STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155620	A. BUILDING -- B. WING	03/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/06/18 Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290 At this Emergency Preparedness survey, Zionsville Meadows was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 185 certified beds. At the time of the survey, the census was 126. Quality Review completed on 03/12/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	March 23, 2018 Mr. Matthew Foster Indiana State Department of Health 2 North Meridian St. Indianapolis, IN 46204 Dear Mr. Foster; Please accept this 2567 Plan of Correction for the Life Safety Code with Emergency Preparedness Survey ending March 6, 2018 as our Letter of Credible Allegation and this facility respectfully request a Desk Review in lieu of a post survey revisit on or after April 5, 2018. Thank you for your time in reviewing our plan of correction and please call with any questions. Respectfully, Cathy S. Greene Executive Director Zionsville Meadows Enclosure	
E 0018 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the	E 0018	The creation and submission of this Plan of Correction does not constitute an admission by this	04/05/2018

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

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

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	location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator on 03/06/18 at 10:27 a.m., the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location. Based on inter vie at the time of the record review, the Administrator acknowledged that the facility emergency preparedness plan failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency.		provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible allegation and respectfully request a Desk Review in lieu of a post survey revisit on or after April 5, 2018. **E018 Procedure for tracking of Staff and Patients** It is the practice of this provider to ensure emergency preparedness policies and procedures include a system to track the location of on duty staff and sheltered residents in our facility's care during and after an emergency **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** ·No direct resident affected by this alleged deficient practice. ·Staffing schedule, staffing phone numbers, matrix face sheets and Resident bed board , as well as the Evacuation Tracking Log will be utilized as a means to track the staff and residents during the emergency **How will you identify other residents having the potential to be affected by the same deficient practice and what**	

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			corrective action will be taken. ·All residents have the potential to be affected by the alleged deficient practice. ·Staffing schedule, staffing phone numbers, matrix face sheets and Resident bed board as well as the Evacuation Tracking Log will be utilized as a means to track the staff and residents during the emergency **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** ·Staffing schedule, staffing phone numbers, matrix face sheets and Resident bed board as well as the Evacuation Tracking Log will be utilized as a means to track the staff and residents during the emergency ·Above mentioned forms will be updated monthly by Maintenance Director/Designee ·Staff will be re-educated on the tracking procedure by Maintenance Director/SDC/Designee at Disaster training by 4-5-18. **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.**	

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			·The QA tool "Disaster and Emergency Preparedness " will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds. ·The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: April 5, 2018**	
E 0030 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers in accordance with 42 CFR 483.73(c)(1). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator at 10:37 a.m. on 03/06/18, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing	E 0030	**E030 Names and Contact Information** It is the practice of this provider to ensure the emergency preparedness communication plan includes names and contact information for the following, Staff, Entities providing services under arrangement, Residents' physicians, other LTC facilities and volunteers. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.**	04/05/2018

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	services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers. Based on interview at the time of record review, the Building Manager acknowledged the facility failed to ensure emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers.		·No direct resident affected by this alleged deficient practice. ·Staffing schedule, staffing phone numbers, matrix face sheets (including next of kin), Entities providing services under arrangements, Resident physicians, volunteers, other LTC facilities and Resident bed board through our Communication Plan will be utilized as a means to track the staff and residents during the emergency **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·All residents have the potential to be affected by the alleged deficient practice. ·Staffing schedule, staffing phone numbers, matrix face sheets and Resident bed board through our Communication Plan will be utilized as a means to track the staff and residents during the emergency ·Above mentioned forms will be updated monthly ·Staff will be re-educated on the tracking procedure by Maintenance Director /SDC/Designee at Disaster training by 4-5-18. **What measures will be put into place or what systemic changes you will make to**	

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			ensure that the deficient practice does not recur. ·Staffing schedule, staffing phone numbers, matrix face sheets (including next of kin), Entities providing services under arrangements, Resident physicians, volunteers, other LTC facilities and Resident bed board through our Communication Plan will be utilized as a means to track the staff and residents during the emergency ·Above mentioned forms will be updated monthly ·Staff will be re-educated on the tracking procedure by Maintenance Director SDC/Designee at Disaster training by 4-5-18. **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.** ·The QA tool “Disaster and Emergency Preparedness “ will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds. ·The QAPI Team reviews the audits monthly and action plans	

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			are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: April 5, 2018**	
E 0035 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator at 10:47 a.m. on 03/06/18, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Based on interview at the time of record review, the Administrator acknowledged that the emergency preparedness communication plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives.	E 0035	**E035 LTC and ICF/IID Sharing Plan with Patients** It is the practice of this provider to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** ·No direct resident affected by this alleged deficient practice. ·A letter will be sent out to family/responsible parties concerning our procedure for Natural Disasters and other Emergencies annually, it will also be placed in the admission packet for new admits and will be given to the residents as well as reviewed with residents at residents council. ·Staffing schedule, staffing	04/05/2018

