STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING -- B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/23/24 Facility Number: 001156 Provider Number: 155505 AIM Number: 100453350 At this Emergency Preparedness survey, Robin Run Health Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 84 certified beds. At the time of the survey, the census was 56. Quality Review completed on 09/25/24	E 0000		
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation	E 0039	E039 1. No residents were adversely affected by not having a second full-scale exercise that is community based or an individual, facility based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed	10/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Blevins	Administrator	10/10/2024

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	of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan on 09/23/24 between 10:15 a.m. to 11:20 a.m. with the Administrator, documentation of a tabletop exercise conducted on 06/19/24 was available for review but the facility could not provide documentation of: a second full-scale exercise that is community-based or an individual, facility-based functional exercise, a mock disaster drill, or a tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to		messages, or prepared questions designed to challenge the emergency plan 2. All residents have the potential to be affected. 3. A second full-scale exercise will be conducted on an annual basis as a part of the emergency preparedness plan. 4. The administrator/designee will be responsible for monitoring a second full scale exercise is conducted on an annual basis as a part of the emergency preparedness plan and the quality assurance program. To ensure compliance, the exercises will be added to the quality assurance program.	

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	challenge an emergency plan. Based on interview at the time of record review, the Administrator agreed that another emergency drill or exercise could not be located for review as of the time of this survey. This finding was reviewed with the facility Administrator, the Director of Engineering and the Safety Director during the exit conference.			
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review of the facility maintenance records for the emergency generator on 09/23/24 at 12:06 p.m., the following was noted: a) No load percentage and transfer time were documented on the monthly generator testing documents b) No weekly generator inspection documents could be provided for record review from 11/19/23 to 03/18/24. c) An annual fuel quality test for the facility generator could not be provided for review. Based on an interview at the time of record review, the Maintenance Supervisor advised that the previous maintenance staff all quit at the same time and they took or discarded many of the testing records with them. Because of this, many of the necessary records and testing documents	E 0041	E041 1. No residents were adversely affected by not having the weekly generator inspection documents, an annual fuel quality test, and an annual load-bank test. 2. All residents the potential to be affected. 3. The maintenance director/designee will document Percentage and transfer times will be documented on the monthly generator, weekly generator inspections, an annual fuel quality test, and an annual load-bank test occurs. 4. Maintenance director/designee will be responsible to monitor documentation that a weekly generator inspection, an annual fuel quality test, and an annual load-bank test occurs and report it to the quality assurance committee monthly for 6 months.	10/10/2024

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	would not be available for review for the current survey. This finding was reviewed with the facility Administrator, the Director of Engineering and the Safety Director during the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/23/24 Facility Number: 001156 Provider Number: 155505 AIM Number: 100453350 At this Life Safety Code survey, Robin Run Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and was 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 smoke detectors hard wired to the nurses call system in all resident sleeping rooms. The facility has a capacity of 84 and had a census of 56 at the time of this survey.	K 0000	Plan of Correction: Please accept the following plan of correction as credible evidence of compliance to the deficiencies cited during our recent Life Safety Survey at Robin Run Village. The Plan of Correction is not to be construed as an admission of our agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. We are requesting a Paper Compliance Review with the submission of these remedies.	

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	All areas where residents have customary access were sprinklered. The facility has one detached maintenance building which was not sprinklered. Quality Review completed on 09/25/24			
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on records review with the Administrator, Executive Director, Director of Engineering and Safety Director on 09/23/24 at 10:48 a.m., the fire watch plan stated to notify the State Regulatory/Licensure Agency but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Also, the fire watch plan did not state to contact the insurance carrier, and monitoring company or provide contact phone numbers. Based on interview during the record review, the Executive Director confirmed the Fire Watch policy did not include the Gateway link and that contact information was missing from the policy for the fire department and monitoring company, but located in other area of the	K 0346	K346 1.The contact information for the ISDH Gateway link and to the contact the insurance carrier, and monitoring company with contact information was added to the Fire Watch Plan. 2.All residents had the potential to be affected by the deficient practice. 3.The Community Fire Watch Policy was updated to include the contact information for the ISDH Gateway link as well as email, the insurance carrier, and monitoring company with contact information. 4.The Maintenance Director/ designee will review Fire Watch Policy every 6 months to ensure that contact information is included in policy. Results of these reviews will be shared at QAPI meeting.	10/10/2024

