STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING -- B. WING	03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/17/2025 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this Emergency Preparedness survey, Dyer Nursing and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 161 certified beds. At the time of the survey, the census was 120. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review conducted on 03/24/25	E 0000		
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 patients in the event of limitations or cessation of operations to maintain the continuity of services to facility resident. This deficient practice could affect all residents, and staff.	E 0025	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 patients in the event of limitations or cessation of operations to maintain the	04/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bradley Macklin	Administrator	04/11/2025

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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	Findings include: Based on record review and interview with the Administrator and Director of Maintenance on 03/17/2025 at 11:30 a.m. the facility failed to provide documentation of the development of arrangements with other LTC facilities and other providers to receive residents in the event of limitations or cessation of operations. Based on interview at 3:33 p.m. during the exit conference, the Senior Administrator stated the facility would use other facilities within the same company, however, no written agreements were available for review. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference.		continuity of services to facility resident. This deficient practice could affect all residents, and staff. The corrective action that the Facility will take is to develop the arrangement with other LTC facilities and other providers to receive patients in the event of limitations or cessations of operations to maintain the continuity of services to facility residents This potentially can affect all residents in the community. Transfer agreements will be formed. The Administrator/designee will review the agreement yearly to ensure that they are accurate and up to date. The agreements will be placed in the ERP binder Date of compliance for this deficiency: 4/14/2025	
E 0031 SS=F Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(Emergency Officials Contact Information Based on record review and interview, the facility failed to ensure the Emergency Preparedness Communication Plan includes: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c)(2). This deficient practice could affect all occupants. Findings include:	E 0031	Based on record review and interview, the facility failed to ensure the Emergency Preparedness Communication Plan includes: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of	04/14/2025

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	Based on record review and interview with the Administrator and Director of Maintenance on 03/17/2025 at 10:59 a.m. the Emergency Preparedness Communication Plan did not include Gateway.isdh.in.gov or incidents@isdh.in.gov as contact information for IDOH. Based on interview the Director of Maintenance acknowledged the emergency officials contact information did not include the contact information for IDOH. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference.		assistance in accordance with 42 CFR 483.73(c)(2). This deficient practice could affect all occupants. The Facility will ensure that the emergency preparedness communication plan is complete. This plan will include the Federal, state, tribal, regional and local emergency preparedness staff, The state licensing and certification agency, Office of state long term care ombudsman and any other applicable sources of assistance. All residents may have been affected by this deficiency. The Administrator/Designee will ensure that the emergency preparedness communication plan is complete and readily available for review. Each week for 6 months the Administrator/Designee will ensure that the emergency preparedness communication plan is available at the front desk for any and all to review. The date of compliance for this deficiency: 4/14/2025	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was based on the emergency plan, risk assessment, policies and procedures of the plan, and the communications plan of the emergency	E 0036	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was based on the emergency plan, risk	04/14/2025

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	preparedness plan in accordance with 42 CFR 483.73(d). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 11:53 a.m. on 3/17/2025 no documentation could be provided that ensured the emergency preparedness training and testing program was developed and maintained. Based on interview, the Director of Maintenance stated he was not able to locate documentation of an emergency preparedness training and testing program. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference.		assessment, policies and procedures of the plan, and the communications plan of the emergency preparedness plan in accordance with 42 CFR 483.73(d). This deficient practice could affect all residents, staff and visitors. The Administrator/Designee will develop and maintain an emergency preparedness training and testing programs. This program includes emergency plan, risk assessment policies and procedures. This affects all staff, residents and visitors in the community. This plan will be discussed during the next QAPI meeting and implemented. Each month during QAPI, The Administrator/Designee will review and maintain the emergency preparedness plan which includes Risk Assessment , communication of policies and procedures of the plan. Date of Compliance: 4/14/2025	
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	E 0037	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	04/14/2025

