testing, and maintenance program. NFPA 72 29.10 states fire-warning equipment shall be maintained and tested in accordance with manufacturer's published instructions and per the requirements of Chapter 14. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the battery operated smoke alarm maintenance documentation failed to indicate battery replacement during the past 12 month period or prior. The most recent battery replacement was documented on 01/18/24, which is over a month past due. Based on interview at the time of record review, the Maintenance Director confirmed the batteries in the resident room smoke alarms have not been replaced in the past 12 month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**MONITORING** The Maintenance Director and facility Administrator will monitor the testing dates and log for consistency and proceed with the appropriate follow up as soon as possible. The results of the smoke detector checks will be presented in the monthly Quality Assurance Performance Improvement Meeting. This monitor will be ongoing to reflect the various opportunities for action. **Competition Date 4/17/2025** er documentation and logbook to be kept.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 01 B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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K 0324 SS=F Bldg. 01	NFPA 101 Cooking Facilities 1. Based on observation and interview, the facility failed to ensure staff were instructed in the proper use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff plus all residents while in the adjoining main dining room. Findings include: Based on observations on 02/25/25 between 3:00 p.m. and 5:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the kitchen was provided with a UL 300 hood system. Based on interview with the Assistant Kitchen Manager and a cook, when asked what they would do first if there was a fire underneath the range hood and the range hood suppression system had not automatically activated, they both said they would grab the silver fire extinguisher (and pointed to it). They did not mention activating the pull station for the range hood suppression system until they were asked if they knew where it was located. This was acknowledged by the Maintenance Director at the time of observation and interview with the kitchen staff.	K 0324	No residents were affected by this tag. No other residents were affected. Maintenace Director will have a class with kitchen staff and directions will also be posted. An in-service sheet will be kept prove compliance. **CORRECTIVE ACTION** No residents were affected by the alleged deficiency. **RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED.** Residents who are in the area of the dining room have the potential to be affected. **MEASURES PUT INTO PLACE / SYSTEMIC CHANGES** The Maintenance Director will provide in-service to the kitchen staff regarding the proper use of the UL 300hood fire suppression system. Instructions for use of the portable fire extinguisher will be posted in a conspicuous area. The content of the information provided including staff signatures will be documented and filed int the appropriate area. Aside from routine cleaning , if appliances must be removed then	04/17/2025

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. 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, states cooking appliances requiring protection shall not be moved, modified, 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 states 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 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect mostly kitchen staff. Findings include: Based on observations on 02/25/25 between 3:00 p.m. and 5:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the		proper installment and verification will be professionally completed by Koorsen Environmental. **MONITORING** The Maintenance Director, facility Administrator will ensure following up for the instruction, content, and staff signatures including legible and updated posting. A summary will be provided in the next Quality Assurrance / Performance Improvement Meeting. A summary will be submitted thereafter with new hires. This monitor will be ongoing to reflect changes in staffing. **Completion Date** **4/17/2025**	

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	stove located under the range hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved designed location after it had been moved for maintenance and/or cleaning. Based on interview at the time of observation, the Administrator and Maintenance Director said they were not aware an approved method had to be provided to ensure the appliances were returned to an approved designed location after maintenance or cleaning. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy for the protection of all occupants indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the facility did provide fire watch documentation from the Emergency Preparedness Manual, however, it was incomplete. The plan failed to include contacting the IDOH with the web link for contacting the Incident Reporting System located on the IDOH	K 0346	No residents were affected by this tag. No other residents were affected, and the manual will be update appropriately. Inservice staff to ensure awareness of updated manuals at each nurse's station. Annual monitoring and updates will be placed in the manual as needed. **CORRECTIVE ACTION** No residents were affected by the alleged deficiency.	04/17/2025

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	155354	A. BUILDING 01 B. WING	02/25/2025

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	Gateway. Based on an interview at the time of record review, this was confirmed by the Administrator. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. The policy for Firewalks including the essential elements will be reviewed for revisions. The revisions will include trained personnel to continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department. The person should not only be looking for the fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are functioning properly. The event will be reported to the Indiana Stated Department Of Health reporting system per reportable guidelines. The policy for the sprinkler system will be reviewed for revisions. The revisions will include trained personnel to continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department. The person should not only be looking for the fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are functioning properly. In the event the sprinkler system is out of service for 10 or more hours in a 24- hour period then that portion of the building will be	

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	155354	A. BUILDING 01 B. WING	02/25/2025

