STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155154	A. BUILDING -- B. WING	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRING MILL MEADOWS	2140 W 86TH ST INDIANAPOLIS, IN 46260

(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: 07/18/22 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Emergency Preparedness survey, Spring Mill Meadows was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 130 certified beds. At the time of the survey, the census was 77. Quality Review completed on 07/21/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).			

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

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	*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.			

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	(v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and			

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	whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting			

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	equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency			

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	preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Policies & Procedures" documentation dated 03/14/22 with the Administrator and the Director of Maintenance during record review from 9:40 a.m. to 12:20 p.m. on 07/18/22, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Administrator stated staff training on emergency preparedness program documentation is tracked in a Relias database on computer but was not able to provide the documentation for staff training on the emergency preparedness program within the most recent twelve month period because she had an off-site appointment and had to leave the building before the facility was able to provide the Relias training documentation. This finding was reviewed with the Director of Maintenance during the exit conference.	E 0037	**E037 EP Training Program** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Attached content of all staff meeting held 7-28-22. **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. ·Annual requirements of education are reviewed in QAPI monthly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Executive Director/Designee monitors completion of online training and all staff education monthly through the QAPI process. **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?** · A life safety Review QA tool will be utilized monthly x 3	08/01/2022

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			months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Date of Correction August 1, 2022**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/18/22 Facility Number: 000074 Provider Number: 155154 AIM Number: 100290050 At this Life Safety Code survey, Spring Mill 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 two story facility with a basement 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	K 0000	Please accept State form 2567, Plan of Correction, for the annual Life Safety Code survey conducted on July 18, 2022. The facility respectfully requests that the 2567 serve as our letter of credible allegation of compliance. The facility also respectfully requests a desk review in lieu of a post survey revisit on or after August 1, 2022.	

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	battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 130 and had a census of 77 at the time of this survey. All 74 resident sleeping rooms were surveyed. All areas where residents have customary access were sprinklered. The facility has one detached storage shed providing facility storage services which was not sprinklered. Quality Review completed on 07/21/22			
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 maintain the means of egress free from obstructions in 1 of 9 means of egress on the first floor. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following:	K 0211	**K211 Means of Egress General** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The cooler was removed immediately from the corridor. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · 10 residents and staff and visitors could be affected by the alleged deficient practice.	08/01/2022

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	i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/18/22, two wheeled carts for isolation supplies and a cooler were stored up against the corridor wall opposite one another near the first floor nurse's station by resident Room 100 and reduced the unobstructed corridor width to less than 60 inches for the eight foot wide corridor. Based on an interview at the time of the observations, the Director of Maintenance agreed wheeled carts were stored on each side of the corridor and moved the cooler cart into the nurse's station. This finding was reviewed with the Director of Maintenance during the exit conference. 3.1-19(b)		· All staff will be inserviced by the Executive Director on the regulatory standard indicated by this requirement by August 1, 2022. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All staff will be inserviced by the Executive Director/designee on keeping and 5-foot clearance in the corridors and the regulatory standard indicated by this requirement by August 1, 2022. · The Maintenance Supervisor/designee will make environmental rounds daily to ensure facility corridors remain clear of obstructions. **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?** · A life safety Review QA tool will be utilized daily x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be	

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			developed to ensure compliance **Date of Correction August 1, 2022**	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to replace 3 of over 50 battery operated smoke alarms installed in resident sleeping rooms in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/18/22, manufacturer's documentation affixed to the Kidde Model i9050 battery operated smoke alarm installed on the ceiling in resident sleeping Room 121 on the first floor indicated the device was manufactured 02/07/12. The manufacturer's documentation stated to replace the smoke detector 10 years from the date of manufacture. Manufacturer's documentation affixed to the USI Model 1122L	K 0300	**K300 Protection - other** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The smoke detector in room 210 was replaced. · 50 smoke detectors were ordered and replaced by August 1, 2022. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · 20 residents could be affected by the alleged deficient practice. · The Maintenance Supervisor will be inserviced by the Executive Director on the regulatory standard indicated by this requirement by August 1, 2022.	08/01/2022

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	battery operated smoke alarm installed on the ceiling in resident sleeping Room 210 indicated the device was manufactured 03/21/11 and to "replace the alarm by year 2021". Manufacturer's documentation affixed to the USI Model 1122L battery operated smoke alarm installed on the ceiling in resident sleeping Room 236 indicated the device was manufactured 12/28/11 and to "replace by 12/28/21". No installation date was recorded on the smoke detectors. Based on interview at the time of the observations, the Director of Maintenance Supervisor agreed the three smoke alarms were each more than ten years old. This finding was reviewed with the Director of Maintenance during the exit conference. 3.1-19(b)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director on the regulatory standard indicated by this requirement by August 1, 2022 · A TELs system prompt was added to the Maintenance Director's preventative management system. · A date will be recorded for each battery operated smoke detector effective 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?** · A life safety QA tool will be utilized monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Date of Correction August 1, 2022**	

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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 Based on record review, observation and interview; the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice	K 0353	**K353 Sprinkler system – Maintenance and Testing** **What corrective action(s) will be accomplished for those residents found to have been** · The inspection contractor corrected all listed items on 7-27-22. · The canopy is not combustible as noted from the inspection letter attached. **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 could be affected by the alleged deficient practice.	08/01/2022

