| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155780 | A. BUILDING -- B. WING | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| HOMESTEAD HEALTHCARE CENTER | 7465 MADISON AVE INDIANAPOLIS, IN 46227 |

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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 12/12/24<br><br>Facility Number: 012225<br>Provider Number: 155780<br>AIM Number: 200983560<br><br>At this Emergency Preparedness survey, Homestead Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73.<br><br>The facility has 88 certified beds. At the time of the survey, the census was 52.<br><br>Quality Review completed on 12/13/24 | E 0000 | | |
| E 0039<br>SS=F<br>Bldg. -- | 403.748(d)(2), 416.54(d)(2), 418.113(d)(<br>EP Testing Requirements<br><br>Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or<br>a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.<br>b. If the LTC facility experiences an actual natural or man-made emergency that requires activation | E 0039 | **E 039 EP Testing Requirement**<br><br>**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** All residents have the potential to be affected by the alleged practice. Facility is working with local law enforcement to get an active shooter drill for all staff | 01/31/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jakob Barbour | ED | 12/27/2024 |

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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| | of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event.<br>(ii) Conduct an additional exercise that may include, but is not limited to the following:<br>a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise.<br>b. A mock disaster drill; or<br>c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.<br>(iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2).<br>This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on record review and interview with the Executive Director and Regional Maintenance Director from 10:15 a.m. to 1:40 p.m. on 12/12/24, the facility was able to provide documentation of an actual event dated 09/27/24, however, the facility was unable to provide documentation of a community-based or facility-based functional exercise performed, tabletop exercise or workshop that are designed to challenge the emergency plan during the past 12 month period. At time of record review the Executive Director stated no other exercises were available for review. | | **Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** All residents have the potential to be affected. There were no residents affected by the practice. Facility to audit all emergency preparedness exercises<br><br>**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with Q.A on bi annual emergency preparedness drills and community drills<br><br>**How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for continued compliance. | |

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| | This finding was reviewed with the Executive Director and Regional Maintenance Director at the exit conference. | | | |
| E 0041 SS=F Bldg. -- | 482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power<br><br>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).<br><br>Findings include:<br><br>Based on records review of 'Monthly Generator Test Under Load' with the Regional Maintenance Director on 12/12/24 at 11:53 a.m., documentation for March, April and November 2024 was not available for review. Based on interview at the time of record review, the Regional Maintenance Director stated he searched for the aforementioned monthly load testing and was unable to locate documentation at the time of the survey.<br><br>This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. | E 0041 | **E 041 Hospital CAH and LTC Emergency Power**<br><br>**Corrective actions accomplished for those residents founds to be affected by the alleged practice:** Residents have the potential to be affected by the alleged practice. Facility generator load test is up to date for current month.<br><br>**Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken:** Residents have the potential to be affected. There were no residents affected by the practice. Facility to audit monthly generator load tests.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with maintenance staff on monthly load testing for the generator.<br><br>**How the corrective measures will be monitored to ensure the alleged deficit practice does** | 01/31/2025 |

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| | | | **not recur:** The executive director will monitor the monthly generator load test monthly for 6 months to ensure generator load was tested every month. The results of the audit observations will be reported, reviewed, and trended for compliance through the facility Quality Assurance Committee for a minimum of six months and then randomly thereafter for further recommendation. | |
| K 0000<br><br>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).<br><br>Survey Date: 12/12/24<br><br>Facility Number: 012225<br>Provider Number: 155780<br>AIM Number: 200983560<br><br>At this Life Safety Code survey, Homestead Healthcare Center 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.<br><br>This one-story facility was determined to be of Type III (200) construction and fully sprinklered. The facility has a fire alarm system with smoke | K 0000 | | |

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| | detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms except in Room 502 which has a smoke detector hard wired to the facility's fire alarm system. The facility has a capacity of 88 and had a census of 52 at the time of this visit.<br><br>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for one detached storage shed.<br><br>Quality Review completed on 12/13/24 | | | |
| K 0321 SS=E Bldg. 01 | NFPA 101<br>Hazardous Areas - Enclosure<br><br>Based on observation and interview, the facility failed to ensure 1 of 6 hazardous areas such as a soiled linen room was separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 17 residents, 4 staff, and 2 visitors in one smoke compartment.<br><br>Findings include:<br><br>Based on observations made with the Regional Maintenance Director and Maintenance Tech on 12/12/24 at 2:18 p.m., the corridor door to the soiled utility room by the nurse station near the 700 wing entrance, a hazardous room greater than 50 square feet in size was equipped with a self-closing device, but the door would not latch when tested four times. Based on interview at the time of observation, the Regional Maintenance Director agreed the corridor door to the aforementioned hazardous area would not | K 0321 | **K 321 Hazardous Areas – Enclosure**<br><br>**Corrective actions accomplished for those residents founds to be affected by the alleged practice** Residents have the potential to be affected by the alleged practice. The soiled utilities door was fixed and now fully latches.<br><br>**Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken** Residents have the potential to be affected by the alleged practice. No residents affected by the practice. Facility to audit doors to soiled utility rooms to ensure proper closing and | 01/31/2025 |