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	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 record review and interview with the Administrator and Director of Maintenance on 3/17/2025 at 11:53 a.m., no documentation of annual EPP training was available for review. Based on interview at 3:33 p.m. during the exit conference, the Senior Administrator stated EPP training was conducted using the Relias computer based training program, furthermore, the Director of Maintenance stated he reviewed the facility specific EPP, however, no documentation of facility specific training was available for review. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference.		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. The Administrator/Designee will conduct an annual training for the Emergency Preparedness Program (ERP). This will be conducted 4/14/2025 This affects all staff, residents and visitors in the community. Once the training is completed, the documentation will be maintained for the year. The next QAPI meeting scheduled is 4/8/2025, the ERP training will be reviewed and training date will be scheduled for the facility. Date of Compliance: 4/14/2025	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana	K 0000		

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	Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/17/2025 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this Life Safety Code survey, Dyer Nursing and Rehabilitation 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. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The facility has a capacity of 161 and had a census of 120 at the time of this survey. All areas where residents have customary access and all areas providing facility services were sprinklered. Quality Review conducted on 03/24/25			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Based on observation and interview, the facility failed to ensure 1 of 1 exit signs in the West Memory Care Unit Dining Room was continuously illuminated. This deficient practice could affect residents, staff and visitors in the	K 0293	Based on observation and interview, the facility failed to ensure 1 of 1 exit signs in the West Memory Care Unit Dining Room was continuously	04/14/2025

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	West Memory Care Unit. Findings include: Based on observation and interview with the Director of Maintenance on 03/17/2025 at 2:16 p.m., an exit sign above the exit door in the West Memory Care Unit Dining Room, also known as the Garden Unit was not illuminated, furthermore, the Director of Maintenance removed the cover of the exit sign and stated the light was not hardwired and was relying on battery power only. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference. 3.1-19(b)		illuminated. This deficient practice could affect residents, staff and visitors in the West Memory Care Unit. The Maintenance Director/Designee will repair and ensure that the exit signs in West Memory Care unit dining room is continuously illuminated. This could potentially affect all the residents on the west memory care unit. The Maintenance Director/Designee will conduct a weekly audit for 6 months on 5 exit signs to ensure that all the exit signs are illuminated thorough out the building including the west memory care unit dining room. Date of compliance: 4/14/2025	
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 systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*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 The fire-extinguishing system	K 0324	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 systems. The Maintenance Director/Designee will outline on the floor the area in which the cooking appliance are to remain. This could potentially affect all of the staff in the kitchen	04/14/2025

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	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 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff. Findings include: Based on observation with the Director of Maintenance on 03/17/2025 at 1:51 p.m., cooking appliances including a gas 6-burner stove and oven and 1 flat-top grill with an oven, located under the hood in 1 of 1 kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview with the Director of Maintenance at 1:51 p.m., he said he was not aware of any method or procedure in place. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference. 3.1-19(b)		The Maintenance Director/Designee will outline on the floor the area in which the cooking appliance are to remain. Those items should be moved, modified or rearranged without prior re-evaluation of the fire extinguisher system by the system installer or service agent. Date of Compliance: 4/14/2025	
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 in the	K 0346	Based on record review and interview, the facility failed to	04/14/2025

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	155220	A. BUILDING 01 B. WING	03/17/2025

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	event the fire alarm system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 9:41 a.m. on 03/17/2025, the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference. 3.1-19(b)		provide a complete written policy in the event the fire alarm system has to be placed out-of-service for 4 hours or more in a 24-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. The Administrator/Designee will compose a written policy in the event of the fire alarm placed out of service for 4 hours or more in a 24 hours period. This has to potential to affect all staff, residents and visitors. The policy will be put in the ERP for usage in the event that the fire alarm system is out of service for 4 hours or more in a 24 hour period. Anytime that the policy will be used we will review the outcome and assess during the follow QAPI monthly meeting Compliance Date: 4/14/2025	
K 0352 SS=F Bldg. 01	NFPA 101 Sprinkler System - Supervisory Signals Based on observation and interview, the facility failed to maintain automatic sprinkler systems in accordance with LSC 9.7. LSC 19.3.5.1 states buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. LSC 9.7.2.1 states where supervised automatic sprinkler systems are required by another section of this Code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and a distinctive	K 0352	Based on observation and interview, the facility failed to maintain automatic sprinkler systems in accordance with LSC 9.7. The Maintenance/Designee will maintain and ensure that the automatic sprinkler systems are properly working. This has the potential to affect all staff, residents and visitors. The facility will get the	04/14/2025

