STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155621	A. BUILDING -- B. WING	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

(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: 12/02/24 Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510 At this Emergency Preparedness survey, River Bend Nursing and Rehabilitation was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 113 certified beds and had a census of 63 at the time of this visit. Quality Review completed on 12/06/24 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12/30/24, the annual licensure survey completed on November 14, 2024. The facility respectfully asks for a desk review.	
E 0025 SS=F 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.	E 0025	**It is the practice of this facility to assure that 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**	12/30/2024

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

Eric Ross | Administrator | 12/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING -- B. WING	12/02/2024

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RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

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	Findings include: Based on review of the Emergency Preparedness Binder on 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Maintenance Director and Administrator 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 2018 for two of the facility's, and 2001 for the other facility. Based on interview at the time of record review, the Administrator agreed the documentation of arrangements with other facilities needs to be updated. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**continuity of service to LTC residents. The corrective action taken for those residents found to be affected by the deficient practice include:** Arrangements with other LTC Facilities were made current. **Other residents that have the potential to be affected have been identified by:** No further issues were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Administrator was Re-educated by RDO that arrangements with other LTC facilities must be made annually. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews the emergency preparedness binder to	

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			ensure that it is current. The Administrator, or designee, will complete this tool monthly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(EP Training Program Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Binder on 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Maintenance Director and Administrator present, no documentation of annual emergency	E 0037	**It is the practice of this facility to assure that annual emergency preparedness training is completed with all staff. The corrective action taken for those residents found to be affected by the deficient practice include:** Emergency preparedness training Was completed with all staff. **Other residents that have the potential to be affected have been identified by:** No further issues were identified. **The measures or systematic**	12/30/2024

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	preparedness training and no documentation to show staff could demonstrate knowledge of the emergency preparedness plan was available for review. Based on an interview during a tour of the facility, when asked, the Human Resources person said she is responsible for new hires being trained in Emergency Preparedness and other training courses but has not been responsible for Emergency Preparedness annual training for existing staff, and further said she didn't think it was being performed currently. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**changes that have been put into place to ensure that the deficient practice does not recur include:** Maintenance Director was Re-educated by Administrator That all staff must receive annual Emergency preparedness training And that new staff must receive emergency preparedness training before working the floor. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all staff to ensure that emergency preparedness training is completed upon hire and annually thereafter. The Administrator, or designee, will complete this tool Monthly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	

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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). Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 41 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly since February 14, 2024. Furthermore, the cover	E 0041	**It is the practice of this facility to assure that emergency generator is inspected/tested weekly. The corrective action taken for those residents found to be affected by the deficient practice include:** The generator was inspected/tested On (DATE). There were no issues Found. **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. No issues were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Maintenance Director was Re-educated by Administrator That the emergency generator	12/30/2024

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	page for the weekly inspection of the emergency generator in the life safety folder stated, "As of 2/28/24 we no longer do weekly generator testing on equipment." Based on interview at the time of record review, the Maintenance Director said he was under the impression that he no longer needed to perform weekly inspections of the generator but was recently told by his regional support person that he needed to continue the weekly inspections. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		Must be inspected/tested on A weekly basis. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews documentation to assure that the emergency generator is inspected/tested on a weekly basis. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
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: 12/02/24 Facility Number: 000442	K 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our	

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	Provider Number: 155621 AIM Number: 100266510 At this Life Safety Code survey, River Bend Nursing and Rehabilitation 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 building consists of two sections; the original portion of the building was a two story, fully sprinklered building determined to be of Type II (222) construction, and the Stocker Addition I and Stocker Addition II were a one story, fully sprinklered building determined to be of Type V (111) construction. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms in the Stocker Addition I and Stocker Addition II, plus battery operated smoke detectors in all resident sleeping rooms in the original two story section. The facility has a capacity of 113 and had a census of 63 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 12/06/24		regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12/30/24, the annual licensure survey completed on November 14, 2024. The facility respectfully asks for a desk review.	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through 1 of at least 10 delayed egress locks were readily	K 0222	**It is the practice of this facility to assure that exit doors equipped**	12/30/2024

