STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155679	A. BUILDING -- B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHLEHEM WOODS NURSING AND REHABILITATION	4430 ELSDALE DR FORT WAYNE, IN 46835

(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: 05/09/23 Facility Number: 000260 Provider Number: 155679 AIM Number: 100267820 At this Emergency Preparedness survey, Bethlehem Woods Nursing and Rehabilitation was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 90 and had a census of 75 at the time of this survey. Quality Review completed on 05/10/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 05/09/23 Facility Number: 000260 Provider Number: 155679 AIM Number: 100267820 At this Life Safety Code survey, Bethlehem Woods Nursing and Rehabilitation was found in compliance with Requirements for Participation in	K 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of Credible Allegation. Based on past survey history and no harm identified to any resident; this facility respectfully requests a desk review in lieu of a post survey	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
JoElyn Louise Morris	Administrator	05/19/2023

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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	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 smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 90 and had a census of 75 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except a maintenance shed used to store maintenance supplies and a shed used for storage of paperwork. Quality Review completed on 05/10/23		revisit on or before May 22, 2023.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 5 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 25 residents on the 300-hall.	K 0211	K 211 It is the practice of this provider to ensure that all corridor means of egresses are	05/22/2023

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	Findings include: Based on observation with the Maintenance Director and the Field Maintenance Supervisor on 05/09/23 at 11:08 a.m., the 300-hall exit corridor contained a dresser, trashcan not on wheels, and a mattress taking up two feet of corridor width. Based on an interview at the time of observations, the Maintenance Director agreed there were items stored on the 300-hall exit corridor and the items were removed. This finding was reviewed with the Administrator, Field Maintenance Supervisor, and Maintenance Director during the exit conference. 3.1-19(b)		continuously maintained free of all obstructions. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The items found on 300 hall during survey (dresser, trashcan not on wheels, and a mattress) were all removed immediately on 5/9/23. **How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken:** All residents have the potential to be affected by the alleged deficient practice. All corridor means of egresses in facility are free of obstructions. Department head personnel made sure	

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			Of this on May 9th. Daily Life Safety Code rounds are performed to ensure that all corridor means of egresses are continuously kept free of obstructions. All staff in-servicing was completed as of May 22nd, 2023 to ensure that all employees are aware of the importance and necessity of ensuring that all means of egresses are to be continuously maintained free of all obstructions for full use in case of emergency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**: Daily Life Safety Code rounds sheets are utilized daily. These daily round sheets will include ensuring that all corridor means of egresses are free of all obstructions. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of	

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			Nursing are responsible to collect and review these rounds sheets consistently and ensure any areas found needing attention will be addressed immediately. This will include ensuring that all corridors are barrier free. Administrator and Director of Nursing and other Departmental Leaders will also perform daily rounds. How the corrective action will be **monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** To ensure compliance, the Administrator and/or Designee will ensure that daily rounds are occurring and the round sheets are turned in daily. The results of these daily rounds and the observations and corrections identified will be reviewed by the Leadership Team at least 5 days out of 7 at the daily morning	

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			meeting. Repetitive concerns found will be addressed via re- in-servicing and follow up. Results of these daily rounds will be reviewed at the monthly QAPI meetings overseen by the Administrator. **By what date the systemic changes will be completed:** May 22, 2023	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 5 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side	K 0232	K 232 It is the practice of this provider to meet the clear width requirement for all corridors. **What corrective action will be accomplished for those residents found to have been affected by the**	05/22/2023

