DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155788	A. BUILDING -- B. WING	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENWOOD MEADOWS	1200 N SR 135 GREENWOOD, IN 46142

(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: 03/29/18 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Emergency Preparedness survey, Greenwood Meadows was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 169 certified beds. At the time of the survey, the census was 150. Quality Review completed on 04/05/18 - DA	E 0000	F000 This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUEST A DESK REVIEW IN LIEU OF POST SURVEY REVIEW on or after April 13, 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: 03/29/18 Facility Number: 012564 Provider Number: 155788 AIM Number: 201018510 At this Life Safety Code survey, Greenwood	K 0000	F000 This provider respectfully requests that the 2567 PLAN OF CORRECTION BE CONSIDERED THE LETTER OF CREDIBLE ALLEGATION AND REQUEST A DESK REVIEW IN LIEU OF POST SURVEY REVIEW on or after April 13, 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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	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 V (111) 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 hardwired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 169 and had a census of 150 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 04/05/18 - DA			
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 8 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice	K 0211	**K211 Means of Egress** - **Aisles Means of Egress – General Aisles, passageways, corridors, exit discharges, exit**	03/30/2018

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	could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 03/29/18, the following was noted: a. a weigh scale which projected five feet into the twelve foot wide corridor was stored outside Room 520. An upholstered chair was also stored in the corridor outside Room 520 across from the weigh scale which reduced the path of egress in the corridor to 40 inches wide and provided obstructions and impediments for egress in the corridor. b. furniture, chairs, tables, stacked cardboard boxes, a resident bed and milk crates were stored in the service corridor. The service corridor was marked as a facility exit with an exit sign. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress were not continuously maintained free of all obstructions or impediments to full instant use. 3.1-19(b)		**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 by18/19.2.2 through 18/19.2.11.18.2.1, 19.2.1, 7.1.10.1,** **Facility failed to ensure 2 of 8 means of egress were free of obstructions and impairments.** **a. Weigh scale and furniture outside room 520 reduced path to egress.** **b. Furniture, Chairs, Tables, Stacked Cardboard, Resident Bed and Milk Crates in service hallway.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The building removed all furniture and weigh scale outside of room 520. · Furniture, Chairs, Tables, Stacked Cardboard, Resident Bed and Milk Crates removed from service hallway. **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 currently living in the facility, visitors and staff have the potential to be affected by this alleged deficient practice.	

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			What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Maintenance Supervisor/Designee will monitor service hallway and facility daily to ensure egress is not compromised. **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?** Maintenance Director and Executive Director will walk through the building monthly and visually confirm the corrective action is maintained. -	
K 0222 SS=F 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			

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	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 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			

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	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 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 3 of 3 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once	K 0222	**K 222 Egress Doors** **On the door adjacent to the release device, there share be a readily visible, durable sign in letters not less than 1' high and 1/8 inch in stroke width on a contrasting background that reads "Push Until Alarm Sounds. Door Can Be Opened in 15 Seconds.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 4/11/2018, the Maintenance Director placed on Exit doors outside of Room 228, 425, and 520 a durable sign in letters not less than 1' high and 1/8 inch in stroke width on a contrasting background that reads "Push Until Alarm Sounds. Door Can Be Opened in 15 Seconds. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	04/11/2018

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	the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 50 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 03/29/18, the exit doors to the outside of the facility by Room 228, by Room 425 and by Room 520 were each marked as a facility exit. Each door was not equipped with the necessary signage indicating the door was a delayed egress door and could be opened after pushing for 15 seconds. Each door opened when it was pushed to release for 15 seconds. Each exit door could also be opened by entering a four digit code in a keypad with the code posted. Based on interview at the time of the observations, the Maintenance Director agreed each of the aforementioned doors were delayed egress doors without the necessary delayed egress signage. 3.1-19(b)		·Residents currently living in the facility, visitors and staff have the potential to be affected by this 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?** · Maintenance Supervisor will place "Push Until Alarm Sounds. Door Can Be opened in 15 seconds" at any of the doors leading out of the facility. **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?** Maintenance Director and Executive Director will walk through the building monthly and visually confirm the corrective action is maintained. - -	
K 0291 SS=F	NFPA 101 Emergency Lighting			