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	accessible for residents, staff, and visitors. LSC 7.2.1.6.1, Delayed Egress Locking Systems, says approved, listed, delayed-egress locking systems shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 11 through 43, provided: (4*) A readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice could affect at least 14 residents, staff and visitors. Findings include: Based on observations on 12/02/24 between 1:30 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director, the South Unit south exit door from the dining room area was equipped with a magnetic lock with 15 second delayed egress. This exit door was not provided with signage that read, PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. When tested by the Maintenance Director, the doors did release from the magnetic holder when pushing on the panic bar and activating the 15 second delayed egress. Based on interview at the time of observation, the Maintenance Director acknowledged the South Unit south exit door was not equipped with the proper signage.		**with a magnetic lock with 15 second delayed egress has a sign that reads PUSH UNTIL ALARM SOUND DOOR CAN BE OPENED IN 15 SECONDS. The corrective action taken for those residents found to be affected by the deficient practice include:** The signage for the south unit south Exit door from the dining room area Was placed on the door on (DATE). There were no issues found. **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. An audit of all exit doors was completed to ensure there was signage. No other issues were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not**	

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**recur include:** Maintenance Director was Re-educated by Administrator That all exit doors with a magnetic Lock with 15 second delayed egress must have proper signage. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all exit doors with a magnetic lock with 15 second delayed egress to ensure They have the proper signage. The Maintenance director will complete This tool weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure 1. Based on observation and interview, the facility failed to ensure the corridor door to 1 of 4	K 0321	**It is the practice of this facility to assure that rooms containing**	12/30/2024

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	155621	A. BUILDING 01 B. WING	12/02/2024

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	bathrooms/shower rooms, which contained two soiled linen containers and one trash container with a capacity over 32 gallons each, was not provided with an impediment to self-closing automatically. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 12/02/24 between 1:30 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director, the South Unit bathroom/shower room had two soiled linen barrels and one trash barrel, each over 32 gallons, stored within. The door to the corridor was provided with a self-closing device, however, it was held wide open with a rubber door wedge which did not allow the door to self-close. This was acknowledged by the Maintenance Director at the time of observation and removed the rubber door wedge immediately. 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 ensure 3 of over 20 hazardous area doors, such as storage room doors and a maintenance shop door, were provided with self-closing devices. This deficient practice could mostly involve staff while in the Harmony Unit (currently no resident rooms are occupied). Findings include: Based on observations on 12/02/24 between 1:30 p.m. and 4:15 p.m. during a tour of the facility with		**potentially hazardous materials will have a self closing door and will not be propped open. The corrective action taken for those residents found to be affected by the deficient practice include:** The rubber door wedge that was holding south unit bathroom/shower door open was removed immediately. A self-closing device was installed for room 106, 100, and the maintenance shop door. **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. An audit was completed for the entire facility to ensure that no other hazardous area doors were propped open and had a self-closing device installed. No further issues were identified. **The measures or systematic changes that have been put into**	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	the Maintenance Director, the following was noted: a. Room 106 corridor door was not provided with a self-closing device. The room was over 50 square feet in size and stored at least 50 large cardboard boxes full of combustible supplies. b. Room 100 corridor door was not provided with a self-closing device. The room was over 50 square feet in size and stored at least 11 large cardboard boxes full of combustible supplies. c. The Maintenance Shop corridor door was not provided with a self-closing device. The room was over 50 square feet in size and stored items such as cardboard boxes, sprays and other combustible supplies. Based on interview at the time of each observation, the Maintenance Director acknowledged that the previously mentioned hazardous area doors were not provided with self-closing devices. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**place to ensure that the deficient practice does not recur include:** All staff were Re-educated by Administrator or designee Hazardous area doors cannot Be propped open. Maintenance Director was re-educated by the Administrator that hazardous area doors must have a self-closing device installed. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all hazardous area doors to ensure they are not propped open and have working self-closing devices installed. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the	

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			tools.	
K 0324 SS=E 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. Section 10.2.2 states that a placard shall be conspicuously placed near each extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. This deficient practice could affect mostly kitchen staff. Findings include: Based on observations on 12/02/24 between 1:30 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director, the kitchen was provided with a UL 300 hood system. Based on interview with the lead 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, The lead cook pointed to and said she would grab the K Class fire extinguisher located close to the cooking area. This was acknowledged by the Maintenance Director at the time of observation and interview with the lead cook.	K 0324	**It is the practice of this facility to assure that Staff working in the kitchen know how to activate the range hood suppression system if it doesn't automatically activate and there is an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed. The corrective action taken to correct the deficient practice include:** Tape was placed on the floor to indicate Were the appliances should be located On (DATE). **Other residents that have the potential to be affected have been identified by:** All residents and staff have the potential to be affected by the deficient	12/30/2024