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	of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 20 residents using the main entrance. Findings include: Based on observation with the Maintenance Director and the Field Maintenance Supervisor on 05/09/23 at 11:38 a.m., two chairs and a desk were in the corridor near the main entrance and extended about two feet into the corridor and were not affixed to the floor or to the wall when tested. Based on interview at the time of the observations, the Maintenance Director agreed the chairs and desk were not securely attached to the floor or to the wall when tested. This finding was reviewed with the Administrator, Field Maintenance Supervisor, and Maintenance Director during the exit conference.		**deficient practice:** Two chairs and a desk that were in the main entrance were removed on 5/9/23 and 5/10/23. No residents were affected. **How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken:** No residents were affected by this practice, however the potential existed for all residents to be affected. No furniture will be placed in the front main entrance, unless it abides with the Life Safety Code regulation of being fixed furniture that is securely attached to the floor or wall, and does not reduce the clear unobstructed corridor width to less than six feet, along with all other legal requirements. The main entrance will be checked daily for compliance to this regulation by utilizing a daily Life	

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	3.1-19(b)		Safety Code rounds sheet checkoff list. All staff in-servicing was completed as of May 22nd, 2023 to ensure that all employees are aware of the importance and necessity of ensuring that the main entrance is to be continuously maintained free of all unsecured furniture, desks, or any other obstructions to allow for full use in case of emergency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Daily rounds sheets are utilized daily. These daily round sheets will include ensuring that all corridor means of egresses are free of all obstruction, including the Main entryway. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and review these rounds sheets daily and ensure any areas	

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			found needing attention will be addressed and fixed immediately. This will include ensuring that all corridors are barrier free and within regulation, including the main entryway. Administrator and Director of Nursing and other Departmental Leaders will also perform daily rounds. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** To ensure compliance, the Administrator and/or Designee will ensure that Life Safety Code daily rounds are occurring and the round sheets are turned in daily. The results of these daily rounds and the	

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			observations and corrections identified will be reviewed by the Leadership Team at least 5 days out of 7 at the daily morning meeting. Repetitive concerns found will be addressed via re- in-servicing and follow up. Results of these daily rounds will be reviewed at the QAPI meetings overseen by the Administrator. **By what date the systemic changes For each deficiency will be completed**:	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 7 exit doors were properly marked as an exit. LSC 7.10.1.1 states where required the means of egress shall be marked in accordance with Section 7.10 where required in Chapters 11 through 43. This deficient practice	K 0293	K 293 It is the practice of this provider to always ensure that all exit doors are properly marked as exits.	05/22/2023

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	could affect 25 residents on the 300-hall. Findings include: Based on observation with the Maintenance Director and the Field Maintenance Supervisor on 05/09/23 at 11:18 a.m., conflicting signage was provided for the 300-hall exit door. Above the door there was an "EXIT" sign and in the middle of the door there was a "NOT AN EXIT" sign. Based on interview at the time of the observations, the Maintenance Director stated the door is an exit and the "Not An Exit" sign was for visitors so they would only use the main entrance. The "NOT AN EXIT" sign was removed. This finding was reviewed with the Administrator, Field Maintenance Supervisor, and Maintenance Director during the exit conference. 3.1-19(b)		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** No residents were affected. All residents on 300 hall had the potential to be affected. The “Not an Exit” sign was immediately removed during the Survey on May 9th from the 300 hall Exit door. **How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken:** No residents were affected. All residents in the building have the potential to be affected by conflicting signage on Exit doors. On the day of the survey, May 9th, all exit doors were checked to ensure that no “Not an Exit” sign	

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			or any conflicting signage existed on any of the exit doors. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Daily Life Safety Code rounds sheets are utilized daily. These daily rounds sheets will include ensuring that all exit doors have correct exit signage with no other conflicting exit information or signage. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and review these rounds sheets daily and ensure any areas found needing attention will be addressed and fixed immediately. This will include ensuring that all corridors are barrier free and within regulation, including the main entryway, and that no conflicting Exit signage information exists on any of the exit doors. Administrator and Director of	

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			Nursing and other Departmental Leaders will also perform daily rounds to ensure compliance. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** To ensure compliance, the Administrator and/or Designee will ensure that daily rounds are occurring and the round sheets are turned in daily. The results of these daily rounds and the observations and corrections identified will be reviewed by the Leadership Team at least 5 days out of 7 at the daily morning meeting. Repetitive concerns found will be addressed via re- in-servicing and follow up. Results of these daily rounds will be reviewed at the QAPI meetings overseen by the Administrator.	

