STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155523	A. BUILDING -- B. WING	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	5911 STATE ROAD 46 ELLETTSVILLE, IN 47429

(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: 08/22/22 Facility Number: 000558 Provider Number: 155523 AIM Number: 100267550 At this Emergency Preparedness survey, Richland Bean Blossom Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has a capacity of 79 certified beds and had a census of 46 at the time of this visit. Quality Review completed on 08/24/22	E 0000	**The facility respectfully requests paper compliance for this citation** ***This plan of correction is the centers credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.***	
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: 08/22/22 Facility Number: 000558 Provider Number: 155523 AIM Number: 100267550 At this Life Safety Code survey, Richland Bean	K 0000	**The facility respectfully requests paper compliance for this citation** ***This plan of correction is the centers credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the***	

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

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

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	Blossom Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hardwired smoke detectors in the corridors and spaces open to the corridors. All resident rooms were equipped with battery powered smoke alarms. The facility has the capacity for 79 residents and had a census of 46 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered, except three detached buildings used for facility storage and maintenance. Quality Review completed on 08/24/22		***statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.***	
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered			

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	2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building construction type of the facility. This deficient practice could affect all occupants within the facility. Findings include: Based on observations on 08/22/22 during a tour of the facility at 1:14 p.m. with the Maintenance Director, the ceiling above the drop ceiling in the corridor by the Activities Room had a three foot by three foot section of drywall opening in the ceiling. The section of drywall was lying on top of	K 0161	1. Immediate action taken The three foot by three-foot section of drywall opening was corrected leaving no further openings in the ceiling above the drop ceiling in the corridor by the activities room. 2. How the facility identified other similar building construction non-compliance. A random audit was conducted of the ceiling above the drop ceiling	09/09/2022

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	sprinkler piping, exposing the above attic space. Based on interview at the time of observation, the Maintenance Director confirmed that the building construction was not maintained and stated he did not know that there was an opening in the ceiling and would get it fixed. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		(8/25/22) to identify any further building/ construction concerns. No new concerns identified during this audit. 3. Measures put into place/ system changes A monthly facility audit put into place on the ceiling structure between the drop ceiling and the attic. The Maintenance Director or designee will randomly audit 3 sections of the ceiling 5 days a week x 4 weeks, then 3 times a week x 4 weeks, then 1 x a week for 4 weeks then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored; The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA			

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	13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Memory Care Dining Room in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and at least 12 residents in the 400 Hall smoke compartment. Findings include: Based on observation with the Administrator and the Maintenance Director during a tour of the facility from 12:25 p.m. to 1:17 p.m. on 08/22/22, a sprinkler in the dining room across the corridor from resident room 404 in the Memory Care wing had a missing escutcheon. Based on interview at the time of observation, the Maintenance Director confirmed the escutcheon was missing, and would have it replaced.	K 0351	1. Immediate action taken The miss escutcheon identified was replaced. 2. How the facility plans to establish compliance A random audit throughout the facility of sprinkler heads/ missing escutcheon was completed with corrective measures taken for identified missing escutcheon's. 3. Measures put into place/ system changes A monthly facility audit has been put into place to ensure that all annular space around the sprinkler is covered with an escutcheon cover. The Maintenance Director or designee will randomly audit 5 sprinklers throughout the facility, 5 days a week x 4 weeks, then 3 times a week x 4 weeks, then 1 x	09/09/2022

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	This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)		a week for 4 weeks then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored; The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
K 0353 SS=C 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 document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for	K 0353	1. Immediate action taken Review of the TELs data system indicates that the weekly sprinkler	09/09/2022

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	the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of documentation for the most recent twelve month period on 08/22/22 from 9:45 a.m. to 12:25 p.m. with the Maintenance Director, weekly dry sprinkler system gauge inspection documentation for 5 weeks of the most recent 52 week period was not available for review. The weeks of 10/18/21, 10/25/21, 11/1/21, 11/8/21 and 11/15/21 had no sprinkler system gauge documentation. Based on interview at the time of record review, the Maintenance Director stated he has only been on the job since the end of November 2021 and agreed sprinkler system gauge and control valve inspection documentation for the aforementioned weekly periods was not available for review. This finding was reviewed with the Administrator and the Maintenance Director at the exit conference.		system inspections have been completed and documented in full as of 11/21/22. 2. How the facility plans to establish compliance A random audit of the TEL's documentation was completed to ensure accuracy of the weekly sprinkler system/ gauge reading inspection with no further identified concerns. 3. Measures put into place/ system changes A monthly facility audit has been put into place to ensure that the weekly sprinkler system checks are completed. The Administrator or designee will randomly audit the weekly documentation 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored; The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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K 0372 SS=E Bldg. 01	3.1-19(b) 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 the penetrations caused by the passage of wire and/or conduit through 1 of 3 smoke barrier walls were protected to maintain the smoke resistance of each 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 could affect staff and at least 31 residents. Findings include: Based on observation with the Maintenance Director on 08/22/22 at 1:14 p.m., an unsealed penetration of a quarter inch gap around 2 wires in the smoke barrier near resident room 101 was discovered. Based on interview at the time of observation, the Maintenance Director confirmed the unsealed smoke barrier penetration by resident room 101.	K 0372	1. Immediate action taken The unsealed penetration of a quarter inch gap around 2 wires in the smoke barrier near resident room 101 was sealed 2. How the facility plans to establish compliance A random audit of the buildings smoker barrier system was completed with no further findings. 3. Measures put into place/ system changes A monthly facility audit has been put into place to ensure the integrality of the smoke barrier system is compliant. The Maintenance director or designee	09/09/2022