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			evacuated or an approved fire watch will be provided until the sprinkler system has returned to service. The event will be reported to the Indiana State Department Of Health reporting system. Facility staff will be in serviced to ensure knowledge of the updates. The information will be included in the Facility New Hire Packets. Policies will be reviewed annually with staff. The Emergency / Disaster Manual will be updated to include the changes. **MONITORING** The Maintenance Director and facility Administrator or designee will monitor the event and proceed with the appropriate follow up. The facility Staff Development Coordinator will ensure New Hires and annual inservices are provided. The results will be presented in the monthly Quality Assurance Performance Improvement Meeting. This monitor will be ongoing to reflect the various opportunities for action. **Completion Date 4/17/2025**	
K 0351 SS=F	NFPA 101 Sprinkler System - Installation			

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	155354	A. BUILDING 01 B. WING	02/25/2025

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Bldg. 01	Based on observation and interview, the facility failed to ensure the sprinkler system piping was properly secured in 1 of 1 attic area throughout the facility. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 9.2.3.7 states Sprigs 4 feet or longer shall be restrained against lateral movement. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. the Maintenance Director presented a proposal dated 10/01/24 from the facility's sprinkler vendor to add seismic bracing for the sprinkler piping in the attic. The proposal included horizontal and vertical sprig sprinkler pipes. Based on interview at the time record review, the Maintenance Director said there is no scheduled date for the sprinkler vendor to start the work. Based on observations between 3:00 p.m. and 5:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, there were at least 150 or more sprinkler pipe sprigs in the attic space that were not restrained against lateral movement. The sprinkler pipe sprigs were at least 5 feet in length. This was acknowledged by the Maintenance Director at the time of observations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0351	No residents were affected by this tag. No other residents were affected. This tag has been corrected. Annually visualize system. **CORRECTIVE ACTION** The bracing for the attic sprinkler sprigs has been corrected by Tristate Fire Protection. No residents were affected. **RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by the alleged deficiency. **MEASURES PUT INTO PLACE / SYSTEMIC CHANGES** The system will be manually visualized by the Maintenance Director annually and as the need may arise. The facility will continue the Services of Tristate Fire Protection. **Monitoring** The Maintenance Director will monitor and follow up with the facility Administrator annually and as needed. A summary of reports will be included in the next Quality Assurance Performance Meeting and annually thereafter. **Competition Date 4/17/2025**	03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 01 B. WING	02/25/2025

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its 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 record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, documentation of an internal inspection of the sprinkler system performed within the most recent five year period was not available for review. Documentation for the most recent internal pipe inspection performed was dated 01/14/20, which was over a month past due. Based on interview at the time of record review,	K 0353	No residents were affected by this tag. No other residents were affected. This tag has been corrected. 5 year visualize system. **K 353** **CORRECTIVE ACTION** The sprinkle system has been assessed and completed by Tristate Fire Protection. **RESIDENT'S HAVING THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by the alleged deficiency. **MEASURES / SYSTEMIC CHANGES** The Maintenance Director will maintain a 5 year schedule or log for inspection and visualization of the sprinkler system. **MONITORING** The Maintenance Director will review the schedule / log with the facility administrator. A summary of the report will be reviewed at the next Quality Assurance Performance Improvement Meeting and as needed.	03/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 01 B. WING	02/25/2025

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	the Maintenance Director said there is no scheduled date for the sprinkler vendor to perform the internal pipe inspection/investigation, but he will contact and schedule them as soon as possible. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**Completion Date 4/17/2025**	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility.	K 0354	No residents were affected by this tag. No other residents were affected. Policy will be written to ensure are staff are in-serviced. Conduct random questions with staff to ensure understanding.	04/17/2025

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	155354	A. BUILDING 01 B. WING	02/25/2025

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	Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the facility provided fire watch documentation from the Emergency Preparedness Manual, however, it was incomplete. The plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway, furthermore, the plan failed to include contact information for the facilities insurance carrier with contact information. Based on an interview at the time of record review, the Administrator agreed the fire watch policy lacked the previously mentioned information. This finding was reviewed with the Administrator and Maintenance Director during the exit conference 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of all residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms	K 0711	No residents were affected by this tag. No other residents were affected, and the manual will be update appropriately. Inservice staff to ensure awareness of updated manuals at each nurse's station and communication plan. Annual monitoring and updates will be placed in the manual as needed.	04/17/2025

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	155354	A. BUILDING 01 B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	(5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states that any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: 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 all occupants in the event of an emergency. Findings include: Based on a review of the facility's Fire Procedure plan on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Director present, the plan did not address the following: a. The plan did not address evacuation of the smoke compartment, furthermore, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. b. The plan did not address staff response to the activation of battery powered smoke alarms in the residents' rooms. Based on interview at the time of record review, the Administrator and Maintenance Director acknowledged the Fire Procedure plan did not include the previously mentioned items.			

