STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155352	A. BUILDING -- B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

(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: 11/15/22 Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830 At this Emergency Preparedness survey, Elkhart Meadows was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.475 The facility has 58 certified beds. All beds are certified for Medicare and Medicaid. At the time of the survey, the census was 52. Quality Review completed on 11/22/22	E 0000	The facility requests that this plan of correction be considered its 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 it is required by the provisions of federal and state law. We respectfully request a desk review for compliance instead of a post visit review on or before 12/11/22.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Evan Wiedeman	Executive Director	12/19/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155352	A. BUILDING -- B. WING	11/15/2022

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	§491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.			

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	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] 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			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization 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; or (B) If the PACE experiences an actual natural			

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	or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] 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] facility experiences an actual natural or man-made emergency that			

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	requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator 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] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID 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; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual,			

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	facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a 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 every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2			

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	years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, 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; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and 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. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

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	the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	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 of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a 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	E 0039	**E039** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** An after action report was completed from a severe winter weather scenario that had occurred. **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. An after action report was completed for the emergency	12/11/2022

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	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 staff. Findings include: Based on record review with the Administrator and Maintenance Director on 11/15/22 between 10:14 a.m. and 2:00 p.m., no documentation of an additional exercise was available for review. The facility had a documented COVID outbreak report dated 9/21/22, but a second exercise was not available at the time of the survey. Based on interview, the Administrator stated the facility did not participate an additional exercise within the last 12 months. Findings were discussed with the Administrator and Maintenance Director at exit conference.		scenario. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** ED educated on running two emergency preparedness drills in the calendar year. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** ED and maintenance director will review exercises and documentation and report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/11/22	
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: 11/15/22	K 0000	The facility requests that this plan of correction be considered its credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement	

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	Facility Number: 000243 Provider Number: 155352 AIM Number: 100289830 At this Life Safety Code survey, Elkhart Meadows 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 III (200) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and resident sleeping rooms had battery-powered smoke detectors. The facility has a capacity of 58 and had a census of 52 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered, except, one detached shed used for facility storage. Quality Review completed on 11/22/22		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 it is required by the provisions of federal and state law. We respectfully request a desk review for compliance instead of a post visit review on or before 12/11/22.	
K 0321 SS=D 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			

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	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)			
	Based on observation and interview, the facility failed to ensure 2 of 5 Hazardous storage room corridor doors in the service hall were not obstructed from closing. This deficient practice could affect staff in the service hall. Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Director on 11/15/22 between 2:06 p.m. and 3:15 p.m., the Laundry Room and Linen Storage Room contained fuel-fired appliances, combustible materials, and was greater than 50 square feet making this a hazardous area. The doors to the laundry room and linen room were self-closing but	K 0321	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Laundry room and linen storage room doors were closed and ties from doors removed. **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	12/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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	the doors were tied by the handle to prevent closing. Based on interview at the time of observation, the Maintenance Director confirmed doors were tied open and contained large amounts of combustible storage and were larger than 50 square feet. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		be affected by the deficient practice. Laundry room and linen storage room doors were closed and ties from doors removed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD/HSK supervisor educated on ensuring laundry and linen room doors remain closed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will monitor to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/11/22	
K 0331 SS=F Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of			

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	interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). Based on observation, records review, and interview, the facility failed to ensure materials used as an interior finish for resident rooms, offices, and an entrance way on 1 floor met the flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect all residents and staff Findings include: Based on observation with the Administrator and Maintenance Director on 11/15/22 between 2:06 p.m. and 3:15 p.m.,wood paneling was used as an interior finish in the main entrance way, all resident rooms, and staff office ceilings. Based on records review between 10:14 a.m. and 2:00 p.m.,	K 0331	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Facility requesting a temporary life safety waiver request to ensure that paneling on ceilings has documentation for flame spread rating. **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. MD and ED toured entire facility to identify all areas that have paneling in the facility that does not have flame spread rating. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD/ED will review any paneling that is installed in the facility to ensure the proper flame spread rating.	04/15/2023

