STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155412	A. BUILDING -- B. WING	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/19/22 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Emergency Preparedness survey, Greenwood Health & Living Community was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 121 certified beds. At the time of the survey, the census was 93. Quality Review completed on 07/25/22	E 0000	August 8, 2022 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: ULTN21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on July 19th, 2022. This letter is to inform you that the plan of correction attached is to serve as Greenwood Health & Living Community credible allegation of compliance. We allege substantial compliance on August 8, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-796-9776. Sincerely, Dan Kern, HFA Administrator Greenwood Health and Living Submission of this plan of correction in no way constitutes an admission by Greenwood Health and Living or its management company that the allegations contained in the survey	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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			report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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: 07/19/22 Facility Number: 000509 Provider Number: 155412 AIM Number: 100266620 At this Life Safety Code survey, Greenwood Health And Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated	K 0000	August 8, 2022 Brenda Buroker, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Re: Allegation of Compliance Event ID: ULTN21 Dear Mrs. Buroker: Please find enclosed the Plan of Correction for the State Licensure Survey conducted on July 19th, 2022. This letter is to inform you that the plan of correction attached is to serve as Greenwood Health & Living Community credible allegation of compliance. We allege substantial compliance on August 8, 2022. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-796-9776.	

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	smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 121 and had a census of 93 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were not sprinklered. Quality Review completed on 07/25/22		Sincerely, Dan Kern, HFA Administrator Greenwood Health and Living Submission of this plan of correction in no way constitutes an admission by Greenwood Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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 maintain latching hardware on 1 of 1 door sets to the north dining room per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This	K 0100	K- 100- - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**;	08/08/2022

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	deficient practice could affect over 20 residents, staff and visitors in the vicinity of the north dining room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, the latching hardware for the east door in the door set serving as the entrance to the north dining room failed to latch the door into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director agreed the east door in the door set failed to latch into the door frame when tested to close multiple times. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		Door latch has been repaired and door now properly latches - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents and staff of the north side of the facility have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; The Maint Director has inspected all doors to ensure proper latching mechanism is in place and functioning properly. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task is in place for the Maint director to inspect all latching doors to ensure proper functioning. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means			

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	of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain the means of egress free from obstructions in 4 of 8 means of egress. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 8:40 a.m. to 8:48 a.m. on 07/19/22, a plastic three drawer chest of drawers was stored in the corridor outside resident sleeping Room 100 and Room 506. In addition, two 32 gallon wheeled carts were also stored in the corridor outside Room 506. A wheeled plastic three drawer chest of drawers was stored up against the corridor wall outside resident sleeping Room 505 opposite the chest of drawers and carts stored outside Room	K 0211	K- 211 - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; All items have been moved to one side of the hall in order to keep means of egress open and at least 60 inches of clear space. All chairs were returned to the offices they are stored in after cleaning was completed. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Staff have been educated to ensure hallways have a means of egress and that all wheeled equipment must be removed from hallways during an emergency. Facility staff will ensure that all	08/08/2022

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	506 causing storage on both sides of the corridor. A chair was stored in the path of egress for the exit access at the exit door to the outside of the facility in the 200 Hall. Six chairs were stored outside the Administrator's office at the end of the 200 Hall with each chair projecting 18 inches into the eight foot wide corridor. A chair was also stored in the corridor outside Room 106, Room 108 and Room 416. A large upholstered chair was also stored in the corridor outside Room 106 and blocked nearly half of the eight foot wide corridor. Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, all the chest of drawers, chairs and carts observed being stored in the corridor during the initial walk through of the facility were still stored in the corridor. No cleaning of the chairs was observed during the initial walk through or the tour of the facility in the afternoon. Based on interview at the time of the observations, the Maintenance Director stated all the chairs were being stored in the corridor because they were in the process of being cleaned but agreed all chest of drawers, chairs and carts which were stored in the corridor did not maintain the aforementioned means of egress free from obstructions. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		items in the hall are to be stored on one side of the hallway only and that 60 inches of space is always clear resident and staff movement. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task has been entered to ensure that maintenance director checks all means of egress daily to ensure items are stored to one side of the hallway throughout the facility. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	
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			

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	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 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			

