STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155275	A. BUILDING -- B. WING	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

(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: 09/25/23 Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440 At this Emergency Preparedness survey, The Waters of Princeton was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 95 certified beds and had a census of 56 at the time of this visit. Quality Review completed on 09/28/23	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
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: 09/25/23 Facility Number: 000175 Provider Number: 155275 AIM Number: 100274440 At this Life Safety Code survey, The Waters of Princeton was found not in compliance with	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Seibel	HFA	10/12/2023

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

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	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 (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 95 and had a census of 56 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except one detached wood shed and one detached metal pod, both structures used for facility storage. Quality Review completed on 09/28/23		**with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer room enclosure was free of lint. NFPA 101 at 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	K 0100	**K100 -** It is the intent of the facility to ensure laundry area dryer room enclosure is free of lint to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**:	10/20/2023

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	evacuation of occupants. This deficient practice could affect mostly laundry staff. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the floor, wall, and equipment in the back of the dryer enclosure within the laundry area was substantially covered with dryer lint. Based on interview at the time of observation, the Administrator agreed there was a substantial amount of dryer lint on the floor, wall, and equipment within the enclosure behind the dryers, and further said they would increase the cleaning schedule. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		a On 9-25-2023 and on 10-10-2023 the Maintenance Supervisor/designee cleaned the dryer lint from the floor, wall and equipment in the back of the dryer enclosure within the laundry area to meet set standards. The Administrator verified the work on 9-25-2023 and on 10-10-2023. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 9-25-2023 the Administrator in serviced the Maintenance Supervisor/Laundry Staff/designee on the requirement that laundry area dryer room enclosure must be free of lint to meet set standards. b Maintenance Supervisor/Laundry Staff/designee will inspect the laundry area dryer room enclosure to ensure it is kept free of lint as a part of the facility's weekly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance	

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			schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023 .**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the			

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	clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS			

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	Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 locked exit courtyard gate was readily accessible for residents, staff, and visitors. This deficient practice could affect at least 13 residents, as well as staff and visitors in The Crossing Unit. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the courtyard exit gate from The Crossing Unit was equipped with a magnetic lock that required a four digit code on the adjacent keypad to release. When the code was entered on the keypad the gate did release from the magnetic lock, however, the gate was difficult to open because it dropped down slightly on the magnetic lock side and wedged against the supporting post. To open, the gate had to be lifted slightly and pushed open. This was acknowledged by the Administrator at the time of observation who indicated the gate doesn't get used often and was unaware the gate was difficult to open.	K 0222	**K222**– It is the intent of the facility to ensure the means of egress through locked exit courtyard gate is readily accessible for residents, staff and visitors to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10-11-2023 the Maintenance Supervisor/designee will repair the courtyard exit gate from the crossing unit to meet set standards. The Administrator will verified the work on 10-11-2023 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10-9-2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement to ensure	10/20/2023

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	This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		means of egress through locked exit courtyard gate is readily accessible for residents, staff and visitors to meet set standards. b Maintenance Supervisor/designee will ensure means of egress through locked exit courtyard gate is readily accessible for residents, staff and visitors as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as	

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			deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023.**	
K 0291 SS=C Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency light set was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, one of the two light bulbs in the battery backup light set located at the generator did not illuminate when tested several times. Based on interview at the time of	K 0291	**K291** – It is the intent of the facility to ensure battery powered emergency light set is maintained in accordance with LCS 7.9 to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10-11-2023 the Maintenance Supervisor/designee replaced the battery backup light set located on the generator that did not illuminate when tested to meet set standards. The Administrator verified the work on 10-11-2023. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 10-9-2023 the Administrator in serviced the	10/20/2023

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	observation, the Administrator agreed one of two light bulbs did not illuminate when the battery backup light set at the generator was tested several times. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Maintenance Supervisor/designee on the requirement to provide and maintain battery powered emergency light including the battery backup light set located on the generator to meet set standards. 2.Maintenance Supervisor/designee will ensure to provide and maintain battery powered emergency lighting including the battery backup light set located on the generator as a part of the facility's Monthly Preventive Maintenance Program and document those tests on the Battery-Operated Emergency Lights and signs Test Log and will maintain emergency lighting to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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			Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A			

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	a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as a laundry room door, was provided with a properly working self closing device. This deficient practice could affect mostly staff while in the Service Hall corridor as well as resident on the way to the smoking area. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the right side laundry room corridor door was provided with a self closing device, however, the arm of the self closing device was not attached to the door frame. When tested, the door stayed in the wide open position. This was confirmed by the Administrator at the time of observation. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)	K 0321	**K321**– It is the intent of the facility to ensure hazardous area doors, such as a laundry room door, is provided with a properly working self-closing device to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10-11-2023 the Maintenance Supervisor/designee will repair the self-closing device and attached the arm to the door frame on the right side laundry room corridor door to meet set standards. The Administrator will verify the work on 10-11-2023 . **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 9-25-2023 the Administrator in serviced the Maintenance Supervisor/Laundry Staff designee on the requirement to ensure self-closing devices work properly to meet set	10/20/2023