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	155621	A. BUILDING 01 B. WING	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

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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 observation on 12/02/24 between 1:30 p.m. and 4:15 p.m. during the tour of the facility		practice. No further issues were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Maintenance Director was Re-educated by Administrator That there must be tape on the Floor to indicate where cooking Appliances are to be returned In case they are moved. All kitchen Staff were educated on what to Do if the range hood suppression System does not automatically Activate when there is a fire under The range hood. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews kitchen appliances to ensure that they are placed in their proper position and have tape marking their spots. The Maintenance director will complete this tool Weekly x 6 months. Any issues identified will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 01 B. WING	12/02/2024

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	with the Maintenance Director, the gas stove and flat grill located under the hood in the kitchen were not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on interview at the time of observation, the Maintenance Director was not aware an approved method had to be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning, but said he would ensure it was completed as soon as possible. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect at least 14	K 0345	**It is the practice of this facility to assure that all ceiling mounted smoke detectors are secured to the ceiling about one fourth inch to one half inch from the ceiling on at least one side of the smoke detector. The corrective action taken to correct the deficient practice include:** The five smoke detectors were secured To the ceiling.	12/30/2024

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	155621	A. BUILDING 01 B. WING	12/02/2024

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	residents, as well as staff, and visitors. Findings include: Based on observations on 12/02/24 between 1:30 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director, there were five ceiling mounted smoke detectors in the South Unit corridor and dining room/serving area hanging loosely from their wires and not secured to the ceiling about one fourth inch to one half inch from the ceiling on at least one side of the smoke detector. Based on interview at the time of each observation, the Maintenance Director acknowledged the previously mentioned smoke detectors not being flush with the ceiling and said he would correct them as soon as possible. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. An audit was completed to ensure that all smoke detectors were installed properly. No further issues were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Maintenance Director was Re-educated by Administrator That all smoke detectors must Be secured to the ceiling about one fourth inch to one half inch from the ceiling on at least one side of the smoke detector **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews smoke detectors to ensure that they are secured to the ceiling about one	

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			fourth inch to one half inch from the ceiling on at least one side of the smoke detector. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
K 0346 SS=F 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 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Administrator and Maintenance Director present, the facility did provide fire watch documentation, 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	**It is the practice of this facility to assure that emergency preparedness plan includes instructions on the fire watch process to include who will contact IDOH at the provided web link as well as contact information for the local fire department and other required notifications. The corrective action taken for those residents found to be affected by the deficient practice include:**	12/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Gateway, as well as contact information for the local Fire Department, and other required notifications. 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)		The emergency preparedness plan was updated to include who will contact IDOH at the provided web link as well as contact information for the local fire department and other required notifications On (DATE). **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. No other issues were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Administrator was Re-educated by RDO that the Emergency preparedness plan For fire watch must include contacting IDOH with the web link for contacting The Incident Reporting System located On the IDOH Gateway, as well as	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			contact information for the local fire department, and other required notifications. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews the emergency preparedness binder to ensure that it is current. The Administrator, or designee, will complete this tool monthly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
K 0354 SS=F 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	K 0354	**It is the practice of this facility to assure that in the case that the sprinkler system is out-of-service for more than 10 hours in a 24 hour period the emergency preparedness**	12/30/2024

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	155621	A. BUILDING 01 B. WING	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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. Findings include: Based on record review on 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Administrator and Maintenance Director present, the facility provided fire watch documentation from the Emergency Preparedness Binder, 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 local Fire Department and failed to mention contacting 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)		**plan includes instructions on the fire watch process to include who will contact IDOH at the provided web link as well as contact information for the local fire department and other required notifications. The corrective action taken for those residents found to be affected by the deficient practice include:** The emergency preparedness plan was updated to include who will contact IDOH at the provided web link as well as contact information for the local fire department and other required notifications On (DATE). **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. No other issues were identified. **The measures or systematic changes that have been put**	

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			into **place to ensure that the deficient practice does not recur** **include:** Administrator was Re-educated by RDO that the Emergency preparedness plan For fire watch must include contacting IDOH with the web link for contacting The Incident Reporting System located On the IDOH Gateway, as well as contact information for the local fire department, and other required notifications. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews the emergency preparedness binder to ensure that it is current. The Administrator, or designee, will complete this tool monthly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as	