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	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 1 of 8 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6.	K 0222	K- 222- Egress Door - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Front doors now properly disengage after pushing for 15 seconds. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to**	08/08/2022

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	(b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, the exit door set in the main entrance lobby was marked as a facility exit with an exit sign. The door set was magnetically locked and could be released by entering a four digit code which was posted at the exit door set to release the doors to open. The exit door set was also equipped with delayed egress signage stating the doors would release to open after 15 seconds but the doors failed to release to open after pushing for more than 15 seconds		**ensure that the deficient practice does not recur**; Maintenance director will ensure that all exit doors function properly on a weekly basis. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task has been entered to ensure that Maintenance director is checking all exit doors weekly to ensure proper functioning. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	

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	multiple times. Based on interview at the time of the observations, the Maintenance Director stated he was not certain the doors were arranged as delayed egress doors but agreed the doors were equipped with delayed egress signage and would not release to open after pushing for 15 seconds multiple times. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observations and interview, the facility failed to ensure 1 of 8 exit discharges was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the southeast exit of the north dining room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, patio chairs and a patio table were stored in the means of egress in	K 0271	K- 271- Discharge from exit - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Patio Furniture has been moved back so that it no longer blocks the full swing of the door as it opens. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will**	08/08/2022

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	the exit discharge for the southeast exit from the north dining room which provided obstruction and impediments to full instant use for the path of egress in the exit discharge. Based on interview at the time of the observations, the Maintenance Director agreed the patio table and chairs in the exit discharge would provide an impediment to full instant use in the case of fire or other emergency. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		**be taken**; Residents eating in the north dining room have the potential to be affected by the deficient practice. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maintenance director will monitor all exit doors to ensure that they are free from obstructions when swinging open. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task has been created to ensure that Maintenance director is checking all exit doors weekly to ensure they are free from obstructions. **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	
K 0291 SS=F 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 record review, observation and interview; the facility failed to ensure 1 of 3 battery powered emergency lighting systems 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	K 0291	K- 291- Emergency Lighting (documentation) - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/08/2022

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	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. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Battery-operated Emergency Lights-Test Log for Year: 2021" documentation and Direct Supply TELS Logbook Documentation "Emergency and Exit Lighting" with the Administrator and the Maintenance Director during record review from 8:50 a.m. to 12:25 p.m. on 07/19/22, the facility has a total of three battery operated emergency lighting systems. Based on interview at the time of record review, the Maintenance Director stated the facility removed one battery operated lighting system which was located inside the emergency generator housing of the former emergency generator and now has a total of three battery operated emergency lighting systems in the facility. Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, three battery operated lighting systems were noted in the facility and each battery operated light functioned when its respective test button was pushed except for the battery operated light located on the north wall of the building at the emergency generator location outside the building. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Administrator		**practice**; A battery has been installed on the light above the emergency generator to ensure that it has proper lighting. **--how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maintenance director will ensure that all emergency lights function properly on a weekly basis - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task has been created to ensure the maintenance director checks all emergency lights on a weekly basis. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155412	A. BUILDING 01 B. WING	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD HEALTH AND LIVING COMMUNITY	937 FRY RD GREENWOOD, IN 46142

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	and the Maintenance Director during the exit conference. 3.1-19(b)			
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 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)			

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	Based on observation and interview, the facility failed to ensure 1 of over 6 hazardous areas such as soiled linen and trash collection rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Soiled Utility Room by Room 209. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, the annular space surrounding a three inch in diameter capped water line which penetrated the wall of the Soiled Utility Room by Room 209 was not firestopped. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned opening in the Soiled Utility Room wall did not separate this hazardous area from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0321	K- 321 Hazardous Area enclosure - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Maintenance director placed appropriate fire rated caulk in the hole between soiled UTL and room 209. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; Residents living on the 200 hall have the potential to be affected by the deficient practice. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Fire caulk that was installed ensured that the deficient practice will not recur. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, Photograph (attached to POC) of installed fire caulk demonstrates that deficient practice has been resolved and will not recur. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	08/08/2022

