STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155700	A. BUILDING -- B. WING	11/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/28/22 Facility Number: 002982 Provider Number: 155700 AIM Number: 200382090 At this Emergency Preparedness survey, Catherine Kasper Home was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 82 and had a census of 40 at the time of this survey. Quality Review completed on 12/01/22	E 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Requesting a desk review in lieu of a post survey visit on or after December 30, 2022.**	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeff Brinkman	Executive Director	12/23/2022

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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	155700	A. BUILDING -- B. WING	11/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(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
	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in			

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	155700	A. BUILDING -- B. WING	11/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

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

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	155700	A. BUILDING -- B. WING	11/28/2022

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

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

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

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	required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.			

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	(ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i)			

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	of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.			

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	*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or	E 0039	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents affected by the deficient practice. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The facility performed a second exercise from the Emergency Preparedness Plan. The	12/30/2022

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	c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Technician #1 and Executive Director on 11/28/22 between 9:16 a.m. and 12:22 p.m., no documentation of a 2nd exercise of choice conducted within the last year was available for review. Based on interview at the time of records review, the Executive Director stated that they have not conducted an additional exercise within the past 12 months. Findings were discussed with the Executive Director and Maintenance Technician #1 at exit conference.		maintenance director was educated on how many emergency preparedness trainings have to be completed. *To ensure the deficient practice does not recur, the monitoring system established is*: The Executive Director or designee will review of all drills quarterly to assure that emergency preparedness testing is occurring. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/28/22 Facility Number: 002982	K 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Requesting a desk review in lieu of a post**	

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	Provider Number: 155700 AIM Number: 200382090 At this Life Safety Code survey, Catherine Kasper Home 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 was fully sprinklered. The facility has a monitored fire alarm system with hardwired smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 82 and had a census of 40 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 12/01/22		**survey visit on or after December 30, 2022.**	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting 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 Based on record review and interview, the facility failed to ensure 2 of 2 battery backup emergency lights were tested annually for 90 minutes. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not	K 0291	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the*	12/30/2022

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CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

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	less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (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 staff in the basement Findings include: Based on records review with the Maintenance Technician #1 and Executive Director on 11/28/22 between 9:16 a.m. and 12:22 p.m., annual testing for the battery backup emergency lights was past due. The Battery Operated Emergency Light Test Log indicated the last annual 90 minute testing for the two battery backup emergency lights was conducted on 06/20/18 Based on an interview at the time of records review, the Maintenance Technician #1 stated the annual 90 minute testing for the nine battery backup emergency lights has not been conducted in the past 12 months. Findings were discussed with the Maintenance Technician #1 and Executive Director at exit conference. 3.1-19(b)		*residents found to have been affected by the deficient practice was*: No residents or staff in the basement affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents or staff in the basement affected by the deficient practice. The maintenance director performed the 90 minute test on the two backup emergency lights located in the basement. The test was done on 12/1/22 for laundry and backup generator rooms. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: Maintenance director was educated on how often and how long the backup emergency lights need tested on an annual basis. *To ensure the deficient practice does not recur, the monitoring system established is*: The Executive Director or designee will review on a quarterly basis the emergency test logs to assure testing was completed. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	

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	155700	A. BUILDING 01 B. WING	11/28/2022

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K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon	K 0324	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents or kitchen staff affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*:	12/30/2022

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	inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect at least 20 residents in the dining room and kitchen staff. Findings include: Based on record review with the Maintenance Technician #1 and Executive Director during record review from 9:16 a.m. to 12:22 p.m. on 11/28/22, recent documentation of the kitchen exhaust system inspection was not available for review. The last documented hood cleaning was conducted on 12/02/20. Based on interview at the time of record review, Maintenance Technician #1 stated the cleaning company had come within the past year, but did not have supporting documentation. Based on observation with the Executive Director and the Maintenance Technician #! during a tour of the facility from 12:28 a.m. to 1:38 p.m. on 11/28/22, grease build-up and dirt was noted on the hood exhaust system in the kitchen. This finding was reviewed with the Executive		No residents or kitchen staff affected by the deficient practice. Facility obtained the report for the first inspection of the kitchen exhaust system with the next one scheduled for Dec. 5th, 2022. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The maintenance director was educated on how often the kitchen exhaust system needs inspected and the importance of obtaining the reports. *To ensure the deficient practice does not recur, the monitoring system established is*: Executive Director or designee will review documentation on a quarterly basis to assure inspection of the exhaust system was inspected and report obtained. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	