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			phone numbers, matrix face sheets (including next of kin), Entities providing services under arrangements, Resident physicians, volunteers, other LTC facilities and Resident bed board will be utilized as a means to track the staff and residents during the emergency **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·All residents have the potential to be affected by the alleged deficient practice. ·Staff will be re-educated on the tracking procedure by Maintenance Director/ SDC/Designee at Disaster training by 4-5-18. ·Staffing schedule, staffing phone numbers, matrix face sheets (including next of kin), Entities providing services under arrangements, Resident physicians, volunteers, other LTC facilities and Resident bed board will be utilized as a means to track the staff and residents during the emergency ·A letter will be sent out to family/responsible parties concerning our procedure for Natural Disasters and other Emergencies annually, it will also be placed in the admission packet for new admits and will be given to	

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			the residents as well as reviewed with residents at residents council. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** ·Staffing schedule, staffing phone numbers, matrix face sheets (including next of kin), Entities providing services under arrangements, Resident physicians, volunteers, other LTC facilities and Resident bed board will be utilized as a means to track the staff and residents during the emergency ·Above mentioned forms will be updated monthly ·Staff will be re-educated on the tracking procedure by Maintenance Director/ SDC/Designee at Disaster training by 4-5-18. ·A letter will be sent out to family/responsible parties concerning our procedure for Natural Disasters and other Emergencies annually, it will also be placed in the admission packet for new admits and will be given to the residents reviewed with residents at residents council. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place. ·The QA tool "Disaster and Emergency Preparedness " will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds. ·The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: April 5, 2018**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/06/18 Facility Number: 000538 Provider Number: 155620 AIM Number: 100267290 At this Life Safety Code survey, Zionsville Meadows was found not in compliance with Requirements for Participation in	K 0000	March 23, 2018 Mr. Matthew Foster Indiana State Department of Health 2 North Meridian St. Indianapolis, IN 46204 Dear Mr. Foster; Please accept this 2567 Plan of Correction for the Life Safety Code with Emergency Preparedness Survey ending March 6, 2018 as our Letter of Credible Allegation	

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	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 is a split level facility with each of the two floors exiting at ground level was determined to be of Type II (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 185 and had a census of 130 at the time of this visit. All areas where residents have customary access were sprinklered. The facility has one detached building providing facility storage services which was not sprinklered. Quality Review completed on 03/12/18 - DA		and this facility respectfully request a Desk Review in lieu of a post survey revisit on or after April 5, 2018. Thank you for your time in reviewing our plan of correction and please call with any questions. Respectfully, Cathy S. Greene Executive Director Zionsville Meadows Enclosure	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 12 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 45 residents, as well as 8 staff and 4 visitors.	K 0211	**K211 Means of Egress - General** It is the practice of this provider to ensure corridor means of egress are continuously maintained free	04/05/2018

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	Findings include: Based on an observation with the Maintenance Director 03/06/18 between the hours of 10:44 a.m. and 12:56 p.m., the following was noted: a) at 11:04 a.m., there was a bed stored on one side of the hall and a Hoyer lift on the opposite side of the hall near resident rooms #136 and #138. b) at 12:50 p.m. there as a floor scale stored in the corridor immediately outside the Cottage dining area Based on interviews at the time of each observation, the Maintenance Director acknowledged that each of the aforementioned items were not allowed to be kept or stored out in the corridor. 3.1-19(b)		of obstructions. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** ·No direct resident affected by this alleged deficient practice. ·Egress by room #136 was cleared immediately of the bed and hoyer. Egress by Cottage Dining room, the scale was removed by the Maintenance Director. **How will you identify other residents having the potential to be affected aby the same deficient practice and what corrective action will be taken.** ·All residents have the potential to be affected by the alleged deficient practice. ·Egress by room #136 was cleared immediately of the bed and hoyer. Egress by Cottage Dining room, the scale was removed by the Maintenance Director. ·All other egresses were assessed for the same alleged deficient practice by the Maintenance Director immediately. Any other egress that was that was obstructed was cleared immediately by Maintenance Director 3-6-18. ·Staff was re-educated on maintaining egresses free of	

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			obstructions. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** ·All other egresses were assessed for the same alleged deficient practice by the Maintenance Director immediately. Any other egress that was that was obstructed was cleared immediately by Maintenance Director 3-6-18. ·Staff was re-educated on maintaining egresses free of obstructions. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds **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.** ·The QA tool “Disaster and Emergency Preparedness “ will be utilized by the Interdisciplinary Team weekly for four weeks,	

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			monthly for three months and quarterly thereafter. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds. ·The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: April 5, 2018**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS			

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	Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler			

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	155620	A. BUILDING 01 B. WING	03/06/2018