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K 0324 SS=D 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 1. Based on record review and interview, the facility failed to ensure 1 of 1 kitchen fire suppression systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect over three staff	K 0324	K- 324 Cooking facilities -**what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; maintenance director has ensured that Metal drip pan is in place below range hood and an additional pan is available during cleaning of other pan. Requested documentation of semi-annual report for inspection of kitchen fire suppression system between feb 21 and feb 22. Will send in when	08/08/2022

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	and visitors in the kitchen. Findings include: Based on review of the kitchen fire suppression system inspection contractor's inspection documentation dated 02/18/21 and 02/01/22 with the Administrator and the Maintenance Assistant during record review from 8:50 a.m. to 12:50 p.m. on 07/19/22, documentation of semiannual fire suppression system inspection six months after 02/18/21 was not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Director agreed documentation of semiannual fire suppression system inspection six months after 02/18/21 was not available for review. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the kitchen range hood system in accordance with the requirements of LSC 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.2.4.1 states kitchen range hood system filters shall be equipped with a drip tray beneath their lower edges. The tray shall be kept to the minimum size needed to collect grease and shall be pitched to drain into an enclosed metal container having a capacity not exceeding 1 gal (3.785 L). This deficient practice could affect over three staff and visitors in the kitchen.		we receive. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maint Director will ensure that we are scheduled to have semi annual inspections of the kitchen fire suppression equipment and that all documentation is in the maintenance binder upon receipt of completion. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task has been created to semi annually remind maintenance director to check for completion of kitchen fire suppression equipment. Dietary Director will ensure Drip pan is in place. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, one of one designated locations underneath the kitchen range hood system drip tray was missing an enclosed metal container for grease to drain into. The designated location for a grease container had a one half inch in diameter hole in the drip tray beneath the system filters but no metal container was in place. Based on interview at the time of the observations, the Maintenance Director agreed the designated location underneath the kitchen range hood system drip tray was missing its enclosed metal container for grease to drain into. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
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 _____			

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	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 1. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 13.3.3.1 states each control valve shall be operated annually through its full range and returned to its normal position. NFPA 25, Section 13.3.3.2 state post indicator valves shall be opened until spring or torsion is felt in the rod, indicating that the rod has not become detached from the valve. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Quarterly Water-Based Fire Protection Systems Inspection" documentation dated 05/09/22 with the	K 0353	K- 353 - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; PIV valve has been repaired. 20 year sample test has been completed on 8/15/2022. Cintas completed 20 year inspection. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maintenance director ensured that Lock was placed on PIV valve. Maintenance director requested 20 year sample test be conducted and is awaiting visit from CINTA to complete. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**,	08/08/2022

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	Administrator and the Maintenance Director during record review from 8:50 a.m. to 12:25 p.m. on 07/19/22, deficiencies were noted for the facility's Post Indicator Valve (PIV). The "Fire Service Mains" section of the 05/09/22 sprinkler system inspection report stated "Fail" in response to "Valves exercised through full range to ensure proper operation (13.3.3.2)". Based on interview at the time of record review, the Maintenance Director stated the facility was working on corrections being made to the PIV and stated documentation of PIV repair or replacement on or after 05/09/22 was not available for review. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.1.1.1.3 states sprinklers manufactured using fast-response elements that have been in service for 20 years shall be replaced, or representative samples shall be tested and then retested at 10 year intervals. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall		Lock in place ensures that PIV valve will not be used and no longer needs to be monitored. Maintenance director will follow up with CINTAS to get update on when they will be out to complete test. We have also contacted PIPE to seek their assistance in completing the test as well. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	

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	be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Quarterly Water-Based Fire Protection Systems Inspection" documentation dated 11/03/21 with the Administrator and the Maintenance Director during record review from 8:50 a.m. to 12:25 p.m. on 07/19/22, deficiencies were noted for the facility's wet and dry sprinkler systems. The "Deficiencies" section of the 11/03/21 sprinkler system inspection report stated "20 year sample test due" in response to "Sprinklers with fast response elements in service for 20 years have been replaced or sample tested" for the "Mechanical room across 203". Review of the contractor's "Service Order" documentation dated 11/03/21 stated "Conduct 20 year sample test for both wet and dry systems". Based on interview at the time of record review, the Maintenance Director stated the facility was working on corrections being made and stated documentation of sprinkler head testing on or after 11/03/21 was not available for review. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0355 SS=E	NFPA 101 Portable Fire Extinguishers			