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Bldg. 01	Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document monthly and annual testing for 1 of 1 battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Executive Director and the Maintenance Director during from 9:20 a.m. to 11:30 a.m. on 03/29/18, documentation of monthly testing of all battery powered emergency lights in the facility within the most recent twelve month period was not available for review. In addition, annual battery	K 0291	**K 291 Emergency Lighting One battery powered emergency lighting system was noted for the facility inside the weatherproof shell for the emergency generator which failed to illuminate when the electrical power cable for the system was unplugged.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 4/11/2018, the Maintenance Director replaced the LED 2-Light Emergency Unit with Adjustable Heads. **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 currently living in the facility, visitors and staff have the potential to be affected by this 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?** · Maintenance Director will monitor monthly and yearly and	04/11/2018

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	powered emergency light testing documentation within the most recent twelve month period was also not available for review. Based on interview at the time of record review, the Maintenance Director stated monthly and annual testing documentation for all facility battery powered lights was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 03/29/18, one battery powered emergency lighting system was noted for the facility inside the weatherproof shell for the emergency generator which failed to illuminate when the electrical power cable for the system was unplugged. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 03/29/18, one battery powered emergency lighting system was noted for the facility inside the weatherproof shell for the emergency generator which failed to illuminate when the electrical power cable for the lighting		track on the "Battery Operated Emergency Lights- Test log". Replace immediately based upon test results. **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?** Maintenance Director will monitor monthly and yearly and track on the "Battery Operated Emergency Lights- Test log". Replace immediately based upon test results. Executive Director will review log monthly as part of the safety meeting. - -	

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	system was unplugged from an outlet in the shell. Based on interview at the time of the observations, the Maintenance Director agreed the battery powered emergency lighting system inside the weatherproof shell for the emergency generator failed to illuminate when electrical power to the unit was disconnected. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)			
	Based on observation and interview, the facility failed to ensure 1 of 10 doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: 'NO EXIT'. The 'NO EXIT' sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8th's inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect over 10 residents, staff and visitors in the 100 Hall Dining Room. Findings include: Based on observations with the Maintenance	K 0293	**K293 Exit Signage** **Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 1 of 10 doors to the outside of the facility were not mistaken as a facility exit sign.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · On 4/12/18, the facility placed 'No Exit' sign on the 100 Hall Door that exits to the	04/12/2018

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	Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 03/29/18, the door to the outside of the facility in the 100 Hall Dining Room was not marked as a facility exit with an exit sign and it was not marked as 'NO EXIT'. Based on interview at the time of the observations, the Maintenance Director stated the door is not an exit for the facility because the door opens into a courtyard for memory care residents in the 100 Hall and agreed the door did not have a 'NO EXIT' sign posted. 3.1-19(b)		courtyard. **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 currently living in the facility, visitors and staff have the potential to be affected by this 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?** · Maintenance Supervisor placed "not an exit sign" at any of the doors leading out of the facility to the courtyard. **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?** · Maintenance Director and Executive Director will walk through the building monthly and visually confirm the corrective action is maintained.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic			

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	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)			
	Based on observation and interview, the facility failed to ensure the spray pattern for automatic sprinklers were not obstructed in 1 of 2 Activities Room closets in accordance with NFPA 13. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect over 5 residents, staff and visitors in the Activities Room near the 100 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:30	K 0351	**K351 Sprinkler System** - **Means of egress shall be continuously maintained free of all obstructions.** The facility failed to ensure the spray pattern for automatic sprinklers were not obstructed in 1 of 2 Activities Room closets in accordance with NFPA 13. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On 3/29/2018, the Maintenance Director removed all obstructed items in the identified 1 of 2 Activity Room Closets. **How will you identify other residents having the potential**	03/29/2018

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	a.m. to 1:45 p.m. on 03/29/18, board game boxes and other miscellaneous Activities Room supplies were stored up to the ceiling on the top shelf of the shelving in the Activities Room closet which caused automatic sprinkler head spray pattern obstruction for the pendent sprinkler in the closet. Based on interview at the time of the observations, the Maintenance Director agreed storage on the top shelf in the closet up to the ceiling caused automatic sprinkler head spray pattern obstruction. 3.1-19(b)		**to be affected by the same deficient practice and what corrective action will be taken?** ·Residents currently living in the facility, visitors and staff have the potential to be affected by this 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?** · Maintenance Supervisor marked storage closet per regulation so this deficient practice doesn't occur. **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?** Maintenance Director and Executive Director will walk through the building monthly and visually confirm the corrective action is maintained.	
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 Based on observation and interview, the facility failed to maintain 1 of over 10 portable fire	K 0355	**<u>K 355 Portable Fire Extinguishers</u>**	03/29/2018

