STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155271	A. BUILDING -- B. WING	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

(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: 10/23/24 Facility Number: 000171 Provider Number: 155271 AIM Number: 100267050 At this Emergency Preparedness survey, The Waters of Castleton Skilled Nursing Facility was found 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 45. Quality Review completed on 10/25/24	E 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
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: 10/23/24 Facility Number: 000171 Provider Number: 155271 AIM Number: 100267050 At this Life Safety Code survey, The Waters of	K 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sherice Ricks	Admin	11/08/2024

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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	Castleton Skilled Nursing Facility was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type III (211) construction and 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 in all resident sleeping rooms. The facility has a capacity of 114 and had a census of 45 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing storage services which was not sprinklered. Quality Review completed on 10/25/24		**This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Based on observation and interview, the facility failed to replace battery operated smoke alarms installed in 1 of over 60 resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.2.1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service	K 0300	**K300**– It is the intent of the facility to ensure to replace battery operated smoke alarms installed in over 60 resident sleeping rooms in accordance with NFPA 72 to meet set standards. **1 CORRECTIVE ACTIONS TAKEN**: a On 10.23.24 the Maintenance Supervisor/designee replaced the battery-operated smoke detector including the battery in resident room 104 to	11/08/2024

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	longer than 10 years from the date of manufacture. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room 104. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 2:40 p.m. on 10/23/24, "01/12/12" was written on the outside of the battery operated smoke detector mounted on the suspended ceiling of resident sleeping Room 104 The smoke detector could not be removed from the ceiling to check any manufacturer's documentation affixed to the smoke detector. Based on interview at the time of the observations, the Maintenance Director stated Room 104 was being used as a showroom for prospective resident families. The showroom was not accessible when all other resident sleeping smoke detectors were replaced last year due to their age and agreed the battery operated smoke detector installed in Room 104 was more than ten years old. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		meet set standards. The Administrator verified the work on 10.23.24. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10.30.24 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure to replace the battery-operated smoke alarms installed in resident sleeping rooms to meet set standards. b Maintenance Supervisor/designee will ensure all battery-operated smoke alarms are maintained and tested per manufactures guidelines and will document the results on the Battery-Operated Smoke Detector Maintenance Log to be filed in the Life Safety Binder as a part of the facility's Preventive Maintenance Program. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4 MONITORING CORRECTIVE ACTION: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be	K 0353	**K353** – It is the intent of the facility to ensure to maintain automatic sprinkler systems in accordance with NFPA 25 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10.3.24 the licensed sprinkler contractor made repairs to the dry and wet sprinkler systems and corrected all deficiencies, and the documentation was put into the	11/08/2024

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	performed by qualified maintenance personnel or a qualified contractor. NFPA 25, Section 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the sprinkler system inspection contractor's "Invoice #: i129173" documentation dated 01/26/24 with the Administrator, the Director of Operations and the Maintenance Director during record review from 9:20 a.m. to 12:45 p.m. on 10/23/24, deficiencies were noted for the facility's wet sprinkler system. In addition, review of the sprinkler system inspection contractor's "Work Performed" documentation dated 07/22/24 indicated deficiencies were also noted for the facility's dry sprinkler system. The 01/26/24 wet sprinkler system inspection documentation stated "Further Work Required: Send quote to replace 1/4 in gauge valve that was broken at the packing nut". The 07/22/24 dry sprinkler system inspection documentation stated "Further Work Required: Send quote to replace Tyco accelerator on 4" CSC dry pipe valve. Accelerator did not reset after the trip test". Based on interview at the time of record review, the Maintenance Director stated the contractor repaired the wet and dry sprinkler systems but agreed repair documentation was not available for review at the time of the survey. Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 2:40 p.m. on 10/23/24, the facility has supervised wet and dry sprinkler systems.		Life Safety Binder to meet set standards. The Administrator verified the work on 10.23.24. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 10.30.24 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure the dry and wet sprinkler system inspections are conducted and if any deficiencies are corrected and documented to meet set standards. 2.Maintenance Supervisor/designee will ensure the dry and wet sprinkler system inspections are conducted and if any deficiencies are found they are corrected and documented as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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	These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills 1. Based on record review and interview, the facility failed to document quarterly fire drills on the second shift for 1 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator, the Director of Operations and the Maintenance Director during record review from 9:20 a.m. to 12:45 p.m. on 10/23/24, documentation of a fire drill conducted within the most recent twelve month	K 0712	**K712** –It is the intent of the facility to ensure to document quarterly fire drills on the second shift for all 4 quarters and to conduct quarterly fire drills at unexpected times under varying conditions on all three shifts for all four quarters to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 11.6.24 the Administrator in-serviced the Maintenance Supervisor on	11/08/2024

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	period on the second shift in the fourth quarter (October, November, December) 2023 was not available for review. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day, additional fire drill documentation was not available for review and agreed documentation of a fire drill conducted on the second shift in the fourth quarter 2023 was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator, the Director of Operations and the Maintenance Director during record review from 9:20 a.m. to 12:45 p.m. on 10/23/24, first shift fire drills conducted within the most recent twelve month period on 01/19/24, 07/22/24 and on 10/05/24, were conducted at, respectively, 10:00 a.m., 10:15 a.m. and 11:00 a.m. Based on interview at the time of record review, the Maintenance Director stated the facility operates three shifts per day and agreed the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions.		conducting fire drills once per shift, per quarter, at unexpected times, under varying conditions to meet set standards. The Administrator verified the work on 11.6.24. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: 1.On 10.30.24 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure fire drills are completed once per shift, per quarter, at unexpected times, under varying conditions and documented to meet set standards. b Maintenance Supervisor/designee will ensure fire drills are completed once per shift, per quarter, at unexpected times, under varying conditions as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance	