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			needed based on the outcomes of the tools.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 68 resident room corridor doors, and one staff-only room corridor door would easily close completely and latch into their door frames. This deficient practice could affect at least 10 residents, staff and visitors. Findings include: Based on observations on 12/02/24 between 1:30 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. The corridor door to resident room 215 would not easily close completely and latch into the door frame. The door had to be lifted and pulled into its door frame to close completely. b. The wheelchair washing room corridor door in the Harmony Unit service hall could not be closed completely and latched several times. The door frame was too tight to allow the door to close completely and latch. Based on interview at the time of each observation, the Maintenance Director acknowledged the corridor door to room 215 and the wheelchair washing room failed to easily close complete and latch into their door frames. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**It is the practice of this facility to assure that corridor doors will easily close completely and latch into their door frames. The corrective action taken for those residents found to be affected by the deficient practice include:** Corridor door to resident room 215 and the wheelchair washing room in Harmony unit was fixed so that it would easily close completely and latch into the door frame. **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. An audit was completed on all corridor doors to ensure that they would easily close completely and latch into the	12/30/2024

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	155621	A. BUILDING 01 B. WING	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			door frame. Any further issues were fixed as well. **The measures or systematic changes that have been put into** **place to ensure that the deficient practice does not recur** **include:** Maintenance Director was Re-educated by the Administrator that all corridor doors must easily close completely and latch into the door frame. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews corridor doors to ensure that they easily close completely and latch into the door frame. The Maintenance Director will complete this tool on all corridor doors weekly x 4 weeks, monthly x 5 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled	

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	155621	A. BUILDING 01 B. WING	12/02/2024

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RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

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			meetings with recommendations as needed based on the outcomes of the tools.	
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 (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	K 0711	**It is the practice of this facility to assure that the fire safety plan includes identifying the staff member who is responsible for calling 911 in the event of a fire emergency, where the smoke barriers are located in the facility and evacuation in detail, the use of k-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, staff response to the activation of battery powered smoke alarms and removal of all wheeled equipment from the egress corridor. The corrective action taken for those residents found to be affected by the deficient practice include:** The emergency preparedness plan	12/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 01 B. WING	12/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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 Emergency Procedure-Fire plan on 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Administrator and Maintenance Director present, the plan did not address the following: a. Identifying the staff member who is responsible for calling 911 in the event of a fire emergency. b. The plan did address evacuation of a smoke compartment; however, the plan did not identify where the smoke barriers were located in the facility and evacuation in detail. c. The use of the K-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system. d. Staff response to the activation of battery powered smoke alarms. e. Removal of all wheeled equipment from the egress corridor. Based on interview at the time of record review, the Administrator acknowledged the Emergency Procedure-Fire plan did not include the previously mentioned items. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		was updated to include identifying the staff member who is responsible for calling 911 in the event of a fire emergency, where the smoke barriers are located in the facility and evacuation in detail, the use of k-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, staff response to the activation of battery powered smoke alarms and removal of all wheeled equipment from the egress corridor. **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 01 B. WING	12/02/2024

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			Administrator was Re-educated by RDO that the Emergency preparedness plan must Include identifying the staff member who is responsible for calling 911 in the event of a fire emergency, where the smoke barriers are located in the facility and evacuation in detail, the use of k-class fire extinguisher in the kitchen in relationship with the use of the kitchen overhead extinguishing system, staff response to the activation of battery powered smoke alarms and removal of all wheeled equipment from the egress corridor. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews the emergency preparedness binder to ensure that it is current. The Administrator, or designee, will complete this tool monthly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee	

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			will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of all fire door assemblies was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of	K 0761	**It is the practice of this facility to assure that an annual inspection and testing of all fire door assemblies is completed. The corrective action taken for those residents found to be affected by the deficient practice include:** The annual inspection and testing Of all fire door assemblies was completed On (DATE) **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. **The measures or systematic changes that have been put**	12/30/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 01 B. WING	12/02/2024

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RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

(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
	either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the fully open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on record review on 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Maintenance Director present, the facility was unable to provide documentation for an annual inspection of all fire door assemblies for the past 12 month period. The most recent fire door assembly inspection was dated 10/20/23. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of all fire door assemblies available to		**into place to ensure that the deficient practice does not recur include:** Maintenance Director was Re-educated by Administrator that all fire door assemblies must be inspected and tested annually. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all annual required tests. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	