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	Emergency Preparedness Plan. The finding was reviewed with the Administrator, Director of Engineering and Safety Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. 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. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility.	K 0353	K353 1. The spare sprinklers were placed in cabinet in protected slots. No residents were adversely affected by not having all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. No residents were adversely affected by the spare sprinklers placed in cabinets with other spare sprinklers unprotected. 2. All residents are potential to be affected. 3. The maintenance director/designee will be responsible for ensuring that all inspections, tests, and maintenance of the system and its components occur and are available to the authority having jurisdiction. Maintenance director/designee will ensure all spare sprinklers are placed in cabinet in protected slots by inspecting monthly. 4. The finding will review monthly	10/10/2024

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	Findings include: Based on review of the quarterly sprinkler system inspection records on 09/23/24 from 11:20 a.m. to 1:10 p.m. with the Safety Director and Director of Engineering present, there was no quarterly sprinkler system inspection report available for the second quarter (April, May, June) of 2024. During an interview at the time of record review, the Safety Director confirmed there was no written documentation available to show the sprinkler system had been inspected during the second quarter of 2024. This finding was reviewed with the Administrator, Director of Engineering and Safety Director at the exit conference. 2. Based on observation and interview, the facility failed to ensure spare spinklers of the sprinkler systems were protected from damage. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include:		in quality assurance meeting for 6 months.	

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	Based on observations and interview during a tour of the facility with the Safety Director and Director of Engineering on 09/23/24 at 2:30 p.m., there were four spare sprinkler cabinets on the wall in the riser room. Two of the spare sprinkler cabinets were sat on top of the other two mounted cabinets. Inside the cabinets, at least 10 spare sprinklers were sitting loose in the cabinets with other sprinklers in protected slots. Based on interview at the time of the observation, the Director of Engineeting agreed the spare sprinkler cabinets had spare sprinklers not in protected slots. This finding was reviewed with the Administrator, Director of Engineering and Safety Director at the exit conference. 3.1-19(b)			
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to	K 0354	K354 1. No residents were adversely affected by failure to provide written policies in the event the automatic sprinkler system is to be placed out-of-service for 10 hours or more in a 24-hour period which includes the IDOH Gateway link. 2. All residents are potentially at risk for not having a written policy in place in the event that the sprinkler system is out-of-service for 10 hours or more in a 24 hour period. 3. The Emergency Management	10/10/2024

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	consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review with the Administrator, Executive Director, Director of Engineering and Safety Director on 09/23/24 at 10:48 a.m., the fire watch plan stated to notify the State Regulatory/Licensure Agency but failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Also, the fire watch plan did not state to contact the insurance carrier, and monitoring company or provide contact phone numbers. Based on interview during the record review, the Executive Director confirmed the Fire Watch policy did not include the Gateway link and that contact information was missing from the policy for the fire department and monitoring company, but located in other area of the Emergency Preparedness Plan. The finding was reviewed with the Administrator, Director of Engineering and Safety Director during the exit conference. 3.1-19(b)		Plan has been updated with the IDOH Gateway link. 4. Maintenance Director will audit Emergency Plan every 6 months to ensure presence of IDOH Gateway link and will review findings in monthly QAPI meeting.	
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	Based on observation and interview, the facility failed to ensure 1 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 15 residents and staff in one smoke compartment. Findings include: Based on observation with the Director of Engineering and Safety Director on 09/23/24 at 1:25 p.m. during a tour of the facility, the corridor door to Resident Room 37 would not latch into it's frame without lifting up on the door so it would latch into the frame. Based on interview at the time of observation, the Safety Director of confirmed the resident room door would not latch into the frame without lifting up on the door. This finding was reviewed with the Administrator, Director of Engineering and Safety Director at the exit conference. 3.1-19(b)	K 0363	K363 1. No residents were adversely affected. Room 37 latch was repaired. 2. All residents are potentially at risk for not having residents room doors to the corridor not completely close and latch into the door frame. 3. A 100 % audit of corridor doors will be completed by maintenance staff to identify any other doors that were not latching properly 4. Maintenance Director or designee will conduct random audits of corridor doors in health care on a weekly basis for 3 months then monthly x 3 months. Results of these audits will be shared at monthly QAPA meetings.	10/10/2024
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure electrical outlets were protected in the Therapy area according to 19.5.1. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect three residents and staff. Findings include:	K 0511	K511 1.The outlet cover protecting the electrical outlet in therapy area was replaced. No residents were affected by this alleged deficient practice. 2.All residents have the potential to be affected. 3.Maintenance Director or designee will conduct random audits of the electrical outlets in	10/10/2024