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			By what date the systemic changes For each deficiency will be completed: May 22, 2023	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure the spray pattern for 1 of 1 sprinkler heads were not obstructed in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below	K 0353	K 353 It is the practice of this provider to ensure the spray pattern of all sprinkler heads is not obstructed. **What corrective action will be accomplished for those**	05/22/2023

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	the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 5 residents around the marketing office. Findings include: Based on observation with the Maintenance Director and the Field Maintenance Supervisor on 04/26/23 at 11:40 a.m., the closet in marketing office had items stored about 4 to 6 inches away the deflector of the sprinkler head. Based on interview at the time of observation, the Maintenance Director agreed the items were less than 18 inches from the sprinkler and would obstruct sprinkler coverage. This finding was reviewed with the Administrator, Field Maintenance Supervisor, and Maintenance Director during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice:** No residents were affected. The items in the marketing office closet's top shelf were removed immediately during the survey on May 9th. In addition, the top shelf itself in the marketing office closet was removed on May 17th, 2023 so that nothing can be stored to come anywhere close to the sprinkler head in that closet. **How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken:** No residents were affected. All residents could be affected by any obstructed sprinkler heads. A whole house check was performed on May 16th,to ensure that	

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(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
			no sprinkler heads were obstructed in any location. All were found to be clear of obstruction. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Daily Life Safety Code rounds sheets are utilized daily. These daily rounds sheets will include ensuring that no sprinkler heads in the facility are obstructed by anything within 18 inches of the ceiling. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and review these rounds sheets daily and consistently and ensure any areas found needing attention will be addressed and fixed immediately. This will include ensuring that all corridors are barrier free and within regulation, including the main entryway, no conflicting Exit signage exists, and no obstructions are within 18	

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	155679	A. BUILDING 01 B. WING	05/09/2023

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			inches of any sprinkler heads. Administrator and Director of Nursing and other Departmental Leaders will also perform daily rounds. . **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place:** To ensure compliance, the Administrator and/or Designee will ensure that daily rounds are occurring and the round sheets are turned in daily. The results of these daily rounds and the observations and corrections identified will be reviewed by the Leadership Team at least 5 days out of 7 at the daily morning meeting. Repetitive concerns found will be addressed via re- in-servicing and follow up. Results of these daily rounds will be reviewed at the QAPI meetings overseen by the Administrator.	

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			By what date the systemic changes For each deficiency will be completed: May 22, 2023	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 50 of 50 resident sleeping rooms were tested at least annually.	K 0914	K 914 It is the practice of this provider to ensure that all non-hospital grade	05/22/2023

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	NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Field Maintenance Supervisor on 05/09/23 between 11:00 a.m. and 1:00 p.m., the facility's 50 resident sleeping rooms each had four to eight non-hospital-grade electrical receptacles. Based on records review at 10:30 a.m., no documentation was available to show the last time the electrical receptacles in resident sleeping rooms were tested. Based on interview at the time of the observation and records review, the Field Maintenance Supervisor confirmed all the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated it is unknown the last time the annual testing was completed. This finding was reviewed with the Administrator, Field Maintenance Supervisor, and Maintenance		receptacles in all 50 of 50 resident sleeping rooms are tested and documented as such at least annually. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** All non-hospital grade receptacles in 50 of 50 resident rooms have been tested with documented results as of May 18, 2023. Those few found out of compliance were replaced. Final testing results showed all receptacles tested and in compliance per regulation. **How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken:** No residents were affected, but all residents had the	

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	Director during the exit conference. 3.1-19(b)		potential to be affected. The Maintenance Field Supervisor in-serviced two departmental leaders on how to properly test the non-hospital grade receptacles, what testing machine to use, and how to do the appropriate documentation. Those two leaders then tested all resident room receptacles to ensure receptacles tested within required limits. This task is listed in the TELS Preventative Maintenance computer system and will trigger the Maintenance Supervisor or Administrator's Designee to accomplish this required receptacle testing and documentation annually. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:**	