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	Director and Maintenance Technician #1 at exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include:	K 0353	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents, staff, or visitors affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the*	12/30/2022

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	Based on record review with the Maintenance Technician #1 and Executive Director on 11/28/22 between 9:16 a.m. and 12:22 p.m., the sprinkler inspection report from 1/15/22 stated the last internal pipe inspection was completed on 11/22/17 and would be due 11/22/22. Based on interview at the time of record review, the Maintenance Technician #1 did not have documentation to show the internal pipe inspection was done or scheduled to be done. Findings were discussed with the Executive Director and Maintenance Technician #1 at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 3 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical		*same deficient practice is*: No residents, staff, or visitors affected by the deficient practice. (1) The internal pipe inspection of the sprinkler system was completed on 12/14/22. (2) The fourth quarterly sprinkler inspection was completed on 12/14/22. The second and third quarterly inspections did not happen because of COVID and was not rescheduled. (3) The ceiling tile that was missing was replaced with a new ceiling tile. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The maintenance director was educated on how often the internal pipe inspections need to happen and the quarterly sprinkler inspections. *To ensure the deficient practice does not recur, the monitoring system established is*: Executive Director or designee will review documentation on a quarterly basis to assure inspection of the sprinkler system and yearly for the internal pipe inspection. An audit was created for missing tile which will be completed on a monthly basis for a quarter and then quarterly thereafter for compliance by Executive Director or designee. Ongoing compliance with this corrective action will be monitored through the facility Quality	

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	waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the quarterly sprinkler system inspection records with the Maintenance Technician #1 and Executive Director on 11/28/22 between 9:16 a.m. and 12:22 p.m., there was no quarterly sprinkler system inspection report available for the second, third, and fourth quarters. During an interview at the time of record review, the Maintenance Technician #1 acknowledged there was no written documentation available to show the sprinkler system had been inspected during the three quarters. Invoices of the second and third quarter were provided at exit conference, but no reports were able to be obtained. Findings were discussed with the Executive Director and Maintenance Technician #1 at exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 2 exit corridors. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler		Assurance and Performance Improvement Program.	

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	deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect staff in the basement. Findings include: Based on observations with the Maintenance Technician #1 and Executive Director during a tour of the facility between 12:28 p.m. and 1:35 p.m. on 11/28/22, one suspended ceiling tile was missing in the exit corridor by the Pool Room in the basement. The corridor was equipped with one pendant sprinkler installed on the suspended ceiling. Based on interview at the time of the observations, the Maintenance Technician #1 acknowledged the missing ceiling tile in the aforementioned area This finding was reviewed with the Maintenance Technician #1 and Executive Director at the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by			

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	CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 40 corridor doors on the second floor were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect all residents and staff on the second floor Findings include: Based on observation with the Maintenance Technician #1 and Executive Director on 11/28/22	K 0363	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents or staff affected by the deficient practice. *The corrective action taken for*	12/30/2022

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	between 12:28 p.m. and 1:35 p.m., the following deficiencies were noted: a) Resident Room door 267 did not latch when tested b) Corridor doors in B Hall next to room 244 did not latch close when tested These findings were reviewed with the Executive Director and the Maintenance Technician #1 during the exit conference. 3.1-19(b)		*those residents having the potential to be affected by the same deficient practice is*: No residents or staff affected by the deficient practice. Resident room door 267 was adjusted and latches. The corridor doors in B hall next to room 244 was adjusted and latches. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The maintenance director was educated on the importance of resident room doors and corridor doors need to latch. *To ensure the deficient practice does not recur, the monitoring system established is*: An audit was created for resident and corridor doors which will be completed on a monthly basis for a quarter and then quarterly thereafter for compliance by Executive Director or designee. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	
K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life			

