STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155702	A. BUILDING -- B. WING	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(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: 11/26/24 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Emergency Preparedness survey, Aperion Care Peru was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 92 certified beds. At the time of the survey, the census was 85. Quality Review completed on 11/27/24	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: 11/26/24 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Life Safety Code survey, Aperion Care Peru was found not in compliance with	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Matthews	Administrator	12/18/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Requirements for Participation in Medicare/Medicaid, 42 CFR 483.90(a), Life Safety from Fire, the 2012 edition of the NFPA (National Fire Protection Association) 101, LSC (Life Safety Code), and 410 IAC 16.2. This one-story facility was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard-wired smoke detectors in all resident rooms. The facility has a capacity of 92 and had a census of 85 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/27/24			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer rooms was free of lint and other debris. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect laundry staff as well as staff working in the service hall area. Findings include: Based on observations made on 11/26/24 at 1:32 p.m. during a tour of the facility with the Maintenance Director, the semi-enclosed area behind the dryers in the laundry area were	K 0100	**K100 General requirements** **The facility requests paper compliance for this citation** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and or execution of this plan of correction des not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the**	12/05/2024

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	substantially covered with dryer lint. This included the two ceiling mounted sprinkler heads mounted therein. Based on interview at the time of observation, the Maintenance Director agreed there was a substantial amount of dryer lint within the area located behind the dryers and further added that he would have the area cleaned as soon as possible. This finding was reviewed with the Administrator and the Maintenance Director the exit conference on 11/26/24. 3.1-19(b)		**provisions of federal and state law.** **1. Immediate actions taken for those identified who could have been affected:** **Facility Housekeeping supervisor ensured all areas of laundry room were immediately cleaned and free from lint.** 2. How the facility identified other who could be affected. Housekeeping supervisor did a complete walk through of the entire laundry room and service hall to ensure all areas were free from lint. 3. measures put into place / system changes: Cleaning schedule initiated on the lint cleaning schedule to include surrounding areas. Weekly inspection per lint cleaning schedule check list will be completed to ensure all areas are free from lint to include behind dryer. Preventative maintenance check list will include checking sprinkler heads to ensure they are lint free. 4. How the corrective action will be monitored: Maintenance Director /designee and housekeeping supervisor will conduct audits through his preventative maintenance program and her lint cleaning schedule to ensure compliance and report results to QAA meeting to ensure ongoing compliance.	

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			=”” b=””> **b=””>** =”” b=””> **b=””>** =”” b=””> =”” span=””> **bmaintenance director=”” designee=”” and=”” housekeeping=”” supervisor=”” will=”” conduct=”” audits=”” through=”” his=”” preventative=”” maintenance=”” program=”” her=”” lint=”” cleaning=”” schedule=”” to=”” ensure=”” compliance=”” report=”” results=”” qaa=”” meetings=”” ongoing=”” compliance.<=”” span=””> span=””> =”” bhow=””> **span=””>** =”” span=””> **b=””>** =”” b=””> **b=””>** =”” b=””> **span=””>** =”” span=”>	
K 0200 SS=D Bldg. 01	NFPA 101 Means of Egress Requirements - Other Based on observation and interview, the facility failed to ensure 1 of 1 bathroom door in the main entry lobby area was provided with a door latch that required only one operation to open. LSC 19.2.2.1 states doors complying with LSC 7.2.1 shall be permitted. LSC 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with	K 0200	**K200 Means of egress requirements - other** **The facility requests paper compliance for this citation.**	12/05/2024

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	not more than one releasing operation. This deficient practice could staff in the kitchen. Findings include: Based on observations made on 11/26/24 at 11:02 a.m. during a tour of the facility with the Maintenance Director, the staff restroom door in the main entrance lobby area was equipped with an independent dead bolt in addition to the locking punch code doorknob. Based on interview at the time of observation, The Maintenance Director confirmed the staff restroom door had an independent dead bolt, as well as a punch code doorknob. This finding was reviewed with the Administrator and the Maintenance Director the exit conference on 11/26/24. 3.1-19(b)		**This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1) Immediate actions taken for those people identified:** **Maintenance director removed the sliding lock mechanism along with the punch code key pad and replaced them with a door knob using a key which will be kept at the reception desk and therefore the bathroom door only has on locking mechanism.** **2) How the facility identified other residents:** **All other restrooms were**	