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	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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	no documentation of the flame spread rating for the paneling was available for review. Based on interview at the time of record review, the Administrator stated the flame spread documentation for the paneling could not be located and the main office was looking for documentation for verification.. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will monitor to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 1 of 2 sprinkler systems in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25,	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	12/11/2022

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	155352	A. BUILDING 01 B. WING	11/15/2022

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	Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 11/15/22 between 10:14 a.m. and 2:00 p.m., there was no monthly inspection of the wet pipe sprinkler system's gauges for the past 12 months. During an interview at the time of record review, the Maintenance Director stated the inspection of the dry valve and gauge inspections were documented, but had no documentation for the wet system gauges at the time of the survey. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 4 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice		MD/designee to check gauges on wet pipe sprinkler systems monthly. Two inch penetration sealed in laundry room. **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. MD/designee to check gauges on wet pipe sprinkler systems monthly. Two inch penetration sealed in laundry room. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD educated on importance of wet sprinkler gauge checks, and ensuring any penetrations are identified and sealed immediately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will complete daily rounds to ensure compliance	

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	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	could affect all staff in one smoke compartment. Findings include: Based on observation with the Maintenance Director and the Administrator on 11/15/22 at 12:41 p.m., in the laundry room near the service hallway, there was a two inch unsealed gaps around a pipe that ran through the ceiling. This condition could delay the activation of the sprinklers installed in ceiling. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed gaps in the ceiling and would fill it in as soon as possible. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/11/22	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers 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 1. Based on observation and interview, the facility failed to ensure 1 of 2 portable fire extinguishers in the maintenance shop were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was	K 0355	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD removed fire extinguisher from ED office and was properly disposed of, and fire extinguisher on north hallway monthly inspection tag was found and placed on fire extinguisher.	12/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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	not in a resident care area but could affect staff in the maintenance shop. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 11/15/22 at 14:13 p.m., an ABC portable fire extinguisher in the Administrators Office was sitting on top of a metal cabinet unsecured. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the cabinet and stated it is a spare extinguisher used for training. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to inspect 1 of 17 portable fire extinguishers each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers		**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. MD removed fire extinguisher from ED office and was properly disposed of, and fire extinguisher on north hallway monthly inspection tag was found and placed on fire extinguisher. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD educated on importance ensuring all fire extinguishers are properly secured and importance of ensuring monthly inspections are occurring for all fire extinguishers in the building. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will complete daily rounds to ensure compliance is met and will report results to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect staff and residents in North Hallway Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Administrator on 11/15/22 at 3:10 p.m., the monthly inspection tag on the ABC located in the North Hallway was not attached to the extinguisher and could not be located. Based on interview at the time of observation, the Maintenance Director confirmed the extinguisher located in the North Hallway was missing the inspection tag. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/11/22	
K 0511 SS=D	NFPA 101 Utilities - Gas and Electric			

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	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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Bldg. 01	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 ground fault circuit interrupter (GFCI) was properly maintained for 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. This deficient practice could affect 8 residents.. Findings include: Based on observation with the Administrator and the Maintenance Director on 11/15/22 between 2:06 p.m. and 3:15 p.m., when the GFCI electric receptacle in the Assisted Dining Room was tested with a GFCI tester, the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested and would contact the contracted electricians to fix. Findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD had contractor come in to replace/rewire the GFCI electric receptacle in the assisted dining room. **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. MD had contractor come in to replace/rewire the GFCI electric receptacle in the assisted dining room. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD educated on importance of all GFCI electric receptacles in proper working order and having a contactor out to complete work if	12/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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			one is found not functioning. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will complete weekly rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/11/22	
K 0741 SS=C Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited.			