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	Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 2 of 2 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff in the basement. Findings include: Based on observation during a tour of the facility with the Maintenance Technician #1 and the Executive Director on 11/28/22 between 12:28 p.m. and 1:35 p.m., the water heaters located in the basement all had certificates that expired in 2018. Based on interview at the time of the observation, the Maintenance Technician #1 stated the heaters had been inspected, but did not have supporting documentation. Findings were discussed with the Executive Director and Maintenance Technician #1 at exit conference. 3.1-19(b)	K 0500	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents or staff in the basement affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents or staff in the basement affected by the deficient practice. The facility obtained the new boiler certificates with an expiration date of 5/12/23. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The maintenance director was educated on obtaining the certificates after boilers were inspected. *To ensure the deficient practice does not recur, the monitoring system established is*: Executive Director or designee will review documentation on a yearly basis to assure inspection of the boilers and report obtained. Ongoing compliance with this corrective action will be monitored	12/30/2022

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			through the facility Quality Assurance and Performance Improvement Program.	
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 2 of 40 electrical outlets in the basement contained a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect staff in the basement Findings include: Based on observation with the Maintenance Technician #1 and Executive Director on 11/28/22 between 12:28 p.m. and 1:35 p.m., in the ceiling at the East Exit Hall of the basement and in boiler room had two electrical outlets with missing cover plates. Also, in the boiler room there were exposed wires near the condensation pump. Based on interview at the time of observation, the Maintenance Technician #1 agreed outlets were missing a cover plates and exposed wires in the	K 0511	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents or staff in the basement affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents or staff in the basement affected by the deficient practice. (1) The two electrical outlets were fixed with a cover along with the exposed wires that were covered. (2) The electrical panel in the elevator room was fixed by installing the cover back onto the panel. *The measures put into place and*	12/30/2022

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	boiler room. This finding was reviewed with the Maintenance Technician #1 and Executive Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical panel in the Elevator Room was guarded from energized parts. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect maintenance staff in the basement. Findings include: Based on observation with the Maintenance Director on 11/28/22 between 12:28 p.m. and 1:35 p.m., in the Elevator Room in the basement, the freight elevator electrical panel was not enclosed; exposing energized parts. The cover and door to the panel was laying on the floor. Based on interview at the time of observation, the Maintenance Technician #1 agreed the electrical panel was not enclosed and exposed wiring.		*a systemic change made to ensure the deficient practice does not recur is*: The maintenance director was educated on not leaving exposed wires which need to be covered. *To ensure the deficient practice does not recur, the monitoring system established is*: Executive Director or designee will monitor for electrical outlets, exposed wires, and electrical panels to make sure all are covered on a quarterly basis for compliance. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	

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CATHERINE KASPER HOME	9601 S UNION RD DONALDSON, IN 46513

(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
	The finding was reviewed with the Maintenance Technician #1 and the Executive Director during the exit conference. 3.1-19(b)			
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire dampers in the elevator room were inspected and provided necessary maintenance after the first year after instillation and at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. Section 19.4.1.1 states the test and inspection frequency shall be every 4 years except for hospitals where the frequency is every 6 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and	K 0521	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents or staff in the basement affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents or staff in the basement affected by the deficient practice. The smoke/fire damper in the elevator room was inspected on 7/1/2022 and records obtained. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*:	12/30/2022

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	155700	A. BUILDING 01 B. WING	11/28/2022

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	deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect staff in the basement and first floor Findings include: Based on records review with the Maintenance Technician #1 on 11/28/22 between 9:16 a.m. and 12:22 p.m., no documentation of an inspection for the smoke/fire damper in the elevator room was available for review. Based on observation with the Maintenance Technician #1 between 12:28 p.m. and 1:35 p.m., there was a smoke/fire damper in the duct work between the elevator room and the first floor. Based on interview at the time of records review and observation, the Maintenance Technician #1 stated the damper inspection could not be found. Findings were discussed with the Executive Director and Maintenance Technician #1 at exit conference. 3.1-19(b)		The maintenance director was educated on how often the dampers need to be inspected and reports obtained. *To ensure the deficient practice does not recur, the monitoring system established is*: Executive Director or designee will review documentation on a yearly basis to assure inspection of the dampers and report obtained. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	
K 0753 SS=E Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs,			