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Bldg. 01	Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 18 portable fire extinguishers had pressure gauge readings in the acceptable range. LSC 19.3.5.12 states portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1. LSC 9.7.4.1 states where required by the provisions of another section of this Code, portable fire extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, the Standard for Portable Fire Extinguishers. NFPA 10, 2010 Edition, Section 7.2.2(3) states the periodic monthly check shall ensure the pressure gauge reading or indicator is in the operable range or position. Section 7.2.3.1 states when an inspection of any rechargeable fire extinguisher reveals a deficiency listed in 7.2.2(3), the extinguisher shall be subjected to applicable maintenance procedures. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the laundry room. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, the pressure gauge for the wall mounted portable ABC type fire extinguisher located near the dryers near the entrance door to the laundry room from the 200 Hall showed the extinguisher was undercharged. Based on interview at the time of the observations, the Maintenance Director agreed the portable fire extinguisher pressure gauge	K 0355	K- 355- - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Fire Extinguisher has been recharged and is in compliance. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maintenance director will ensure that all Portable fire extinguishers are properly charged on a monthly basis. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task has been created to remind Maintenance director to check all fire extinguishers monthly and document on the	08/08/2022

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	showed the extinguisher was undercharged. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		attached tag ensuring proper charge. **by what date the systemic changes for each deficiency will be completed. 8/8/22**	
K 0363 SS=E 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 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			

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	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 4 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, the following was noted for corridor doors in the facility: a. the Salon door was propped in the fully open position with a wheeled meal tray table. b. the door to resident sleeping Room 109 and Room 501 were propped in the fully open position with a waste basket placed on the floor. c. the resident bed nearest the corridor door in resident sleeping Room 112 was positioned such that the foot of the bed was in the path of the swing of the corridor door to close and would not allow the corridor door to close. The Maintenance Director tried to push the head of the bed closer to the wall to allow more space for the door to close but the bed couldn't be moved far enough to allow the corridor door to close and latch into the door frame. Based on interview at the time of the	K 0363	K- 363- Corridor doors - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Maintenance director has installed a magnetic door holder on beauty salon door that will disengage when tripped by the fire system. All other doors that were propped open are no longer being propped open. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; education was given to educate staff on not propping doors open	08/08/2022

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	observations, the Maintenance Director agreed the aforementioned corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		with any unapproved type of device. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, Facility management team will ensure all doors are free from unapproved door props keeping doors opened. Any doors found to be propped open will have the door prop removed immediately. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 8 smoke barrier walls were protected to maintain the fire resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice	K 0372	K- 372- Smoke barrier - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Maintenance director installed	08/08/2022

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	could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by Room 505. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, the annular space surrounding a one inch in diameter conduit which penetrated the smoke barrier wall above the suspended ceiling above the corridor door set by Room 505 was not firestopped. Based on interview at the time of the observations, the Maintenance agreed the annular space surrounding the conduit would not resist the passage of smoke. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		appropriate fire rated caulk in the 1 inch diameter conduit hole in the smoke barrier wall above the 505 corridor doors in the attic. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; Residents living on 500 hall have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Fire caulk that was installed ensured that the deficient practice will not recur **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, Photograph (attached to POC) of installed fire caulk demonstrates that deficient practice has been resolved and will not recur. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	
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			

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	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 4 electrical outlets in resident sleeping Room 112 were protected in accordance with LSC 19.5.1.1. NFPA 70, National Electric Code, 2011 Edition, Article 406.5, states receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect one resident and staff in resident sleeping Room 112. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, one of four electrical outlets in the wall mounted electrical outlet box in the west wall of resident sleeping Room 112 by the resident bed nearest the corridor door was cracked and chipped. Based on interview at the time of the observations, the Maintenance Director agreed the outlet was cracked and chipped which exposed the internal parts of the outlet. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)	K 0511	K- 511- - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Maintenance director replaced all cracked outlet covers. All outlet covers in facility were audited to ensure that no others were cracked or missing and replaced if necessary - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maintenance director will ensure that all outlet covers are in place and intact. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task was created to remind maintenance director semi	08/08/2022