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| | positively latch when it self closed.<br><br>This finding was reviewed with the Executive Director and Regional Maintenance Director at the exit conference.<br><br>3.1-19(b) | | latching.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with maintenance staff on soiled utility rooms for proper closing and latching<br><br>**How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The executive director or designee will randomly audit doors to Soiled utility rooms for proper closing and latching. Soiled utility room audit will be reviewed by QA for continued compliance. | |
| K 0353 SS=F Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br><br>Based on record review, observation, and interview; the facility failed to document sprinkler system inspections fully in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 12 of the past 52 weeks for the sprinkler system's pressure gauges. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter | K 0353 | **K 353 Sprinkler System Maintenance and Testing**<br><br>**Corrective actions accomplished for those residents founds to be affected by the alleged practice**Residents have the ability to be affected by the alleged practice. The dry sprinkler system sprinkler gauges was inspected.<br><br>**Identification of other residents having the potential to be** | 01/31/2025 |

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| | 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 in the facility.<br><br>Findings include:<br><br>Based on record review on 12/12/24 between 10:15 a.m. and 1:40 p.m. with the Regional Maintenance Director, the facility's dry sprinkler system gauges were not documented as being inspected weekly for four weeks of November 2024 and eight weeks that included July, August, September and October 2024. Based on interview at the time of record review, the Regional Maintenance Director stated the facility is without a Maintenance Director, had gathered all the documentation he could locate and that there were no other weekly gauge inspections available for review at the time of the survey.<br><br>This finding was reviewed with the Executive Director and Regional Maintenance Director during the exit conference.<br><br>3.1-19(b) | | **affected by the same alleged practice and corrective action taken** Residents have the potential to be affected by the alleged practice. There were no residents affected by the practice. Facility to inspect and document sprinkler system gauges weekly.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with maintenance staff on weekly inspection and documentation of sprinkler system gauges.<br><br>**How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The executive director or designee will audit sprinkler system TELS PM Logs once a week for 4 months | |
| K 0712 SS=F Bldg. 01 | NFPA 101<br>Fire Drills<br><br>1. Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff | K 0712 | **K 712 Fire Drills**<br><br>**Corrective actions accomplished for those residents founds to be affected** | 01/31/2025 |

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| | and residents.<br><br>Findings include:<br><br>Based on record review of the facility's fire drills with the Regional Maintenance Director on 12/12/24 at 12:40 p.m., the following was noted:<br>a) no documentation of a first and third shift fire drill for the third quarter (July, August, September) 2024<br>b) no documentation of a second shift fire drill for the fourth quarter (October, November, December) of 2023/2024 Based on interview at the time of record review, the Regional Maintenance Director stated the facility has been without a Maintenance Director and that there are not any additional fire drills available for review at the time of this survey.<br><br>2. Based on record review and interview, the facility failed to ensure 1 of 9 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors.<br><br>Findings include:<br><br>Based on record review of "Fire Drill Report" with the Regional Maintenance Director on 12/12/24 at 12:33 p.m., the 09/05/24 fire drill at 5:30 p.m. did not include transmission of signal to the monitoring station. Based on interview at the time of record review, the Regional Maintenance Director confirmed that the 09/05/24 fire drill did not | | **by the alleged practice** Staff and residents have the potential to be affected by the alleged practice. The facility will conduct fire drills one per month per shift per quarter per regulations.<br><br>**Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken** There were no residents affected by the practice. Facility will insure verification of alarm receipt by Monitoring station and record on fire drill document.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility ED completed education with maintenance staff on fire drill requirements to meet NFPA fire drill regulation.<br><br>**How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The executive director or designee will audit monthly fire drills monthly and at QA to insure continued compliance. | |

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| | include documented transmission of fire alarm signal to the monitoring station.<br><br>These findings were reviewed with the Executive Director and Regional Maintenance Director during the exit conference.<br><br>3.1-19(b)<br>3.1-51(c) | | | |
| K 0761 SS=F Bldg. 01 | NFPA 101<br>Maintenance, Inspection & Testing - Doors<br><br>Based on records review, and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance of 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:<br>(1) No open holes or breaks exist in surfaces of either the door or frame. | K 0761 | **K 761 Maintenance, Inspection & Testing – Doors**<br><br>**Corrective actions accomplished for those residents founds to be affected by the alleged practice**Residents have the ability to be affected by the alleged practice. Fire Door assemblies will be inspected by maintenance department.<br><br>**Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken** ED or designee to complete a building wide inspection of fire doors assemblies to ensure proper function and compliance.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Maintenance Tech or designee will | 01/31/2025 |

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| | (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label.<br>(11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on record review with the Regional Maintenance Director on 12/12/24 at 1:00 p.m., current documentation of an annual inspection for the fire door assemblies was not available for review. The most recent fire door inspections available were dated 06/07/23. Based on interview at the time of records review, the Regional Maintenance Director stated annual fire door inspections within the last 12 months were not available for review at the time of the survey.<br><br>This finding was reviewed with the Executive | | complete fire door inspection per TELS PM Program annually.<br><br>**How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The executive director or designee will review at QA meeting for continued compliance. | |