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	supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on observation with the Director of Maintenance on 03/17/2025 at 2:00 p.m., two sprinkler valves located in the west hall receiving room were not electrically supervised. Based on observation at 2:00 p.m., the two valves on the system had electronic monitoring devices attached but no wiring was connected to the monitoring devices, rendering the system incapable of being monitored. Based on interview at 2:00 p.m., the Director of Maintenance agreed the valves were not electrically supervised. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference. 3.1-19(b)		sprinkler system serviced so that it is properly functioning The Maintenance Director/Designee will contact the sprinkler system service provider and follow the established maintenance plan. Date of Compliance: 4/14/2025	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to ensure 5 of 5 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection	K 0353	Based on record review and interview, the facility failed to ensure 5 of 5 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by	04/14/2025

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	Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 9:59 a.m. on 03/17/2025, no documentation of an internal pipe inspection of the 5 wet pipe systems located in the facility was available for review. Page 3 of 4 of the Sprinkler: Report of Inspection dated 01/27/2025 from the sprinkler vendor, under the sub-title "Wet Systems" line 53 "Number of Systems", the document indicates 5. Line 54 under the same sub-title of the same document further describes each of the 5 systems as wet pipe system. Based on record review at 9:59 a.m. on 03/17/2025, the facility provided a document for a dry sprinkler system inspection that had handwriting on the document indicating it was a 5-year inspection. Based on interview at 9:59 a.m. the Director of Maintenance stated the Assisted Living Facility has a dry system and the Nursing Facility has a wet system. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference. 3.1-19(b)		NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all residents, staff and visitors. The Maintenance Director/Designee will get the 5 year internal piping inspection completed immediately This has the potential to affect the staff, residents and visitors in the facility The Maintenance Director/Designee will contact the sprinkler piping system service provider and follow the established maintenance plan Date of Compliance: 4/14/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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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 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 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 residents, staff and visitors. Findings include: Based on record review and interview with the Administrator and Director of Maintenance at 9:41 a.m. on 03/17/2025, the fire watch plan failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov.	K 0354	Based on record review and interview, the facility failed to provide a complete written policy in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period. The administrator/designee will compose a written policy for usage in the event of the automatic sprinkler system are out of service for 10 hours or more in a 24 hours period. This has to potential to affect all staff, residents and visitors. The policy will be put in the ERP for usage in the event that the automatic sprinkler alarm system is out of service for 10 hours or more in a 24 hour period. Anytime that the policy will be used we will review the outcome and assess during the follow QAPI monthly meeting. Compliance Date: 4/14/2025	04/14/2025

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	155220	A. BUILDING 01 B. WING	03/17/2025

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	This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference. 3.1-19(b)			
K 0500 SS=F Bldg. 01	NFPA 101 Building Services - Other Based on observation and interview, the facility failed to ensure 1 of 1 fuel fired water heater had a current inspection certificate to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice affects all residents, staff and visitors. Findings include: Based on observation with the Director of Maintenance on 03/17/2025 at 12:43 p.m., an inspection certificate located at the boiler in the mechanical room off the front lobby had a certificate issued by the Indiana Department of Homeland Security; however, the certificate had an expiration date of 05/31/2022. Based on interview at 12:43 p.m., the Director of Maintenance stated he was having difficulties with updating the certificate on the state portal. This finding was reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference. 3.1-19(b)	K 0500	Based on observation and interview, the facility failed to ensure 1 of 1 fuel fired water heater had a current inspection certificate to ensure the water heaters were in safe operating condition. The Maintenance director/designee will get the fuel fired water heater inspection completed immediately This has the potential to affect the staff, residents and visitors in the facility The Maintenance Director/Designee will contact the fuel fired water heater service provider and get the boiler inspected. Date of Compliance: 4/14/2025	04/14/2025