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	155354	A. BUILDING 01 B. WING	02/25/2025

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to ensure 4 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, all four third shift fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Director confirmed there was no information included with 4 of 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3-1.19(b)	K 0712	No residents were affected by this tag. No other residents were affected. Monthly times will be changed. Monthly fire book will be updated accordingly. **CORRECTIVE ACTION** The fire Drill Log will be updated to include the activation of the alarm system and the variance in the times of the drills. No residents were affected by the alleged deficiency. **RESIDENT'S HAVING THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. **MEASURES / SYSTEMIC CHANGES** The fire Drill Log will be updated to include the activation of the alarm system and the variance in the times of the drills for each shift. **MONITORING**	04/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155354	A. BUILDING 01 B. WING	02/25/2025

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	3.1-51(c) 2. Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the following was noted: a. 3 of 4 first shift (day) fire drills were performed between 10:15 a.m. and 10:38 a.m. b. 4 of 4 second shift (evening) fire drills were performed between 2:30 p.m. and 3:15 p.m. c. 3 of 4 third shift (night) fire drills were performed between 10:00 p.m. and 10:40 p.m. Based on interview at the time of record review, the Maintenance Director acknowledged the times all three shifts fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		The Maintenance Director will review the log with the facility administrator. A summary of the report will be reviewed at the next Quality Assurance Performance Improvement Meeting and as needed. **Completion Date 4/17/2025**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 area where cigarettes were allowed to be smoked by staff. This deficient practice could affect staff only.	K 0741	No residents were affected by this tag. No other residents were affected by this tag. Maintenance Director will expect	04/17/2025

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	155354	A. BUILDING 01 B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

(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
	Findings include: Based on observations on 02/25/25 between 3:00 p.m. and 5:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the designated staff smoking area outside the rear kitchen exit door had hundreds of cigarette butts scattered on the ground, along with two small metal self-closing ash trays on a table and both full of cigarette butts. There was no metal cigarette butt can with self-closing lid provided at the staff smoking area. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged the issues with the cigarette butts on the ground and lack of ways to dispose of the cigarette butts properly. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		grounds daily. In-service on properly exposing cigarettes.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to provide complete documentation for the testing of 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years (36 months). Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and	K 0918	No residents were affected by this tag. No other residents were affected by this tag. Maintenance Director will maintain logbook. Will place on calendar every 3 years for reminder.	04/17/2025

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	Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, the facility was unable to provide documentation of a four hour load test of the emergency generator conducted within the past 36 month period. This was confirmed by the Maintenance Director at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of routine maintenance and testing for 1 of 1 emergency generator was maintained and available for review. NFPA 110, the Standard for Emergency and Standby Powers Systems, at 8.3.3 requires a written schedule for routine maintenance and operational testing of the EPSS shall be established. 8.3.4 requires a permanent record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. 8.3.4.1 requires the permanent record shall include the following: (1) The date of the maintenance report (2) Identification of the servicing personnel (3) Notification of any unsatisfactory condition and the corrective action taken, including parts replaced (4) Testing of any repair for the time as recommended by the manufacturer. This deficient practice could affect			

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	all residents, staff and visitors. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator has had routine maintenance during the past 12 months. The most recent routine maintenance report for the emergency generator was dated 01/09/24, which was over a month past due. Based on interview at the time of record review, the Maintenance Director said there is currently no scheduled date for the generator vendor to come to the facility to perform routine maintenance service on the emergency generator. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure power strips and extension cords were not used as a substitute for fixed wiring in 1 of 64 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect one resident.	K 0920	No residents were affected by this tag. No other residents were affected by this tag. Maintenance Dir will remove all extensions and power strips out of resident rooms. Visual inspection monthly.	04/17/2025

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	Findings include: Based on observations on 02/25/25 between 3:00 p.m. and 5:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, resident room 19 had two unapproved power strips. One was plugged into the wall receptacle, but had nothing plugged into it, the other had at least two unidentifiable items plugged into it. Those items could not be determined due to being partially obscured by storage items. Furthermore, there was a string of white Christmas lights (approximately 100 to 200 lights) hanging over the window curtains and turned on at the time of observation. When asked, the Maintenance Director said the Christmas lights are always hanging over the window curtains. This was acknowledged by the Administrator and Maintenance Director at the time of observation. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in	K 0921	No residents were affected by this tag. No other residents were affected by this tag. Will ensure PCREE testing is completed as required. Will maintain a logbook for documentation.	04/17/2025

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	accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents. Findings include: Based on record review on 02/25/25 between 10:00 a.m. and 3:00 p.m. with the Maintenance Director present, there was no documentation for the testing of PCREE, such as electric beds, nebulizers, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment. Based on interview at the time of record review, the Maintenance Director said the facility has not tested and documented the PCREE items and was not aware of the requirement. Based on observation between 3:00 p.m. to 5:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, it was revealed the facility provided PCREE such as electric beds, oxygen concentrators, air pumps for air mattresses, and other electrical medical equipment was present in the facility.			

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			