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			Daily Life Safety rounds sheets are utilized daily. These daily round sheets will include ensuring the visible integrity of all resident room receptacles. Any issues found during the rounds will be addressed Immediately. The Administrator or Designee will check The TELS reports to ensure compliance with all tasks assigned prior to each QAPI meeting. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and review these rounds sheets daily and consistently and ensure any areas found needing attention will be addressed and fixed immediately. This will include ensuring that all corridors , including the main entryway, are barrier free and within regulations, no conflicting Exit signage exists, all sprinkler heads in the facility are free of obstructions, and the visible integrity of receptacles is intact. Administrator and Director of Nursing and other Departmental Leaders will perform daily rounds.	

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			How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: To ensure compliance, the Administrator and/or Designee will ensure that daily rounds are occurring and the round sheets are turned in daily. The results of these daily rounds and the observations and corrections identified will be reviewed by the Leadership Team at least 5 days out of 7 at the daily morning meeting. Repetitive concerns found will be addressed via re- in-servicing and follow up, and disciplinary action when necessary. The Administrator or Designee will check The TELS reports to ensure compliance with all tasks assigned prior to each QAPI meeting. Results of these daily rounds will be reviewed	

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			at the QAPI meetings overseen by the Administrator. **By what date the systemic changes For each deficiency will be completed:** May 22, 2023	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			

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	#1.) Based on observation and interview, the facility failed to ensure 1 of 1 multi-plug adaptors was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 5 residents outside of the Activities office. Findings include: Based on observation with the Maintenance Director and the Field Maintenance Supervisor on 05/09/23 at 11:48 a.m., multi-plug adaptor powering computer equipment was being used in the Activities office. Based on interview at the time of observation, the Maintenance Director and agreed a multi-plug adaptor was in use in the Activities office. #2.) Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. This deficient practice could affect up to 5 residents outside of the DON office. Findings include: Based on observation with the Maintenance Director and the Field Maintenance Supervisor on 05/09/23 at 12:18 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the DON office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip	K 0920	K 920 It is the practice of this provider to ensure that multi-plug adapters are not used as a substitute for fixed wiring, and power strips are not used as a substitute for fixed wiring to provide power equipment with a high current draw. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** On May 9th, during survey, the multi-plug adapter in the Activity Office was removed. Nothing will be plugged in unless it is plugged into the wall directly or into a medical grade approved.device. Also, on May 9th, during survey, the refrigerator in the Director of Nursing's office was moved to an area where it could be directly plugged into the fixed wiring wall receptacle.	05/22/2023

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	was supplying power to high power draw equipment. The findings were reviewed with the Administrator, Field Maintenance Supervisor, and Maintenance Director during the exit conference. 3.1-19(b)		**How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action will be taken:** No residents were affected by this practice. All residents could have been affected by this practice. A whole house audit on May 16th was done to ensure that no non-medical grade power devices were being used or being used incorrectly. All high current draw power equipment is plugged directly into the fixed wiring receptacles. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Daily Life Safety Code rounds sheets are utilized daily. These daily round sheets will include ensuring	

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			that all powered devices and equipment are plugged into the regulation approved receptacles. Re-inservicing for all staff was completed effective May 22, 2023. Administrator and Director of Nursing are responsible to collect and review these rounds sheets daily and consistently and ensure any areas found needing attention will be addressed and fixed immediately. This will include ensuring that all corridors , including the main entryway, are barrier free and within regulations, no conflicting Exit signage exists, all sprinkler heads in the facility are free of obstructions, the visible integrity of receptacles is intact, and all powered devices are plugged into regulation approved receptacles. Administrator and Director of Nursing and other Departmental Leaders will perform daily rounds. **How the corrective action will be monitored to ensure the deficient**	

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