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 bathroom in resident room 129 and 1 of 1 sink location in the MDS office was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would	K 0511	Based on observation and interview, the facility failed to ensure 1 of 1 bathroom in resident room 129 and 1 of 1 sink location in the MDS office was provided with ground fault circuit interrupter (GFCI) protection against electric shock. The Maintenance director/designee will ensure that the sink located in the MDS office is provided a fault circuit interrupter protection against electrical shock. This has the potential to affect staff in the MDS officec The Maintenance Director/Designee will fix the GFCI in the office. Weekly for 6 months the maintenance director/designee will inspect 10 outlets per week to ensure proper functionality Date of Compliance: 4/14/2025	04/14/2025

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	create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could one resident in room 129, and staff in the MDS office. Findings include: 1. Based on observation and interview with the Director of Maintenance on 03/17/2025 at 1:12 p.m., there was one electric receptacle within 12 inches of the sink in the bathroom of resident room 129. The electric receptacle was a ground fault circuit interrupter (GFCI) type; however,			

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	when tested the receptacle failed to interrupt the power supplied. 2. Based on observation and interview with the Director of Maintenance on 03/17/2025 at 2:36 p.m., there was one electric receptacle 32 inches from the edge of the sink located in the MDS office and second electric receptacle 43 inches from the edge of the same sink. The electric receptacle was a standard type and when tested failed to provide ground-fault circuit interrupter (GFCI) protection. These findings were reviewed with the Administrator, Director of Maintenance and the Senior Administrator at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect residents, staff and visitors in the Theater located off of the main hall. Findings include: Based on observation during a tour of the facility with the Director of Maintenance on 03/17/2025 at 12:37 p.m., an orange extension cord was found plugged into an electrical receptacle and run	K 0920	Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord was not used as a substitute for fixed wiring. The Maintenance director/designee will ensure that no flexible cords are used in the building for substitute fixed wiring. This has the potential to affect staff, residents and visitors The Maintenance Director/Designee will complete a weekly audit to ensure that no extension cords are used as substitutes for fixed wiring. This audit will continue for 6 months	04/14/2025

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	through the drop ceiling of the theater to the location of previously mounted LED projector. At 12:37 p.m. the Director of Maintenance acknowledged and removed the extension cord. 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords at the nurses' station on the North Memory Care Unit were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect residents, staff and visitors in the North Memory Care Unit. Findings include: Based on observation and interview with the Director of Maintenance on 03/17/2025 at 12:56 p.m., a pink extension cord was found plugged into an electrical receptacle that supplied power to a phone charger. At 12:56 p.m. the Director of Maintenance acknowledged and removed the extension cord. 3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords in the wound care office were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff in the wound care office.		Date of Compliance: 4/14/2025	

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	Findings include: Based on observation and interview with the Director of Maintenance on 03/17/2025 at 1:20 p.m., a computer and accessories were plugged into a power strip of an unknown rating that was plugged into a green extension cord. The end of the extension cord was observed unplugged near an electrical receptacle. At 1:20 p.m., the Director of Maintenance stated the extension cord was unplugged. 4. Based on observation and interview, the facility failed to ensure a multiplug power strip in 1 of 87 resident rooms met UL 1363. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice could affect one resident who resides in resident room 125. Findings include: Based on observation and interview with the Director of Maintenance on 03/17/2025 at 1:25 p.m., resident room 125 was using a multiplug power strip that lacked a UL 1363 label for resident's personal electrical equipment including a stereo. The multi-plug power strip was located against the wall 5 feet from the end of the resident's bed. At 1:25 p.m., the Maintenance Director stated the resident or family members probably brought the power strip in. These findings were reviewed with the Administrator, Director of Maintenance and the			

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	Senior Administrator at the exit conference. 3.1-19(b)			