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| | Director and Regional Maintenance Director at the exit conference.<br><br>3.1-19(b) | | | |
| K 0918 SS=F Bldg. 01 | NFPA 101<br>Electrical Systems - Essential Electric Syste<br><br>1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 3 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 requires spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.<br><br>Findings include:<br><br>Based on records review of 'Monthly Generator Test Under Load' with the Regional Maintenance Director on 12/12/24 at 11:53 a.m., documentation for March, April and November 2024 was not available for review. Based on interview at the time of record review, the Regional Maintenance Director stated he searched for the aforementioned monthly load testing and was unable to locate documentation at the time of the survey. | K 0918 | **K 918 Electrical Systems - Essential Electric System**<br><br>**Corrective actions accomplished for those residents founds to be affected by the alleged practice**Residents and staff have the potential to be affected by the alleged practice. The maintenance tech was educated on weekly generator inspection, Monthly load testing, and battery maintenance.<br><br>**Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken** Residents and staff have the potential to be affected by the alleged practice. There were no residents affected by the practice.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Facility completed education with maintenance staff on weekly generator inspection, monthly load testing and battery maintenance. Maintenance tech to follow TELS | 01/31/2025 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155780 | A. BUILDING 01<br>B. WING | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| HOMESTEAD HEALTHCARE CENTER | 7465 MADISON AVE<br>INDIANAPOLIS, IN 46227 |

| (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 |
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| | 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for all 52 weeks from December 2023 through December 2024. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on review of "Weekly Generator No Load" documentation with the Regional Maintenance Director during record review at 11:37 a.m. on 12/12/24, documentation of weekly emergency generator inspections for six weeks of the past 52 weeks were not available for review. Throughout the 52 weeks, there were two weeks missing in January 2024, one week missing in July 2024, one week missing in October and December 2024. Based on interview at the time of record review, the Regional Maintenance Director stated the facility has been without a Maintenance Director recently, he had searched records and no additional documentation of weekly emergency generator inspections for the aforementioned time frames were available for review.<br><br>3. Based on records review, observation, and | | PM schedules for inspections and maintenance.<br><br>**How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The executive director or designee will audit TELS Generator logbook weekly to ensure compliance for 4 weeks and then monthly after for 6 months. The results of the audit will be brought to QA for 6 months | |

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| | interview, the facility failed to properly inspect and test all components of the emergency generator. NFPA 101, 9.1.3.1 states Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 8.3.7.1 states Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted.<br><br>Findings include:<br><br>Based on records review with the Regional Maintenance Director on 12/12/24 at 11:56 a.m., of the monthly emergency generator inspection and testing records dating back 12 months prior to the survey revealed there was no documentation of monthly specific gravity testing or conductance testing for the lead-acid batteries, as required by section 8.3.7.1 of NFPA 110, Standard for Emergency and Standby Power Systems. The was a line item titled 'Battery Conductivity Testing' on the monthly generator forms that was left blank or 'NA'. Based on interview at the time of record review, the Regional Maintenance Director stated the natural gas generator has a maintenance free type lead acid battery that doesn't require specific gravity testing, and the battery conductance testing isn't completed monthly as far as he knew.<br><br>These findings were reviewed with the Executive Director and Regional Maintenance Director at the exit conference.<br><br>3.1-19(b) | | | |

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| K 0921 SS=F Bldg. 01 | NFPA 101<br>Electrical Equipment - Testing and Maintenanc<br>Based on records review, observation, and interview, the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents.<br><br>The findings include:<br><br>Based on records review and interview with the Regional Maintenance Director on 11/20/24 between 10:15 a.m. and 1:40 p.m., no | K 0921 | **K 921 Electrical Equipment - Testing and Maintenance**<br><br>**Corrective actions accomplished for those residents founds to be affected by the alleged practice** All residents have the ability to be affected by the alleged practice. Maintenance tech educated on guidelines for PCREE testing electric Beds<br><br>**Identification of other residents having the potential to be affected by the same alleged practice and corrective action taken** All residents who use electric beds have the ability to be affected by the alleged practice An inventory of beds will be taken and testing will be performed per manufacturer guidelines.<br><br>**Measures put in place and systemic changes made to ensure the alleged deficit practice does not recur:** Maintenance Tech or designee will continue to keep bed inventory list up to date as well as all manufacturer manuals.<br><br>**How the corrective measures will be monitored to ensure the alleged deficit practice does not recur:** The executive director | 01/31/2025 |

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| | documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The Regional Maintenance Director stated that PCREE such as nebulizers, air mattresses, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. The Regional Maintenance Director stated he was aware of the testing requirement of PCREE but had not been completed for the PCREE in the facility.<br><br>This finding was reviewed with the Executive Director and Regional Maintenance Director at the exit conference.<br><br>3.1-19(b) | | or designee will audit PCREE Bed logs once completed and update as necessary. This will be reviewed during QA every month for 6 months | |