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			inspected to ensure they met compliance. No other concerns were found. **3) Measures put into place/ System changes:** **Maintenance director/designee will make monthly checks to ensure that all restrooms require only one releasing operation to open. This will be put on his monthly preventative maintenance check list.** **4) How the corrective actions will be monitored:** **Maintenance Director will bring results to the QAA meeting for 6 months or until 100% compliance is achieved x3 consecutive months.**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 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	K 0324	**K324 Cooking facilities** This Plan of Correction is the center's credible allegation of compliance. Preparation and or execution of this plan of correction des not	12/05/2024

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	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 as many as 40 residents, 6 staff, and 4 visitors in the kitchen and main dining room area. Findings include: Based on observations made on 11/26/24 at 1:21 p.m. during a tour of the facility with the Maintenance Director, the five (5) burner flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on an interview at the time of the observation, the Maintenance Director stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would paint		constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law. 1. Immediate actions taken for those identified who could have been affected: Facility maintenance supervisor along with life safety inspector agreed to current proper placement of the cooking appliance currently under the hood system. Maintenance director used paint on the floor to mark where the cooking appliance approved design location s to be placed. 2. How others have the potential to be affected will be identified and what corrective action will be taken: No other cooking appliances are located in the building under a hood system therefore no others have the potential to be affected. 3. Measures put into place / system changes: Placement markings for cooking appliance under the hood system will be added to monthly preventative maintenance check list to ensure marking are present and cooking appliance is in the designed location. 4. How the corrective actions will be monitored: Maintenance	

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	four areas on the kitchen floor to assure the stove was returned to it's designed location after cleaning. This finding was reviewed with the Administrator and the Maintenance Director the exit conference on 11/26/24. 3.1-19(b)		Director/designee will conduct and audit through his preventative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance. ="" b=""> **b="">** ="" b=""> **b="">**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in the facility in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff in the vicinity of the time clock in room. Findings include: Based on observation with the Maintenance Director on 11/26/24 during a tour of the facility at 1:15 p.m., the sprinkler in the 'clock in room' lacked an escutcheon. There was a 1/2 inch gap that exposed the space above the drop ceiling. Based on interview at the time of observation, the Maintenance Director confirmed the escutcheon was missing, and would replace it as soon as he could.. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.	K 0351	**K351 Sprinkler system instillation** **The facility requests paper compliance for this citation** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and or execution of this plan of correction des not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of federal and state law.** **1. Immediate action taken Maintenance Director ensured escutcheon was immediately put back on the sprinkler in the time clock room.** **2. How the facility identified other residents who could be**	12/05/2024

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	3.1-19(b)		**affected.** **Maintenance director did a complete audit of all sprinkler's throughout the facility to ensure all escutcheons were present and appropriately placed with no concerns found.** **3. Measures put into place / system changes: Monthly inspections per preventative maintenance check list will be completed to ensure all escutcheons are present and appropriately placed.** **4. How the corrective action will be monitored:** **Maintenance Director / designee will conduct an audit through his preventative maintenance program to ensure compliance an report results to QAA meetings to ensure ongoing compliance.** ="" b="">**b="">**="" b="">="" b="">**b="">**="" b="">="" span="">**span="">**="" span="">="" span="">**span="">**="" span="">="" b="">**b="">**="" b="">="" b="">**b="">**="" b="">**	

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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review from 9:30 a.m. to 12:30 p.m. on 11/26/24 with the Maintenance Director, monthly dry sprinkler system gauge inspection documentation for 12 months of the most recent 12-month period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 12 months of the most recent 12-month period was not available for review. These documents were requested on several occasions, but by the end of the survey, had still not been provided. Based on interview at the time of record review, the Maintenance Director acknowledged sprinkler	K 0353	**K353 Sprinkler System – Maintenance and testing** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **Immediate actions taken for those residents identified:** ="" span="">
="" bhow="">
span="">
="" span="">
Maintenance Director completed inspection of dry sprinkler system gauges along with an inspection for the sprinkler system control valves with no concerns noted.
="" span="">