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	These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)		schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The fire drill documentation will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.**	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review, observation and interview; the facility failed to ensure the proper operation was maintained for 1 of 1 rolling steel fire doors in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of	K 0761	**K761** – It is the intent of the facility to ensure the proper operation is maintained for rolling steel fire doors in accordance with NFPA 80 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 11.7.24 the facilities fire suppression company made	11/08/2024

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	protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 2010 Edition, the Standard for Fire Doors and Other Opening Protectives, Section 11.4.1.1 requires an automatic-closing device shall be installed on every rolling steel door. Section 11.4.1.2 states rolling steel doors shall close automatically upon activation or release of a fusible link or detector. Section 11.4.2.2.1 states after the automatic closing is activated, the door shall remain in the closed position until the automatic-closing device has been reset. This deficient practice could affect over 20 residents, staff and visitors in the main Dining Room on the first floor. Findings include: Based on review of the rolling fire door inspection contractor's "Fire Alarm System Inspection" documentation dated 03/15/24 with the Administrator, the Director of Operations and the Maintenance Director during record review from 9:20 a.m. to 12:45 p.m. on 10/23/24, "the roll door failed to reset mechanically after test" and was listed as "Fail" for the result of 03/15/24 inspection and testing. Review of the rolling fire door inspection contractor's "Work Performed" documentation dated 09/26/24 indicated "was not able to test roll door due to it being broke. They are still waiting for new door to come in". Based on interview at the time of record review, the Director of Operations provided a letter from a rolling fire door contractor stating "The replacement barrel for the kitchen roll down door has been ordered. We attempted to install it on October 5th but the manufacturer sent us the wrong part. We have not got a ETA on the replacement. It will be installed as soon as possible once it arrives". Based on interview at		repairs to the kitchen roll down door to meet set standards. The Administrator verified the work on 11.7.24. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10.30.24 the Administrator inserviced the maintenance Supervisor to ensure proper operation is maintained for rolling fire doors to meet set standards. b Maintenance Supervisor/designee will ensure proper operation is maintained for rolling fire doors as a part of the facility's annual Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance	

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	the time of record review, the Director of Operations stated the facility is still awaiting repairs to the rolling fire door at the time of the survey. Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 2:40 p.m. on 10/23/24, the metal rolling fire door between the kitchen and main Dining Room on the first floor was in the closed position and was equipped with a 90-minute fire resistance label affixed to the door. The Dining Room was open to the corridor. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of	K 0918	**K918** – It is the intent of the facility to ensure to exercise the generator annually to meet the requirements of NFPA 110, 2010 edition, the standard for emergency and standby powers systems, chapter 8.4.2 and to ensure to document 36-month period emergency generator testing for emergency generators in accordance with NFPA 99 and NFPA 110 to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 11.8.24 the licensed contractor conducted the 4-hour	11/08/2024

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	8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review "Emergency Generator-Monthly Test Log" documentation for the most recent twelve month period with the Administrator, the Director of Operations and the Maintenance Director during record review from 9:20 a.m. to 12:45 p.m. on 10/23/24, the actual load percentage achieved for the Cummins diesel fuel fired emergency generator during monthly load testing did not meet or exceed 30% or higher for any of the twelve monthly load tests. Based on interview at the time of record review, the Maintenance Director stated annual supplemental load bank testing documentation for the most recent twelve month period was not available for review. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type		load bank test on the generator and document the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work on 11.8.24. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10.30.24 The Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure the generator is ran at 30% or higher on the monthly load test and documented in the life safety binder to meet set standards. b The Maintenance Supervisor/designee will ensure the generator is ran at 30% or higher on the monthly load test and documented in the life safety binder as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	

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	155271	A. BUILDING 01 B. WING	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CASTLETON SKILLED NURSING FACILITY, THE	8400 CLEARVISTA PL INDIANAPOLIS, IN 46256

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	1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Administrator, the Director of Operations and the Maintenance Director during record review from 9:20 a.m. to 12:45 p.m. on 10/23/24, thirty-six-month period emergency generator testing documentation for four continuous hours for the Cummins diesel fired emergency generator was not available for review. Review of "4 hour Load Bank Load Test Form" for testing conducted by facility staff and dated 08/30/23 indicated the load percent for the duration of the 4 hour test never exceeded 29% load. Based on interview at the time of record review, the Director of Operations and the Maintenance Director stated additional documentation of supplemental load testing for four hours within the most recent three-year period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 2:40		Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.**	

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	p.m. on 10/23/24, the facility has one Cummins diesel fired emergency generator located outside the building on the north side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 80 kW. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Med Room on the 1st floor by the nurse's station. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 1:10 p.m. to 2:40 p.m. on 10/23/24, a refrigerator and a Med Bank device were plugged into a power strip	K 0920	**K920** – It is the intent of the facility to ensure extension cords including power strips are not used as a substitute for fixed wiring to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10.23.24 the Maintenance Supervisor/designee removed the power strip from the med room on the first floor by the nurse's station to meet set standards. The Administrator verified the removal on 10.23.24. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. On 10.23.24 the Maintenance Supervisor/designee inspected all rooms throughout the facility for power strips and extension cords and found no other negative	11/08/2024

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	placed on the floor in the Med Room on the first floor by the nurse's station. Based on interview at the time of the observations, the Maintenance Director agreed a power strip was being used as a substitute for fixed wiring at the aforementioned location and unplugged the refrigerator from the power strip. These findings were reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		findings. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 10.23.24 the Administrator inserviced the Maintenance Supervisor/designee/all other staff that power strips and extension cords are not to be used as a substitute for fixed wiring to meet set standards. 2.Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly to ensure they do not have power strips or extension cords in use as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 11/8/2024.**	