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	review for the past 12 month period. Based on observations during a tour of the facility between 1:30 p.m. and 4:15 p.m., there were two oxygen transfilling room fire door assemblies, four stairway fire door assemblies, and a single fire door assembly separating the original building and the Stocker Additions, which were of different construction types. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0914 SS=B Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Based on observation, record review, and interview; the facility failed to ensure complete documentation was available for 10 of 10 nonhospital-grade electrical receptacles in all 10 Harmony Unit resident room locations tested at least annually. 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	K 0914	**It is the practice of this facility to assure that all nonhospital-grade electrical receptacles are tested at least annually. The corrective action taken for those residents found to be affected by the deficient practice include:** The annual testing of for 10 of 10 nonhospital-grade electrical receptacles in all 10 Harmony Unit resident room locations were was completed On (DATE) **Other residents that have the**	12/30/2024

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	could affect mostly staff since these rooms are not currently being used as resident rooms (but are still licensed as resident rooms). Findings include: Based on record review on 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Maintenance Director present, there was no documentation available of an annual resident room receptacle test for non hospital-grade receptacles for the past 12 month period for resident rooms 100 through 110. These rooms are still licensed resident rooms but are currently not being used as resident rooms. The most recent resident room receptacle test for these rooms was dated 10/04/23. Based on interview at the time of record review, the Maintenance Director said electrical receptacles in these resident rooms were not hospital-grade receptacles as far as he knew. The Maintenance Director said there was no current documentation to show that annual testing per NFPA 99, Receptacle Testing requirements was met with all pertinent information within the past 12 month period for the receptacles in these rooms. Based on observations between 1:30 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director, there were at least four electrical receptacles in each of these resident rooms. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. An audit was completed to identify all nonhospital-grade electrical receptacles. Any issues was corrected immediately. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Maintenance Director was Re-educated by Administrator that All nonhospital-grade electrical Receptacles must be tested at least Annually. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all annual required tests. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations	

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			as needed based on the outcomes of the tools.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 41 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance; exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection and testing reports on 12/02/24 between 9:30 a.m. and 1:30 p.m. with the Maintenance Director present, there was no documentation available to show the emergency generator was inspected/tested weekly since February 14, 2024. Furthermore, the cover page for the weekly inspection of the emergency generator in the life safety folder stated, "As of	K 0918	**It is the practice of this facility to assure that emergency generator is inspected/tested weekly. The corrective action taken for those residents found to be affected by the deficient practice include:** The generator was inspected/tested On (DATE). There were no issues Found. **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. No issues were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur**	12/30/2024

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	2/28/24 we no longer do weekly generator testing on equipment." Based on interview at the time of record review, the Maintenance Director said he was under the impression that he no longer needed to perform weekly inspections of the generator, but was recently told by his regional support person that he needed to continue the weekly inspections. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**include:** Maintenance Director was Re-educated by Administrator That the emergency generator Must be inspected/tested on A weekly basis. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews documentation to assure that the emergency generator is inspected/tested on a weekly basis. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure a multi plugged adapter was not used as a substitute for fixed wiring in 1 of 1	K 0920	**It is the practice of this facility to assure that multi plugged adapters**	12/30/2024

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	beauty shop. 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 1 resident and 1 staff at a time. Findings include: Based on observations on 12/02/24 between 1:30 p.m. and 4:15 p.m. during a tour of the facility with the Maintenance Director, there was a hair dryer plugged into a multi plugged adapter (with no ground plug) in the beauty shop within one foot of the left side hair washing sink. Based on interview at the time of observation, the Maintenance Director acknowledged the use of the multi plugged adapter and removed it immediately. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**are not used as a substitute for fixed wiring. The corrective action taken for those residents found to be affected by the deficient practice include:** The multi plugged adapter was Removed from use immediately **Other residents that have the potential to be affected have been identified by:** All residents have the potential to be affected by the deficient practice. An audit was completed for the entire facility to ensure that multi plugged adapter were not in use. All issues were corrected immediately. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** All staff were Re-educated by Administrator or designee that multi plugged adapters cannot be used as a substitute for fixed wiring. **The corrective action taken to**	

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			monitor performance to assure compliance through quality assurance is: A Performance Improvement Tool has been initiated that reviews facility to identify any multiplug adapters and take them out of use. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	