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	paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 8 corridor walls in E-Hall contain decoration that did not exceed 30 percent of the door. LSC 18.7.5.6 states combustible decorations shall be prohibited in any health care occupancy, unless one of the following criteria is met: (1) They are flame-retardant or are treated with approved fire-retardant coating that is listed and labeled for application to the material to which it is applied. (2) The decorations meet the requirements of NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. (3) The decorations exhibit a heat release rate not exceeding 100 kW when tested in accordance with NFPA 289, Standard Method of Fire Test for Individual Fuel Packages, using the 20 kW ignition source. (4)*The decorations, such as photographs, paintings, and other art, are attached directly to the walls, ceiling, and non-fire-rated doors in accordance with the following: (a) Decorations on non-fire-rated doors do not interfere with the operation or any required latching of the door and do not exceed the area limitations of 18.7.5.6(b), (c), or (d). (b) Decorations do not exceed 20 percent of the wall, ceiling, and door areas inside any room or space of a smoke compartment that is not protected throughout by an approved automatic sprinkler system in accordance with Section 9.7. (c) Decorations do not exceed 30 percent of the	K 0753	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents affected by the deficient practice. The Christmas decoration wrapping paper was removed for the corridor wall. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The maintenance director was educated on not having combustible decorations on the walls. *To ensure the deficient practice does not recur, the monitoring system established is*: Executive Director or designee will monitor the hallways for combustible materials on a	12/30/2022

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	wall, ceiling, and door areas inside any room or space of a smoke compartment that is protected throughout by an approved supervised automatic sprinkler system in accordance with Section 9.7. (d) Decorations do not exceed 50 percent of the wall, ceiling, and door areas inside patient sleeping rooms having a capacity not exceeding four persons, in a smoke compartment that is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. This deficient practice could affect 17 residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Technician #1 and Executive Director on 11/28/22 between 12:28 p.m. and 1:35 p.m., the E-Hall corridor walls were partially covered by wrapping paper. Based on interview at the time of the observation, the Executive Director agreed the corridor wall was covered with a combustible decoration and stated the decoration will be removed. Findings were discussed with the Executive Director and Maintenance Technician #1 at exit conference. 3.1-19(b)		monthly basis for a quarter and then quarterly thereafter. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to			

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	annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8.	K 0918	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents affected by the deficient practice.	12/30/2022

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	NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Technician #1 on 11/28/22 between 9:16 a.m. and 12:22 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Technician #1 stated the facility does have a diesel generator but was unaware of the fuel quality testing requirements and could not determine if they were conducted or not. This finding was reviewed with the Executive Director and Maintenance Technician #1 at the exit conference. 3.1-19(b)		*The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents affected by the deficient practice. The testing of the generator fuel was completed on 12/7/22. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The maintenance director was educated on how often the fuel needs tested. *To ensure the deficient practice does not recur, the monitoring system established is*: Executive Director or designee will review documentation on a yearly basis to assure the fuel in the generator was tested. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	
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			

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	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 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect all staff near the boiler room. Findings include: Based on observation during a tour of the facility with the Maintenance Technician #1 and Executive Director on 11/28/22 between 12:28 p.m. and 1:35 p.m., a condensation pump was plugged into and supplied power by an extension cord in the Boiler Room. Based on interview at the time of observation, the Maintenance Technician and Executive Director acknowledged the extension cord and unplugged the cord at observation. The finding was reviewed with the Maintenance Technician #1 and the Executive Director during the exit conference.	K 0920	It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: *The corrective action taken for the residents found to have been affected by the deficient practice was*: No residents or staff affected by the deficient practice. *The corrective action taken for those residents having the potential to be affected by the same deficient practice is*: No residents or staff affected by the deficient practice. The extension cord in the boiler room was removed. *The measures put into place and a systemic change made to ensure the deficient practice does not recur is*: The maintenance director was	12/30/2022

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	3.1-19(b)		educated that extension cords are not permitted for long term use. *To ensure the deficient practice does not recur, the monitoring system established is*: Executive Director or designee will monitor for extension cords in use for a permanent basis. Ongoing compliance with this corrective action will be monitored through the facility Quality Assurance and Performance Improvement Program.	