="" span="">How the facility identified other residents who could be affected:
="" span="">Maintenance director did a complete audit of all gauges | 12/05/2024 |

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	system gauge and control valve inspection documentation for the aforementioned monthly periods was not made available for review. This finding was reviewed with the Administrator and the Maintenance Director the exit conference on 11/26/24. 3.1-19(b)		and valves concerning our sprinkler system with no concerns noted. ="" span="">> ="" span="">>Measures put into place / system changes: ="" span="">>Monthly inspections per preventative maintenance check list will be completed to ensure all gauges and valves are inspected to meet the requirements. ="" span="">> ="" span="">>How the corrective actions will be monitored: ="" span="">>Maintenance director /designee will conduct an audit through his preventative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance. ="" span="">> ="" span="">> **span="">** ="" span="">> ="" b="">> **b="">** ="" b="">>	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of over 100 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing,	K 0363	**K363 Corridor doors** **The facility requests paper compliance for this citation. This Plan of Correction**	12/05/2024

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	latching, and would resist the passage of smoke. This deficient practice could affect 6 residents, 10 staff, and 2 visitors. Findings include: Based on observations made on 11/26/24 at 9:30 a.m. upon entering the facility, the corridor door to the Physical Therapy room located off the main lobby was propped in the open position with a hand weight. Based on observations made during a tour of the facility at 12:30 p.m., the Physical Therapy entry door was still being held in the open position by a hand weight at the beginning of the facility tour. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned corridor door to the Physical Therapy area as an area where patient care takes place and that the entry door off the main entrance corridor was being held propped in the fully open position with a hand weight. This finding was reviewed with the Administrator and the Maintenance Director the exit conference on 11/26/24. 3.1-19(b)		**is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:Facility Maintenance director removed hand weight from the therapy room door that was being propped open. 2) How the facility identified other residents:Maintenance director did a complete facility audit to ensure no other doors were propped open with no concerns found. 3) Measures put into place/ System changes:All staff were re-educated on not inappropriately propping open doors. Maintenance Director/designee will make monthly checks to ensure that any doors are not inappropriately propped open. Checks will be added to the monthly maintenance logs. 4) How the corrective actions will be monitored:=""**	

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			span=""> **Maintenance Director/designee will conduct an audit through his prevenative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 24 residents, 4 staff and 2 visitors in the facility. Findings include: Based on observations made on 11/26/24 at 12:52 p.m. during a tour of the facility with the Maintenance Director, the set of barrier doors between resident room #127 and resident room #129 did not fully close or latch into the doorframe when tested on three separate occasions. There was a three-foot gap between the doors when closed to their fullest. Based on interview during the time of observations, the Maintenance Director acknowledged these barrier doors did not close completely due to north door rubbing on the floor and stated that he would have them looked at as soon as possible. This finding was reviewed with the Administrator	K 0374	**K374 subdivision of building spaces-smoke barrier** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:Maintenance director made adjustments to ensure the smoke barrier door closed and latched appropriately.** **2) How others having the potential to be affected will be identified and what corrective**	12/05/2024

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	155702	A. BUILDING 01 B. WING	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

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	and the Maintenance Director the exit conference on 11/26/24. 3.1-19(b)		**will be taken:** **span="">** ="" span="">**Maintenance Director did a complete audit of all smoke barrier doors throughout the facility to ensure all barrier doors closed appropriately and latched. No other concerns were found. 3) Measures put into place/ System changes:Maintenance Director/designee will make monthly checks to ensure that any smoke barrier doors not properly closing and or latching will be repaired/replaced immediately. Checks will be added to the monthly maintenance logs. 4) How the corrective actions will be monitored:** ="" span="">**Maintenance Director / designee will conduct an audit through his preventative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance.**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric 1) Based on observation and interview, the facility failed to ensure 1 of 1 electrical wiring in the uniform storage closet was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring	K 0511	**K511 Utilities Gas and electric** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible**	12/05/2024