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			annually to audit all outlets to ensure proper covers are place. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required	K 0711	K- 711- - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Maintenance director ensured that relocation of wheeled equipment during an emergency is addressed in the emergency disaster preparedness manual and that staff have been educated properly. - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will**	08/08/2022

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	width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches. (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Disaster Preparedness Manual" documentation dated 02/15/22 with the Administrator and the Maintenance Assistant during record review from 8:50 a.m. to 12:50 p.m. on 08/10/21, the written fire safety plan for the facility did not address the relocation of wheeled equipment during a fire or similar emergency. Based on interview at the time of review, the Administrator and the Maintenance Assistant during record review from 8:50 a.m. to 12:50 p.m. on 08/10/21, agreed the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observations with the Maintenance Director during the initial walk through of the facility from 8:40 a.m. to 8:48 a.m. on 07/19/22, a hoyer lift was stored in the corridor outside resident sleeping Rooms 108, 110, 205, 210, 404, 410, 412 and 507. A wheelchair was stored in the corridor outside Room 112, 404, 408 and 410. Two 32 gallon wheeled carts were also		**be taken**; All residents have the potential to be affected by the deficient practice. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Staff have been educated on what to do with wheeled equipment in the hallways during an emergency and that all items but be moved as to not block the means of egress - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, Staff will be educated annually on proper procedures to ensure clear means of egress during a fire or similar emergency and to keep the means of egress clear for easier transport and movement of residents and staff during an emergency - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	

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	stored in the corridor outside Room 506. A wheeled plastic three drawer chest of drawers for isolation supplies was stored up against the corridor wall outside resident sleeping Room 505. A crash cart was stored in the corridor outside resident sleeping Rooms 207 and 416. A wheeled stand for a blood pressure cuff was also stored in the corridor outside resident sleeping Room 403. Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, all wheeled equipment observed being stored in the corridor during the initial walk through of the facility was still stored in the corridor. Based on interview at the time of the observations, the Maintenance Director agreed wheeled equipment was stored in the aforementioned means of egress. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)			
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 Based on record review and interview, the facility	K 0712	K- 712- Fire drills (missing fire	08/08/2022

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	failed to document quarterly fire drills on third shift for 1 of 4 quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Administrator and the Maintenance Director during record review from 8:50 a.m. to 12:25 p.m. on 07/19/22, documentation of a third shift fire drill or staff training documentation on fire drill procedures on the third shift in the fourth quarter (October, November, December) 2021 was not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Director stated the facility operates three shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures for the third shift in the fourth quarter 2021 was not available for review. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		drill) (Documentation) - **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Missing fire drill was found and has been included in the POC documentation - **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maintenance director will ensure that fire drills are conducted per policy and documentation is kept in the maintenance binder. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, Administrator will monitor Maintenance binder monthly during QA meetings to ensure that proper documentation is in place for all future fire drills. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	

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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 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life	K 0920	K- 920- **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; Maintenance director affixed approved power strip to the wall per Life Safety directors instructions in order to make it compliant. - **how other residents having the potential to be**	08/08/2022

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	safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect 2 residents in Room 213. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:45 p.m. to 2:20 p.m. on 07/19/22, a fan and the resident's laptop computer were plugged into a power strip placed on the floor underneath the resident bed nearest the corridor door in Room 213. The UL listing of the power strip could not be determined. Based on interview at the time of the observations, the Maintenance Director agreed non-PCREE were plugged into a power strip in the patient care vicinity in the aforementioned resident sleeping room and agreed a power strip was being used as a substitute for fixed wiring in the resident room. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference.		**affected by the same deficient practice will be identified and what corrective action(s) will be taken**; All residents have the potential to be affected by the deficient practice. - **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur**; Maintenance director ensure that any other power strip currently in use in the facility is affixed to the wall to meet code and that all power strips meet proper industry standard to be used in a healthcare facility. - **how the corrective action(s) will be monitored to ensure the deficient practice will not recur**, A TELS task was created to remind maintenance director or affiliate to monitor all resident rooms monthly to ensure proper adherence with policy regarding power strips/extension cords used in resident room. - **by what date the systemic changes for each deficiency will be completed**. **8/8/22**	

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