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	system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 8 delayed egress locks was readily accessible for all residents, staff, and visitors. LSC 7.2.1.6.1.(3)(4) states a readily visible, durable sign in letters not less than 1 in. (25mm) high and not less than 1/8 in. (3.2mm) in stroke width on a contrasting background that reads as follows shall be located on the door leaf adjacent to the release device in the direction of egress: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect 25 residents in the community room. Findings include: Based on observations during tour of the facility with the Maintenance Director on 03/06/18 at 11:06 a.m., the exit door near resident room #146 and #147 was provided with delayed egress locks, but lacked the proper signage indicating the doors can be opened in 15 seconds by pushing on the door. Based on interview at the time of observation, the Maintenance Director acknowledged the door was equipped with a delayed egress and lacked the proper signage. 3.1-19(b)	K 0222	**K222 Egress Doors** It is the practice of this provider to ensure the means of egress through the delayed egress locks is readily accessible for all residents, staff, and visitors. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** ·No direct resident affected by this alleged deficient practice. ·Exit door by resident room #146 and #147 egress signage was ordered immediately and placed on door 3-12-18 by the Maintenance Director. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·All residents have the potential to be affected by the alleged deficient practice. ·Exit door by resident room #146 and #147 egress signage was ordered immediately and placed on door 3-12-18 by the Maintenance Director. ·All other exit doors were assessed for the same alleged deficient practice by the Maintenance Director immediately. Any other exit door	04/05/2018

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			requiring this egress signage had the signage place by Maintenance Director 3-12-18. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** ·All other exit doors were assessed for the same alleged deficient practice by the Maintenance Director immediately. Any other exit door requiring this egress signage had the signage place by Maintenance Director 3-12-18. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds **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.** ·The QA tool “Disaster and Emergency Preparedness “ will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter.	

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			·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds. ·The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: April 5, 2018**	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			

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	Based on observation and interview, the facility failed to ensure steel armover sprinkler pipes in 1 of 8 mechanical rooms were installed in accordance with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, at 9.2.3.5.1 states the cumulative horizontal length of an unsupported armover to a sprinkler, sprinkler drop, or sprig-up shall not exceed 24 inches for steel pipe or 12 inches for copper tube. This deficient practice could affect mostly staff while in the mechanical room. Findings include: Based on observations on 03/06/18 at 12:16 p.m. with the Maintenance Director, the steel sprinkler pipe armover in the mechanical room next to resident room #153 had a 9 foot unsupported section near the H.V.A.C. ductwork in the back of the room. The support section was still hanging on the pipe, but the top had been detached from the ceiling. Based on interview at the time of the observation, the Maintenance Director acknowledged the unsupported section of steel sprinkler pipe, and the unattached hanger. 3.1-19(b)	K 0351	**K351 Sprinkler System - Installation** It is the practice of this provider to ensure sprinkler pipes are installed in accordance with the requirements of NFPA 13, standard for the Installation of Sprinkler Systems. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** ·No direct resident affected by this alleged deficient practice. ·Sprinkler pipe armover in mechanical room next to resident room #153 part to repair was ordered immediately and repaired by 3-23-18 by the Maintenance Director. **How will you identify other residents having the potential to be affected aby the same deficient practice and what corrective action will be taken.** ·All residents and more so the staff have the potential to be affected by the alleged deficient practice. ·Sprinkler pipe armover in mechanical room next to resident room #153 part to repair was ordered immediately and repaired by 3-23-18 by the Maintenance Director. ·The Maintenance Director/Designee is responsible	04/05/2018

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			to monitor for compliance monthly on Preventive Maintenance rounds **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.** ·Sprinkler pipe armover in mechanical room next to resident room #153 part to repair was ordered immediately and repaired by 3-23-18 by the Maintenance Director. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds **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.** ·The QA tool “Disaster and Emergency Preparedness “ will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds. ·The QAPI Team reviews the	

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			audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: April 5, 2018**	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure in 1 of 66 resident rooms, flexible	K 0920	**K920 Electrical Equipment – Power Cords and Extension**	04/05/2018

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	cords were not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects up to 3 residents and staff. Findings include: Based on observation with the Maintenance Director on 03/06/18 at 12:17 a.m., resident room #208 had an extension cord plugged into a wall outlet operating a desk lamp. Based on interview at the time of the observation, the Maintenance Director acknowledged the use of the extension cord plugged into a table lamp. 3.1-19(b)		**Cords** It is the practice of this provider to ensure flexible cords are not used as a substitute for fixed wiring. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** ·The extension cord was removed immediately from the lamp of resident #208 and plugged directly in the wall outlet. ·Resident #208 was informed that extension cords cannot be used. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** ·Residents who have electrical devices have the potential to be affected by the alleged deficient practice. ·Resident rooms were all checked for use of extension cords and removed if found. ·Staff was re-educated on extension cords are not to be used in the facility immediately and by 4-5-18, by SDC/Maintenance Director **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur.**	

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			·Resident rooms were all checked for use of extension cords and removed if found. ·Staff was re-educated on extension cords are not to be used in the facility immediately and by 4-5-18, by SDC/Maintenance Director ·Residents were notified that extension cords cannot be used, at Resident Council and if extension cords found in any other room, at that time. **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.** ·The QA tool "Disaster and Emergency Preparedness " will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months and quarterly thereafter. ·The Maintenance Director/Designee is responsible to monitor for compliance monthly on Preventive Maintenance rounds. ·The QAPI Team reviews the audits monthly and action plans are developed as needed if threshold of 90% is not met to ensure continual compliance. **Compliant Date: April 5, 2018**	