STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING -- B. WING	02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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: 02/08/24 Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720 At this Emergency Preparedness survey, Cardinal Care Strategies was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 104 and had a census of 65 at the time of this survey. Quality Review completed on 02/12/24 The requirements of 42 CFR, Subpart 483.73 are Not Met as evidenced by:	E 0000	February 23, 2024 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID TH3R21 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during this Life Safety Code Recertification and Emergency Preparedness Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Karsen Rauch, HFA Administrator Cardinal Care Strategies	
E 0006 SS=E Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karsen Rauch	HFA - Administrator	02/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.			

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	*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect 10 residents. Findings include:	E 0006	PROPOSED PLAN OF CORRECTION E006 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the information on the 2567 and updated our Hazard Vulnerability Assessment.	02/23/2024

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	Based on records review with the Administrator and the Maintenance Supervisor (MS) on 02/08/24 at 10:45 a.m., documentation was found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach but it was incomplete, as it did not include missing residents. Based on interview at the time of record review, the Administrator agreed the risk assessment utilizing an all-hazards approach did not include missing residents. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)		2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will add "Elopement" to the Hazard Vulnerability Assessment. An in-service on this addition was completed. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 2/23/24.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This deficient practice could affect all residents in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor (MS) on 02/08/24 at 02:30 p.m., the emergency battery powered light at the generator did not work when tested. Based on an interview at the time of record review, the MS agreed the light did not work when tested.	E 0041	PROPOSED PLAN OF CORRECTION E041 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the information on the 2567 and replaced the battery in the emergency light at the generator. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will ensure this light is monitored for battery outage. The battery was replaced and currently works properly. An in-service was completed, and maintenance staff were made aware of the battery replacement and the necessity as to why it needs to be working. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance	02/23/2024

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			Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 2/23/24.	
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: 02/08/24 Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720 At this Life Safety Code survey, Cardinal Care Strategies 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 VIII construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 104 and had a census of 65 at the time of this survey.	K 0000	February 23, 2024 Ms. Brenda Buroker Director of Long Term Care 2 North Meridian St. Indianapolis, IN 46204 Re: Survey Event ID TH3R21 Dear Ms. Buroker: Please find attached my Plan of Correction for deficiencies cited during this Life Safety Code Recertification and Emergency Preparedness Survey. I am respectfully requesting paper compliance. If you have any questions, please feel free to contact me. Sincerely, Karsen Rauch, HFA Administrator Cardinal Care Strategies	

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	All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/12/24			
K 0222 SS=F 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 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			

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	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 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 7 of 9 exit doors in the facility were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise	K 0222	PROPOSED PLAN OF CORRECTION K222 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the	02/23/2024

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	permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 50 residents and visitors. Findings include: Based on observation with the Administrator and Maintenance Supervisor (MS) on 02/08/24 at 1:55 p.m., the exit doors in the facility were marked as a facility exit, were magnetically locked, and could be opened by entering a four-digit code on the access control pad. The code was not posted at the exits by the access control pad. Based on interview at the time of observation, the Administrator stated that it was unsafe to post the door code because residents could elope. The finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)		information on the 2567 and posted the door codes for each exit by the keypad. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will ensure the door codes are posted at each exit. An in-service was completed, and maintenance staff were made aware of the necessity of having codes posted in case of emergency. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 2/23/24.	
K 0232 SS=E Bldg. 01	NFPA 101 Aisle, Corridor, or Ramp Width Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the			

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	convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 Based on observation and interview, the facility failed to meet the clear width requirement for 1 of 8 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect 25 residents in the 100 hall exit area.	K 0232	PROPOSED PLAN OF CORRECTION K232 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the information on the 2567 and attached the two entry-way chairs to the wall. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will ensure that the entry-way chairs stay attached to the wall. An in-service was completed, and maintenance staff were made aware of the necessity of having them attached to the wall and why it was a safety hazard that they were not. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased	02/23/2024

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CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

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	Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Supervisor (MS) on 02/08/24 at 02:55 p.m., two overstuffed chairs in the corridor by the 100 hall nurses station extended about two feet into the corridor and were not affixed to the floor or to the wall when tested. Based on interview at the time of the observations, the Administrator agreed the chairs were not securely attached to the floor or to the wall when tested. The finding was reviewed with the Administrator and the MS during the exit conference. 3.1-19(b)		on the basis of compliance. 5 – Corrective action completed by 2/23/24.	
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			

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	155400	A. BUILDING 01 B. WING	02/08/2024