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	This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)		will randomly audit the 2 sections of the smoke barrier system in the facility 1 day a week x 12 weeks, then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored; The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
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 1 wet location in the dining room, was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault	K 0511	1. Immediate action taken The receptacle next to the hand washing sink in the dining room was replaced. 2. How the facility plans to establish compliance. A random audit of the buildings wet location receptacles was completed to ensure all receptacles and fixed equipment within the area of the wet location	09/09/2022

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	circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations		have working ground-fault circuit interrupter protection. No further concerns identified during the audit. 3. Measures put into place/ system changes A monthly facility audit has been put into place to ensure the integrality of all wet location receptacles. The Maintenance director or designee will randomly audit 3 wet location receptacles for proper GFCI protection 5 days a week x 4 weeks, then 3 times a week x 4 weeks, then 1 x a week for 4 weeks then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored; The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	

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	(7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect at least 20 residents and staff. Findings include: Based on observation on 08/22/22 between 12:25 p.m. and 1:17 p.m. during a tour of the facility with the Maintenance Director, the electric receptacle next to the hand washing sink in the dining room was provided with a GFCI receptacle, however, when tested with a GFCI testing device, it did not break the circuit. Based on interview at the time of observation, the Maintenance Director agreed the receptacle was not GFCI protected. This finding was reviewed with the Administrator and 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.			

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	The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all occupants. Findings include: Based on record review with the Administrator and Maintenance Director on 08/22/22 between 9:45 a.m. and 12:25 p.m., the following quarters and shifts were missing documentation of a completed fire drill or documented orientation training: a) Second and Third shift of the third quarter 2021/2022. c) Second shift of the Fourth Quarter of 2021. Based on interview with the Maintenance Director at the time of record review, he confirmed the aforementioned fire drills were not available for	K 0712	1. Immediate action taken A Fire Drill was completed on 8/31/2022 during the 2nd shift. The fire monitoring company was notified of the fire drill. Staff education with documentation was completed and added to the life safety binder. 2. How the facility plans to establish compliance. The facility initiated a fire drill activity log to ensure/ plan all future fire drill activity in a comprehensive manner amongst all shifts at varying times. 3. Measures put into place/ system changes A monthly facility audit has been put into place to ensure that the monthly fire drills are completed and conducted in a comprehensive manner. The Administrator or designee will randomly audit the monthly fire drills to ensure completion and timing of drills monthly x 6 months. 4. How the corrective action will be monitored; The results of these audits will be	09/09/2022

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	155523	A. BUILDING 01 B. WING	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	5911 STATE ROAD 46 ELLETTSVILLE, IN 47429

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	review at the time of the survey. This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 2. Based on record review and interview, the facility failed to ensure 1 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 9:00 p.m. and 6:00 a.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of titled "Fire Drill Log" with the Maintenance Director on 08/22/22 at 10:02 a.m., the fire drill conducted on 03/01/22 at 1:01 a.m. did not include documented transmission of the fire alarm signal. Based on interview at the time of record review, the Maintenance Director confirmed the aforementioned fire drill did not include the verification of the alarm transmission. This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing			

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	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 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 record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 10 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in	K 0918	1. Immediate action taken The generator was tested under load x 30 minutes with no complications. The monthly test was documented with in the TEL's system to reflect the most current	09/09/2022

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	accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 08/22/22 from 12:15 p.m. to 1:17 p.m., documentation for monthly generator load testing since December 2021 shows the generator only ran for 5 minutes under load for each month. Additionally, there was no monthly generator load testing for November 2021 available for review. Based on an interview at the time of record review, the Maintenance Director stated he was unware of the requirement that the monthly load had to be a minimum of 30 minutes and would start doing so; and confirmed no load testing documentation for November 2021 was available for review. This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)		guidelines. 2. How the facility plans to establish compliance. Education was completed with the maintenance director according to the stated guidelines for the monthly generator testing. 3. Measures put into place/ system changes A monthly facility audit has been put into place to ensure that the monthly load testing for the generator is completed and documented in a comprehensive manner. The Administrator or designee will randomly audit the monthly generator testing to ensure completion and accuracy on the generator load testing monthly x 6 months. 4. How the corrective action will be monitored; The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	
K 0920 SS=B Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and			

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	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 Business Office did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect at least 5 residents and staff near the Business Office. Findings include: Based on observation made with the Administrator and the Maintenance Director on	K 0920	1. Immediate action taken The refrigerator and coffee maker where immediately unplugged from the power strip. 2. How the facility plans to establish compliance. A random facility audit was completed to ensure the proper use of all power strips. No further concerns identified at this time. 3. Measures put into place/ system changes A monthly facility audit has been	09/09/2022

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	08/22/22 during a tour of the facility from 12:25 p.m. to 1:17 p.m., a power strip was in use in the Business Office with a refrigerator and a microwave plugged into it. Based on interview at the time of observation, the Administrator confirmed the power strip usage in the Business Office, unplugged the refrigerator and microwave at the time of observation. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		put into place to ensure that the use of power strips is done so in accordance of the K920 guidelines. The Maintenance director or designee will randomly audit 3 power strips for proper use 5 days a week x 4 weeks, then 3 times a week x 4 weeks, then 1 x a week for 4 weeks then monthly x 3 months to ensure substantial compliance. 4. How the corrective action will be monitored; The results of these audits will be reviewed in the Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan as indicated.	