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	extinguishers were maintained in accordance with the requirements of NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.3 states when an inspection of any fire extinguisher reveals a deficiency in any of the conditions listed in 7.2.2, immediate corrective action shall be taken. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the 400 Hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 03/29/18, the pressure gauge indicator for the portable fire extinguisher located at the entrance to the 400 Hall near the center nurse's station indicated the fire extinguisher was overcharged. Based on interview at the time of the observations, the Maintenance Director stated the indicator for the pressure gauge was not in the green area of the indicator charging status. 3.1-19(b)		**Portable fire extinguishers are selected, installed, inspected and maintained in all health care occupancies in accordance with NFPA 10. The portable fire extinguisher located at the entrance to the 400 Hall nurses station indicated the fire extinguisher was overcharged.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The building replaced fire extinguisher on the 400 hall with an appropriately charged fire extinguisher on 3/29/2018. **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 currently living in the facility, visitors and staff have the potential to be affected by this 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?** · Maintenance Supervisor will follow the “Monthly Preventive Maintenance Log” to ensure that required fire extinguishers are inspected, dated and appropriately	

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			charged each month. **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?** Maintenance Director will review with ED monthly the preventive maintenance log during Safety Meeting. If 100% threshold is not achieved, an action plan will be developed.	
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 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			

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	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 4 of 4 extension cords including power strips and non-fused multiplug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 03/29/18, the following was noted: a. a refrigerator was plugged into a multiplug adaptor in Room 412. b. a refrigerator was plugged into a power strip in the Medical Records office by the center nurse's station. c. a microwave oven was plugged into a power strip in the MDS Office. d. an extension cord was in use for office equipment in the center nurse's station. Based on interview at the time of the	K 0920	**K 920 Electrical Equipment- Power Cords and Extens** - **The facility failed to ensure 4 of 4 extension cords including power strips and non-fused multiple adapters were not used as a substitute for fixed wiring.** - · A refrigerator was plugged into a multiplug adapter in room 412. · A refrigerator was plugged into a power strip in the Medical Records office. · A microwave was plugged into a power strip in the MDS office · An extension cord was in use for office equipment in the center at the nurses' station. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · On 3/29/2018, the Maintenance removed multi plug device in room 412 and utilized wall outlet for refrigerator. · On 3/29/2018, the Maintenance unplugged refrigerator from power strip and	03/29/2018

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	observations, the Maintenance Director agreed a multiplug adaptor and power strips including an extension cord was being used as a substitute for fixed wiring at the aforementioned locations. 3.1-19(b)		plug into appropriate wall outlet in Medical Records Office. · On 3/29/2018, the Maintenance unplugged microwave from power strip and plug into appropriate wall outlet in MDS Office · On 3/29/2018, the Maintenance Director relocated office equipment at the nurses' station and plugged into wall outlet. **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 currently living in the facility, visitors and staff have the potential to be affected by this 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?** · On 4/10/2016, the Executive Director in-serviced staff on importance of not utilizing power strips in the facility. **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?** Maintenance Director and	

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			Executive Director will walk through the building monthly and visually confirm the corrective action is maintained.	
K 0923 SS=D Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the			

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	supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 5 of 12 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen storage and transfilling rooms inside the facility. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 85 cubic meters (3000 cubic feet) shall comply with 5.1.3.3.2 and 5.1.3.3.3. NFPA 99, Section 5.1.3.3.2(7) requires cylinders be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full or empty. This deficient practice could affect 5 staff and visitors in the vicinity of the oxygen storage room and transfilling room in the service hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:30 a.m. to 1:45 p.m. on 03/29/18, five of twelve 'E' type oxygen cylinders were freestanding on the floor in the oxygen storage and transfilling room in the service hall and were not supported in a proper cylinder stand or otherwise secured from falling. Seven liquid oxygen containers and twelve 'E' type oxygen cylinders were observed stored in the room. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned 'E' type oxygen cylinders were	K 0923	**K 923 Gas Equipment- Cylinder and Container Storage Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible with door that can be secured. The facility had 5 of 12 "E" type oxygen cylinders were freestanding on the floor in the oxygen storage and transfilling room in the service hall an were not supported in the proper cylinder stand.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The building ordered and installed additional storage rake to correct the deficiency. **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 currently living in the facility, visitors and staff have the potential to be affected by this	04/12/2018

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	not supported in a cylinder stand or otherwise secured. 3.1-19(b)		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?** · Maintenance Supervisor/Designee we monitor Cylinder Storage room daily to ensure compliance. · Executive Director informed vendor to never leave cylinders freestanding on floor. · Executive Director placed sign “Do Not Place Cylinders on the Floor” in cylinder storage room. **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?** Maintenance Director will review with ED monthly the during Safety Meeting. If 100% threshold is not achieved, an action plan will be developed.	