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			standards. b Maintenance Supervisor/designee will inspect all hazardous area doors to ensure the self-closing devices are working properly as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible**	

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			allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook top for 1 of 1 stove/oven was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room.	K 0324	**K324**– It is the intent of the facility to ensure the cook top for stove/oven is shut off at the switch when not in use to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On 10-10-2023 the Administrator in serviced the Maintenance	10/20/2023

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	155275	A. BUILDING 01 B. WING	09/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

(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
	(2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect up to 5 residents, staff and visitors in the Physical Therapy room. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, there was a cooktop stove/oven in Physical Therapy Room. The stove/oven was not being used at the time of observation and the power to the stove/oven was on. Based on interview at the time of observation, the Administrator confirmed the cooktop stove/oven was not deactivated when not in use, furthermore, the Administrator said she didn't think there was a deactivation switch for the Physical Therapy stove/oven other than unplugging it from the receptacle. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Supervisor/designee/Physical Therapy staff the cooktop stove/oven in Physical Therapy Room must be turned off when not in use to meet set standards. b. On 10-11-2023 the Maintenance Supervisor/designee installed a deactivation switch/lockout tagout to the stove/oven in Physical Therapy Room to meet set standards. The Administrator verified the work on 10-10-2023 . **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a.The Maintenance Supervisor/designee/Physical Therapy staff will ensure the cooktop stove/oven in Physical Therapy Room is turned off when not in use as a part of the facility's daily policy and procedures and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/Physical Therapy staff/designee will review with the Administrator the inspection results. a The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the systems are in compliance.	

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			4. MONITORING CORRECTIVE ACTION: a. The monitoring results will be presented by the Administrator at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023**	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation and interview, the facility failed to ensure 1 of 8 smoke compartments was provided with a complete interior finish with a	K 0331	**K331**– It is the intent of the facility to ensure smoke compartments are provided with a complete	10/20/2023

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	flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect mostly staff while in the Service Hall, plus residents while on the way to the smoking area. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, there was a two foot by two foot plywood attic access panel in the laundry room. This was acknowledged by the Administrator at the time of observation, furthermore, the Administrator said the plywood attic access panel did not have a flame spread rating as far as she knew. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		interior finish with a flame spread rating of Class A or Class B for a sprinklered facility to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10-18-2023 the Maintenance Supervisor/designee will replace the attic access panel in the Laundry Room with a fire rated assembly to meet set standards. The Administrator/designee will verified the work on 10-18-2023 . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10-9-2023 the Administrator/designee in serviced the Maintenance Supervisor/designee on the requirement that smoke compartments are provided with a complete interior finish with a flame spread rating of Class A or B for a sprinklered facility to meet set standards. b Maintenance Supervisor/designee will ensure smoke compartments are provided with a complete interior finish with a flame spread rating of Class A or B for a sprinklered facility as a part of the facility's monthly Preventive Maintenance Program and document those inspection	

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			results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing			

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	Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during 30 of the past 52 weeks for the sprinkler system's pressure gauges, and during 7 of the past 12 months for the sprinkler system's control valves. 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 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	K 0353	**K353** – It is the intent of the facility to ensure to document sprinkler system inspections in accordance with NFPA 25 for dry sprinkler system during 52 for the sprinkler systems' pressure gauges and during the past 12 months for the sprinkler system's control valves to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 10-12-2023 the Maintenance Supervisor/designee performed the weekly inspection on the facility's dry sprinkler system gauges and documented the results to meet set standards. The Administrator verified the work on 10-12-2023 . 2.On 10-12-2023 the	10/20/2023

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	authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: a. Based on record review on 09/25/23 between 9:35 a.m. and 1:15 p.m. with the Administrator present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during 30 of the past 52 week period. Based on interview at the time of record review, the Administrator confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during 30 of the past 52 weeks. Based on observations with the Administrator during a tour of the facility between 1:15 p.m. and 4:15 p.m. the facility had four pressure gauges at the sprinkler riser. b. Based on record review on 09/25/23 between 9:35 a.m. and 1:15 p.m. with the Administrator present, there was no monthly sprinkler system control valves inspection documentation for 7 of the past 12 months. Based on interview at the time of record review, the Administrator confirmed the lack of sprinkler system inspections on the control valves during the past 12 months. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Maintenance Supervisor/designee performed the monthly sprinkler system control valves inspection and documented the results to meet set standards. The Administrator verified the work on 10-12-2023 . **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 10-9-2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly inspected including the weekly inspection on the facilities dry sprinkler system gauges and the monthly sprinkler system control valves inspection to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler system must be properly inspected including the weekly inspection on the facilities dry sprinkler system gauges and the monthly sprinkler system control valves inspection as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee	