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	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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	(4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect all staff. Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Director on 11/15/22 between 2:06 p.m. and 3:15 p.m., in the smoking area behind the kitchen, there were over 15 cigarette butts disposed on the ground in and around the smoking area. Based on interview at the time of observations, the Maintenance Director and Administrator agreed there were cigarette butts on the ground in the aforementioned locations. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0741	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD removed cigarette butts from the smoking area and placed a sign outside the kitchen as a no smoking area. **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. MD removed cigarette butts from the smoking area and placed a sign outside the kitchen as a no smoking area. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	12/11/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155352	A. BUILDING 01 B. WING	11/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELKHART MEADOWS	2600 MOREHOUSE AVE ELKHART, IN 46517

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			MD educated on importance of ensuring smoking area was clear from cigarette butts and ensuring proper disposal containers are available in the smoking area. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/11/22	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For			

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	155352	A. BUILDING 01 B. WING	11/15/2022

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	LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles in 37 of 37 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Administrator and Maintenance Director on 11/15/22 between 2:06 p.m. and 3:15 p.m., the facility's 37 resident sleeping rooms contained four to eight non-hospital-grade electrical	K 0914	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Ordered hospital grade electrical receptacles to install in resident rooms. Electrician coming to facility to test hospital grade receptacles to ensure compliance with Section 6.3.3.2, on 12/21/22. **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. Ordered hospital grade electrical receptacles to install in resident rooms. Electrician coming to facility to test hospital grade receptacles to ensure compliance with Section 6.3.3.2 on 12/21/22. **What measures will be put**	12/21/2022

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	155352	A. BUILDING 01 B. WING	11/15/2022

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	receptacles. Based on records review between 10:14 a.m. and 2:00 p.m., the annual electrical receptacle testing for non-hospital grade electrical receptacles was past due. The provided electrical receptacle testing documentation had a completion date of 04/01/21. Based on interview at the time of the observation and records review, the Maintenance Director could not confirm all of the electrical receptacles in the resident sleeping rooms were hospital-grade nor have updated documentation for testing. Findings were discussed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		**into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD educated on importance of ensuring all electrical receptacles in resident rooms are hospital grade. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will monitor to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/21/22	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly,			

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	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 ensure the continuing reliability and integrity of 1 of 1 emergency generators. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and Maintenance Director on 11/15/22 between 10:14 a.m. and 2:00 p.m., the Generator Maintenance Report from 05/05/22 stated the emergency generator recommended replacement of fuel, coolant, and block heater hoses for preventative maintenance. Generator report states the generator is operable at time of maintenance. During interview with the Administrator and Maintenance Director, they stated they were	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD contacted generator company who has ordered parts to complete generator maintenance. **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	12/11/2022

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	aware of the report, but did not have documentation for verification of the preventative/routine maintenance at the time of the survey. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		practice. MD contacted generator company who has ordered parts to complete generator maintenance. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD educated on importance of ensuring generator maintenance is completed in a timely fashion. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will monitor to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/11/22	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet			

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	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 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could all staff. Findings include: Based on observation with the Administrator and Maintenance Director on 11/15/22 between 2:06 p.m. and 3:15 p.m., in the storage room connected to the Sprinkler Riser Room, a power strip used to power equipment, was not secured, and was dangling from the outlet on the wall. This	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MD removed power strip from supply room near sprinkler riser room, and removed extension cords from MDS office and conference room. **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. MD removed power strip from supply room near sprinkler riser room, and removed extension	12/11/2022

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	condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect all staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 11/15/22 between 2:06 p.m. and 3:15 p.m., a microwave and refrigerator were plugged into and powered by an extension cord. Another extension cord was found in the conference room plugged into an outlet. Based on interview at the time of observation, the Maintenance Director and Administrator acknowledged an extension cord was in use and removed the extension cord when observed. The finding was reviewed with the Maintenance Director and the Administrator during the exit conference. 3.1-19(b)		cords from MDS office and conference room. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** MD educated on importance of ensuring power strips and extension cords are not in use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed;** Maintenance director will complete daily rounds to ensure compliance is met and will report results to QAPI team with an action plan in place if compliance is not met. Deficiencies corrected by 12/11/22	

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