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	could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 04/22/22 with the Administrator and the Director of Maintenance during record review from 9:40 a.m. to 12:20 p.m. on 07/18/22, deficiencies were noted for the facility's sprinkler system during the most recent annual inspection for the facility. The "Deficiency Summary" section of the 04/22/22 annual sprinkler system inspection report stated "(2) heads in Laundry need 2-piece ugly skirt; (1) standard response (SR) 155 pendant in Housekeeping basement needs replaced due to paint on link; (19) SR 155 pendant in Kitchen are loaded and corroded; (2) SR 155 pendants are too close to Kitchen exhaust hood; Therapy has (6) broken semi-recessed escutcheons - concealed escutcheon plates; (1) SR 155 pendant in Therapy bathroom needs replaced with semi-recessed escutcheons; Closet in Therapy room has no sprinkler head; Rooms 126 and 128 have missing chrome semi-recessed escutcheons in closet; 2nd floor Conference (4) SR 155 pendants need replaced due to corrosion and paint; Front canopy needs to have sprinkler heads installed; they have no coverage as of right now; (1) SR 155 pendant outside kitchen door by DON Office". Based on interview at the time of record review, the Administrator stated the inspection contractor has made some of the corrections on or after 04/22/22 but she did not know if all repairs had been made and agreed repair documentation on or after 04/22/22 was not available for review at the time of the survey. Based on observations with		· The Maintenance Supervisor will be inserviced by the Executive Director on the regulatory standard indicated by this requirement August 1, 2022. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · The Maintenance Supervisor will be inserviced by the Executive Director/designee regarding follow up/completion of non compliance issues with contractors within 7 days of the inspection standard indicated by this requirement by August 1, 2022. · The Maintenance Supervisor/designee will review vendor outstanding issues at daily management meeting with ED. **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?** · A life safety Review QA tool will be utilized daily x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not	

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	155154	A. BUILDING 01 B. WING	07/18/2022

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	the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/18/22, the canopy outside the building at the main entrance was attached to the building and had no sprinklers installed on the underside of the canopy. It could not be determined if the canopy was of combustible construction. This finding was reviewed with the Director of Maintenance during the exit conference. 3.1-19(b)		achieved, an action plan will be developed to ensure compliance. **Date of Correction August 1, 2022**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors on the second floor would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined	K 0374	**K374 Smoke Barrier – subdivision of spaces** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The smoke barrier door near room 223 on second floor	08/01/2022

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	as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 20 residents, staff and visitors on the second floor. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/18/22, the corridor smoke barrier door set by resident sleeping Room 223 on the second floor would not fully close leaving a gap of greater than 1/8 inch at the meeting edges of the door set. Each door in the door set swings in the same direction. The meeting edges of each door in the door set kept hitting each other near the floor which caused the door set to not fully close when tested to close multiple times and caused the gap at the meeting edges of the doors. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned corridor door set would not restrict the movement of smoke. This finding was reviewed with the Director of Maintenance during the exit conference. 3.1-19(b)		was repaired to close fully. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·The alleged deficient practice could affect 20 residents, staff and visitors. ·The Maintenance Supervisor will be inserviced on the regulatory standard indicated by this requirement by August 1, 2022. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced on the regulatory standard indicated by this requirement by August 1, 2022. ·Maintenance Supervisor completes preventative maintenance tasks via TELs system which includes testing fire doors, and submits completion to the ED during monthly QAPI meeting. **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?** · A life safety QA tool will be utilized monthly x 6 months, and quarterly thereafter for one year	

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			with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance **Date of Correction August 1, 2022**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 1. Based on observation and interview, the facility failed to ensure electrical wiring on the first floor was maintained in safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 300.15 states a box or conduit body shall be installed at each junction point unless otherwise permitted by 300.15(A) through (I). Article 314.28 states boxes and conduit bodies used as pull or junction boxes shall comply with 314.28 (A) through (E). This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 121 on the first floor. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from	K 0511	**K511 Utilities – Gas and Electric** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · 1 - Facility wiring was repaired near room 121 on the first floor to meet this requirement. · 2 – Electrical outlets were repaired near room 210 as needed to meet the stated requirement on the second floor. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·10 residents, staff and visitors around room 121 on the first floor	08/01/2022

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	12:45 p.m. to 3:10 p.m. on 07/18/22, exposed electrical wiring was noted in an open ended conduit which was above the suspended ceiling near the stairwell wall by Room 121 and were not contained within a junction box or conduit body. Based on interview at the time of the observations, the Director of Maintenance agreed the exposed electrical wiring was not contained within a junction box or conduit body. This finding was reviewed with the Director of Maintenance during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure electrical receptacles in 1 of over 25 resident sleeping rooms on the second floor were properly wired and grounded in accordance with NFPA 70. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding		have the potential to be affected by the alleged deficient practice. ·2 residents staff and visitors near room 210 on the second floor have the potential to be affected y the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will be inserviced by the Executive Director/designee on the regulatory standard indicated by this requirement by August 1, 2022. ·Maintenance Supervisor completes preventative maintenance tasks via TELs system which includes checking electrical wiring and outlets, and submits completion to the ED during monthly QAPI meeting **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?** · A life safety Review QA tool will be utilized monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director.	

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	conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34. Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect two residents and staff in resident sleeping Room 210. Findings include: Based on observations with the Director of Maintenance during a tour of the facility from 12:45 p.m. to 3:10 p.m. on 07/18/22, two of four electrical receptacles in the wall mounted outlet box at the foot of the bed nearest the corridor door in resident Room 210 were each found to have an "open ground" when tested with an Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Director of Maintenance agreed the testing device showed the aforementioned electrical receptacles needed repair. This finding was reviewed with the Director of		· If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. **Date of Correction August 1, 2022**	

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