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	Based on an observation and interview during a tour of the facility with the Director of Engineering and Safety Director on 09/23/24 at 2:10 p.m.., in the Therapy area by a sink, an outlet cover protecting the electrical outlet was missing. Based on interview at the time of observation, the Safety Director confirmed an outlet was missing a cover. This finding was reviewed with the Administrator, Director of Engineering and Safety Director during the exit conference. 3.1-19(b)		health care on a weekly basis for 3 months then monthly x 3 months. 4.Monitoring will be reviewed during monthly quality assurance meetings for 6 months and will be ongoing for continued compliance	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected	K 0761	K 761 1.The annual fire door inspection and testing shall be completed and documented on before date certain. 2.All residents had the potential to be affected by the deficient practice. 3.Maintenance Director/designee will be responsible for ensuring the annual fire door inspection and testing occurs before or on date certain. The maintenance director/designee will be responsible for ongoing compliance. 4.The Administrator/designee will review annually and report to the quality assurance committee.	10/10/2024

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	from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Engineering and Safety Director from 11:20 a.m. to 1:10 p.m. on 09/23/24, annual fire door inspection documentation for the most recent twelve month			

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	155505	A. BUILDING 01 B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN 46268

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	period was not available for review. Based on interview at the time of the review, the Safety Director agreed annual fire door inspection documentation for the most recent twelve month period was not available for review. This finding was reviewed with the Administrator, Director of Engineering and Safety Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review and interview with the Director of Engineering and Safety Director on 09/23/24 between 11:20 a.m. and 1:10 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Director of Engineetring confirmed the most	K 0918	K 918 1. No residents were adversely affected by not having the weekly generator inspection documents, an annual fuel quality test, and an annual load-bank test. 2. All residents the potential to be affected. 3. The maintenance director/designee will document Percentage and transfer times will be documented on the monthly generator, weekly generator inspections, an annual fuel quality test, and an annual load-bank test occurs. 4. Maintenance director/designee will be responsible to monitor documentation that a weekly generator inspection, an annual fuel quality test, and an annual load-bank test occurs and report it to the quality assurance committee monthly for 6 months.	10/10/2024

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	recent fuel quality testing and results for the diesel fired generator was not available to review at the time of the survey. This finding was reviewed with the Administrator, Director of Engineering and Safety Director during the exit conference. 2. Based on record review and interview, the facility failed to document the transfer time to the alternate power source on the monthly load tests for 12 of the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 09/23/24 at 12:06 p.m. with the Director of Engineering and Safety Director, the "Emergency Generator - Monthly Log Sheets' were reviewed over the past year and lacked the transfer time from normal power to emergency power, with just a check mark wrote in the transfer switch column. Based on interview at the time of record review, the Safety Director confirmed the transfer time was not written on the Monthly Test Log Sheets monthly when the load test is conducted. This finding was reviewed with the Administrator, Director of Engineering and Safety Director at the exit conference. 3. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall			

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	be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Engineering and Safety Director on 09/23/24 at 12:06 p.m., documentation for the last twelve months of generator under load testing did not include the percentage under load. Under the Load kW column, 'N/A' was wrote every month. Based on interview at the time of record review, the Safety Director confirmed the generator ran under load on a monthly basis but the load percentage was not documented monthly. This finding was reviewed with the Administrator, Director of Engineering and Safety Director at the exit conference. 3.1-19(b)			

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure entension cords and multi-plug adapters were not used as a substitute for fixed wiring in resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect 30 residents and staff in two smoke compartments. Findings include: Based on observations on 09/23/24 between 1:10 p.m. and 2:25 p.m. during a tour of the facility with the Director of Engineering and Safety Director, the following was noted: a. In resident room 32, a lamp and radio were plugged into a multi-plug adapter that was plugged into a wall outlet. b. In resident room 20, a lamp and clock were plugged into an extension cord that was plugged into the wall. The extension cord was removed at the time of observation by the Director of Engineering. c. In resident room 12 by the bed, a lamp, charger and radio were plugged into a six outlet multiplug adapter that was plugged into a red emergency outlet. Based on interview at the time of each observation, the Director of Engineering confirmed the use of multi-plug adapters/extension cords as a substitute for fixed wiring in the facility.	K 0920	K920 The power strip and extension cord have been removed. No residents were affected by this alleged deficient practice. All residents have the potential to be affected. The staff has been reeducated and in-serviced on not using power strips and extension cords in resident care areas. Facility rounds will be conducted weekly for 3 months then monthly for 3 months by Maintenance Director/designee all findings will be reviewed in the monthly quality assurance meetings for 6 months.	10/10/2024

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	This finding was reviewed with the Administrator, Director of Engineering and Safety Director during the exit conference. 3.1-19(b)			