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	terminals are not exposed to contact. This deficient practice could affect as many as 2 residents, 6 staff and 2 visitors. Findings include: Based on observations made on 11/26/24 at 12:36 p.m. during a tour of the facility with the Maintenance Director, the "uniform closet" just off the main entrance lobby had an electric box with a cover on it, but the cover was missing a screw leaving the 12-gauge high voltage wires therein exposed. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that exposed wiring was visible adding that he would have the cover screw replaced as soon as he could. This finding was reviewed with the Administrator and the Maintenance Director the exit conference on 11/26/24. 3.1-19(b)2) Based on observation and interview, the facility failed to ensure all electrical panels in the main hall were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This		**allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:The missing screw was replaced on the cover of the electric / junction box in the uniform closet. The electric panel was immediately locked. 2) How the facility identified other residents: Maintenance director did a complete audit of the building to ensure no other exposed wires were present in any other area of the building as well as an audit to ensure all electric panels were locked with no other concerns found. 3) Measures put into place/ System changes:Maintenance Director/designee will complete monthly checks to ensure that there are no exposed wires and to ensure all electrical boxes are locked . Theses checks will be added to monthly preventative maintenance log. 4) How**	

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	deficient practice could affect 40 residents and staff. Findings include: Based on observation with Maintenance Director on 11/26/24 at 1:00 p.m., the electrical panel next to resident room 123 was unlocked. This left the electrical panel unsecured and accessible by unauthorized personnel. Based on interview at the time of observation, the Maintenance Director confirmed that the electrical panel was unsecured and locked the panel at the time of observation. The finding was discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b)		**the corrective actions will be monitored:="" b=""> Maintenance Director/designee will conduct an audit through his preventative maintenance program to ensure compliance and report results to QA meetings to ensure ongoing compliance.**	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Based on observation and interview; the facility failure to ensure 1 of 1 portable space heaters were not used in the facility. This deficient practice could affect 25 residents and 3 staff in the Behavioral Unit. Findings include: Based on observations made with the Maintenance Director on 11/26/24 at 12:21 p.m. during a tour of the facility, there was portable space heater at the Behavioral Unit nurse station. The space heater was not plugged into a wall outlet at the time of observation. Based on an interview at the time of the observation, the Maintenance Director agreed that there was a portable space heater in the Behavioral Unit and	K 0781	**K781 Portable space heaters** **The facility requests paper compliance for this citation.** **This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or**	12/05/2024

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	the use of portable space heaters in the facility was not allowed. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** **1) Immediate actions taken for those residents identified:** **Maintenance director removed space heater immediately from the unit.** **2) How others having the potential to be affected will be identified and what corrective will be taken:** **Maintenance Director did a complete audit of the facility to ensure no other space heaters were present with no other concerns found.** **3) Measures put into place/ System changes:** **All staff were re-educated on not using space heaters within the facility. Maintenance Director/designee will make monthly checks to ensure that**	

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			no space heaters are present or being used. Findings will be brought to the executive director. Checks will be added to the monthly preventative maintenance logs. **4) How the corrective actions will be monitored:** **Maintenance Director/designee will conduct an audit through his preventative maintenance program to ensure compliance and report results to QAA meetings to ensure ongoing compliance.**	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure the facility did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 2 residents and staff. Findings include: Based on observations and interview during a	K 0920	**K920 Electrical equipment – power cords and extensions** **The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of**	12/05/2024

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	tour of the facility with the Maintenance Director on 11/26/24 between 12:16 p.m. and 2:00 p.m., the following was noted: a) resident room 131 contained a multi-plug adaptor powering christmas lights b) the employee breakroom contained a multi-plug adapter powering a microwave and a box fan Based on interview at the time of observations, the Maintenance Director agreed mulit-plug adaptor were in use in the resident room 131 and employee breakroom. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified:Maintenance director removed the multiplug adapter from room 131 as well as removed the multiplug adapter in the break room. 2) How others having the potential to be affected will be identified and what corrective will be taken:Maintenance Director did a complete audit of the facility to ensure no other multiplug adapters were present and removed all the multiplug adapters that were found. 3) Measures put into place/ System changes:All staff were re-educated on not using multiplug adapters within the facility. Maintenance Director/designee will make monthly checks to ensure that no multiplug adapters are present. Findings will be brought to the executive director. Checks will be added to the monthly maintenance logs. 4) How the corrective actions will be monitored: Maintenance Director/designee will conduct an audit through his preventative maintenance program to ensure compliance**	

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			and report results to QAA meetings to ensure ongoing compliance.	