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	Area Automatic Sprinkler Separation N/A 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 1 storage rooms with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Supervisor (MS) on 02/08/24 at 02:15 p.m., the old therapy room contained over 50 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room did not self close and latch when tested. Based on interview at the time of observation, the MS agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room did not self-close and latch when tested. The finding was reviewed with the Administrator and the MS during the exit conference.	K 0321	PROPOSED PLAN OF CORRECTION K321 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the information on the 2567 and added a new self-closer to the storage room door. It now self closes and latches. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will ensure the self-closer continues to work properly and the door latches. An in-service was completed, and maintenance staff were made	02/23/2024

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	3.1-19(b)		aware of the necessity of the self-closer and why it was a fire hazard to not have it that way. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 2/23/24.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 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 and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all	K 0353	PROPOSED PLAN OF CORRECTION	02/23/2024

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	automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Supervisor on 02/08/24 at 10:00 a.m., there was no weekly inspection of the dry pipe sprinkler system's gauges and valves for the year 2023 and January 2024. During an interview at the time of record review, the MS stated that he was unaware the weekly inspection of gauges and valves on a dry sprinkler system was required. This finding was reviewed with the Administrator and MS at the exit conference. 3.1-19(b)		K353 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the information on the 2567 and started weekly gauge and valve checks. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will ensure that weekly checks are being done. The gauges are behind a locked door and under supervision. Per this code, we are required to check them monthly. However, we are going to do weekly audits for the next 6 weeks. Bi-weekly audits for 4 weeks after. Monthly audits after that. An in-service was completed, and maintenance staff were made aware of the new auditing plan. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance.	

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			5 – Corrective action completed by 2/23/24.	
K 0511 SS=E 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 5 electrical junction boxes observed were maintained in a safe operating condition. 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, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 20 residents, staff and visitors in the 200 Hall. Findings include: Based on observation with the Maintenance Supervisor (MS) during a tour of the facility at 3:10 p.m. on 02/08/24, one electrical junction box without a cover and with exposed electrical wiring was found in the attic above 200 Hall. The MS agreed there was an electrical box in the attic of 200 Hall that was missing a cover. This finding was reviewed with the Administrator	K 0511	PROPOSED PLAN OF CORRECTION K511 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the information on the 2567 and added a cover to the electrical box. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will ensure that there is a cover on the electrical box. There has been one added as to not have exposed wiring. An in-service was completed, and maintenance staff were made	02/23/2024

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	and MS at the exit conference. 3.1-19(b)		aware of the cover being added. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 2/23/24.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a			

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	program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lights were maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This deficient practice could affect all residents in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Supervisor (MS) on 02/08/24 at 02:30 p.m., the emergency battery powered light at the generator did not work when tested. Based on an interview at the time of record review, the MS agreed the light did not work when tested. 3.1-19(b)	K 0918	PROPOSED PLAN OF CORRECTION K918 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the information on the 2567 and replaced the battery in the emergency light at the generator. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will ensure this light is monitored for battery outage. The battery was replaced and currently works properly. An in-service was completed, and maintenance staff were made aware of the battery replacement	02/23/2024

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			and the necessity as to why it needs to be working. As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 2/23/24.	
K 0920 SS=E 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			

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	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 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could staff and 6 residents in the Activity room. Findings include: Based on observation with the Administrator and Maintenance Supervisor (MS) on 02/08/24 at 02:25 p.m., in the Activity room, a power strip used to power equipment, was not secured, and was dangling from the outlet on the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Administrator agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strip in the Resident room #114 meets UL 1363. This deficient practice	K 0920	PROPOSED PLAN OF CORRECTION K920 1 – Upon notification of deficiency, Administrator and Director of Maintenance reviewed the information on the 2567, secured the hanging power strip to the wall and replaced the power strip in the resident's room with a UL1363 Hospital Grade strip. 2 – The facility has determined that all residents have the potential to be affected. 3 – The Administrator/Director of Maintenance in-serviced maintenance staff and DON. 4 - The Administrator and Director of Maintenace will ensure that the power strip in the office space stays secured to the wall. We will educate the staff member whose office it was, as well as educate the resident on why changes had to be made. We provided a new hospital grade power strip to the resident. An in-service was completed, and maintenance staff were made aware of the changes and the regulations surrounding power strips.	02/23/2024

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	could affect up to 2 residents. Findings include: Based on observation with the MS on 02/08/24 at 02:45 p.m., in Resident room #114 there was a power strip in use providing power to the television that did not meet UL-1363. Based on interview at the time of observation, the MS agreed a power strip was in use in the resident room 114 that did not meet UL-1363. The MS said he could not tell what type power strip was in use in resident room 114. This finding was reviewed with the Administrator and MS during the exit conference. 3.1-19(b)		As a means of quality assurance, results of the reviews and any corrective actions taken shall be reviewed by the Quality Assurance Committee for a minimum of six (6) months, with frequency of monitoring increased or decreased on the basis of compliance. 5 – Corrective action completed by 2/23/24.	