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			will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023_.**	
K 0363 SS=B Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch			

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	solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of at least 20 Service Hall corridor doors would close complete and latch into its door frame. This deficient practice could	K 0363	**K363** – It is the intent of the facility to ensure corridor doors close complete and latch into its door frame to meet set standards.	10/20/2023

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	affect mostly staff, plus any residents going to the smoking area. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the corridor door to the Employee Breakroom did not close completely and latch when tested several times. There was a half inch gap between the door and the frame along the latching side. Based on interview at the time of observation, the Administrator acknowledged the Service Hall corridor door to the Employee Breakroom failed to close complete and latch into its door frame when tested. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		**1 CORRECTIVE ACTIONS TAKEN**: a On 10-9-2023 the Maintenance Supervisor/designee repaired the corridor door to the Employee Breakroom so the door would self-close and latch fully into the frame to meet set standards. The Administrator verified the work on 10-9-2023. **2 ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. The Maintenance Supervisor/designee inspected all corridor doors to ensure they close and latch fully into the frame and found no other negative findings. **3 MEASURES TO PREVENT REOCCURRENCE**: a On 10-9-2023 the Administrator in serviced the Maintenance Supervisor/designee and all staff on the requirement that corridor doors must self-close and latch fully into the frame to meet set standards. b Maintenance Supervisor/designee will inspect all corridor doors throughout the facility monthly to ensure they self-close and latch fully into the frame as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved	

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			immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4 MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING			

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	Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 3 of 3 set of smoke barrier doors which swing in the same direction and equipped with an astragal have a properly equipped and functioning coordinator to ensure the door which must close first always closes first. This deficient practice could affect more than 20 residents, as well as staff and visitors. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the following was noted: a. The set of smoke barrier doors between the west Service Hall and 100 Unit Nurse's Station area closed in the same direction with an astragal attached to one of the doors. There was a door coordinator attached to the door frame, however, it did not function correctly when tested because it was missing the plastic or rubber wheel. When tested, there was a six inch gap between the doors when closed fully due to the faulty coordinator. b. The set of smoke barrier doors in "The Crossing" Unit closed in the same direction with an astragal attached to one of the doors. There was a door coordinator attached to the door frame, however, it did not function correctly.	K 0374	**K374** – It is the intent of the facility to ensure sets of smoke barrier doors which swing in the same direction and equipped with an astragal have a properly equipped and functioning coordinator to ensure the door which must close first always closes first to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10-9-2023 the Maintenance Supervisor/designee ordered the door coordinator for the smoke barrier doors between the west service hall and 100 unit nurse's station to meet set standards. The Administrator verified the order on 10—9-2023. b On 10-9-2023 the Maintenance Supervisor/designee ordered the door coordinator for the smoke barrier doors in "the crossing" unit to meet set standards. The Administrator verified the order on 10-9-2023.	10/20/2023

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	When tested, there was a six inch gap between the doors when closed fully due to the faulty coordinator. c. The set of smoke barrier doors between the 100 southwest corridor and the 100 Unit Nurse's Station area closed in the same direction with an astragal attached to one of the doors. There was a door coordinator attached to the door frame. The coordinator did function correctly when tested, however, the plastic or rubber wheel of the coordinator was missing which could eventually cause the coordinator to not function correctly. Based on interview at the time of observation, the Administrator agreed the coordinators on two of the smoke barrier doors did not allow the sets of smoke barrier doors to function as designed, and further agreed the other coordinator needed the plastic or rubber wheel to function properly as designed. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		c On 10-9-2023 the Maintenance Supervisor/designee ordered the door coordinator on the smoke barrier doors between the 100 southwest corridor and the 100 unit nurse's station area to meet set standards. The Administrator verified the order on 10-9-2023. d The Coordinators are on back order until the 25 at which time they will be installed . 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 10-13-2023 the Maintenance Supervisor/designee inspected all smoke barrier doors throughout the facility and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 10-9-2023 the Administrator in serviced the Maintenance Supervisor/all staff/designee on the requirement that smoke barrier doors which swing in the same direction and equipped with an astragal have a properly equipped and functioning door coordinator to ensure the door which must close first always closes first to meet set standards. b Maintenance Supervisor/designee will inspect all smoke barrier doors throughout the facility monthly to ensure smoke barrier doors which swing	

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			in the same direction and equipped with an astragal have a properly equipped and functioning door coordinator to ensure the door which must close first always closes first as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible**	

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			allegation of compliance with all regulatory requirements. Our date of compliance is 10-25-2023	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. 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. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (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	K 0511	**K511** – It is the intent of the facility to ensure wet locations are provided with ground fault circuit interrupter (GFCI) protection against electric shock to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: 2 On 1011-2023 the Maintenance Supervisor/designee installed a GFCI receptacle in the east unit clean utility room to meet set standards. The Administrator verified the repairs on 10-11-2023 A**LL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. On 10-11-2023 the Maintenance Supervisor/designee inspected all electrical outlets and found no other negative findings. 3 **MEASURES TO PREVENT**	10/20/2023

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	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 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. 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 affect one staff while in the East Unit Clean Utility Room.		**REOCCURRENCE**: a On 10-9-2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that wet locations are provided with GFCI receptacles to protect against electrical shock to meet set standards. a Maintenance Supervisor/designee will inspect all wet locations to ensure they are provided with GFCI receptacles to protect against electrical shock as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: c The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting.	

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	Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, the electric receptacle within four feet of the sink in the East Unit Clean Utility Room was not provided with a GFCI receptacle. When tested with a GFCI testing device the receptacle did not break the electrical circuit. Based on interview at the time of observation, the Administrator agreed the receptacle in the East Unit Clean Utility Room was not properly GFCI protected. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the	K 0712	**K712** – It is the intent of the facility to ensure to provide quarterly fire drill documentation for all shifts every quarter and to ensure fire drill reports include	10/20/2023

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	facility. Findings include: Based on review of the facility's fire drill reports on 09/25/23 between 9:35 a.m. and 1:15 p.m. with the Administrator present, the facility lacked fire drill documentation for the first shift (day) of the fourth quarter (October, November, and December) of 2022. Based on interview at the time of record review, the Administrator confirmed the lack of a fire drill report during the first shift of the fourth quarter of 2022. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to ensure 8 of 11 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 09/25/23 between 9:35 a.m. and 1:15 p.m. with the Administrator present, 8 of 11 fire drill reports performed during the past 12 month period were not provided with documentation for the transmission of the alarm to the monitoring company. These drills were all performed during		complete transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 10-9-2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards. b On 10-16-2023 the Maintenance Supervisor/designee will conduct a fire drill for each of the three shifts and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator will verify the drills on 10-16-2023 c On 10-9-2023 the Administrator in serviced the Maintenance Supervisor/designee on the requirement that fire drill reports must have documentation for the transmission of the alarm to the monitoring company to meet set standards. 2 **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none were. 3 **MEASURES TO PREVENT REOCCURRENCE**: a Maintenance	

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	the second and third shifts. Based on interview at the time of record review, the Administrator acknowledged there was no information on the eight fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator during the exit conference. 3-1.19(b) 3.1-51(c)		Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and that documentation be retained in the facility's Life Safety Binder and all reports will have documentation for the transmission of the alarm to the monitoring company as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as	

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			deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023.**	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure a multi-plug adapter was not used as a substitute for fixed wiring in 1 of 50 resident	K 0920	**K920**– It is the intent of the facility to ensure multi plug adapter is not used as a	10/20/2023

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	rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect one resident in room 215. Findings include: Based on observations on 09/25/23 between 1:15 p.m. and 4:15 p.m. during a tour of the facility with the Administrator, there was a oxygen concentrator and nebulizer plugged into a multi-plug which was plugged into the wall receptacle in resident room 215. Based on interview at the time of observation, the Administrator acknowledged the use of the multi-plug adapter in resident room 215. This finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		substitute for fixed wiring in resident rooms to meet set standards. 1 **CORRECTIVE ACTIONS TAKEN**: a On 9-25-2023 the Maintenance Supervisor/designee removed the multi plug adapter in resident room 215 to meet set standards. The Administrator verified the removal of the cord on 9-25-2023 2 **ALL OTHERS WITH POTENTAL TO BE AFFECTED**: a All residents and all staff and visitors have the potential to be affected but none the Maintenance Supervisor/designee inspected all rooms throughout the facility for multi plug adapters and found no other negative findings. 3 **MEASURES TO PREVENT REOCCURRENCE**: a On 9-25-2023 the Administrator in serviced the Maintenance Supervisor/designee and all other staff on the requirement that multi plug adapters are not to be used in the facility to meet set standards. b Maintenance Supervisor/designee will inspect all rooms throughout the facility monthly and remove any multi plug adapters found as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed	

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			and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4 **MONITORING CORRECTIVE ACTION**: a The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 10-20-2023.**	