STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155772	A. BUILDING -- B. WING	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COBBLESTONE CROSSINGS HEALTH CAMPUS	1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/30/24 Facility Number: 011906 Provider Number: 155772 AIM Number: 20114960 At this Emergency Preparedness survey, Cobblestone Crossings Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 60 certified beds. At the time of the survey, the census was 40. Quality Review completed on 08/01/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/30/24 Facility Number: 011906 Provider Number: 155772 AIM Number: 201114960 At this Life Safety Code survey, Cobblestone	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jodie Bilskie	Executive Director	08/27/2024

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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	Crossings Health Campus 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 was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms. A fire wall with a 2-hour fire resistive rating separates the healthcare occupancy from the assisted living areas. The facility has a capacity of 60 and had a census of 40 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 08/01/24			
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 5 corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 25	K 0211	**K 211 Means of Egress** The Director of Plant Operations and designee ensured that the hallway was immediately cleared	08/01/2024

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	residents in two smoke compartments. Findings include: Based on observation with the Director of Plant Operations and Senior Director of Plant Operations on 07/30/24 between 12:13 p.m. and 2:05 p.m., the exit corridor by resident room 307 contained a seated scale. A bed was stored in the service hall exit corridor taking up two feet of corridor width. Based on an interview at the time of observations, the Director of Plant Operations agreed there were items stored in the exit corridors stating the bed had been in the service hall since Thursday and removed the scale. This finding was reviewed with the Executive Director, Senior Director of Plant Operations, and Director of Plant Operations during the exit conference. 3.1-19(b)		of hazards and furniture was moved to off-site storage unit that day. Furniture in the service hallway was there awaiting to be moved to the storage unit. Seated weight scales were near exit corridor by resident room 307. Scales were moved immediately. To ensure ongoing compliance, any furniture that needs moved to the storage units will stay within the apartments until they can be directly moved to the storage unit. As a quality measure, the Director of Plan Operations or designee will complete walking audits of service hallway and areas of egress to ensure they are clear of hazards. Audit will be completed 5 days a week for 2 weeks, then once a week for 2 months, then monthly for 3 months. Audits will be brought to campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted. The deficient practice affects 25 residents in two smoke compartments. Date of compliance 08/01/24	
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the			

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	approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 2 hazardous area corridor doors to the laundry area, would self-close completely and latch into the door frame. This deficient practice could affect staff in the vicinity of the laundry room. Findings include: Based on observation with the Senior Director of Plant Operations and Director of Plant Operations on 07/30/24 during a tour of the facility from 12:13 p.m. to 2:05 p.m., the corridor door to the clean	K 0321	K321 Hazardous Areas - Enclosure Immediate Intervention: Director of plant operations has corrected the latching equipment to meet deficiency K321. Director of plant operations was educated by Executive director on K321 NFPA 101 hazardous areas enclosure doors. Corridor doors and doors to rooms that contain flammable devices or combustible materials must have positive	08/01/2024

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	laundry room, being used to store clean linen, would not latch into the frame when it self closed. Based on interview at the time of observation, the Director of Plant Operations stated the clean launtry room is about 12X15 in size and confirmed the corridor door would not latch when tested three times. This finding was reviewed with the Executive Director, Senior Director of Plant Operations and Director of Plant Operations at the exit conference. 3.1-19(b)		latching hardware. Director of plant operations will verify positive latching hardware to doors protecting corridor openings. Weekly X 3months and Monthly X3. The Executive Director will present the results of inspection through the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved. Date of Compliance 08/01/24	
K 0341 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm annunciator panels was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states	K 0341	**K341- Fire Alarm System – Installation** **Immediate intervention** The fire panel was locked immediately by the Director of	08/01/2024

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	the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation on 07/30/24 1:06 p.m. during a tour of the facility with the Director of Plant Operations and Senior Director of Plant Operations, the fire alarm control panel door had a key inserted into the lock. The panel is located in the lounge area next to the 200 Hall nurse station where staff, residents, and visitors have access. Based on interview at the time of the observation, the Director of Plant Operations agreed there was a key in the lock of the fire panel and removed the key. This finding was reviewed with the Executive Director, Senior Director of Plant Operations and Director of Plant Operations at the exit conference. 3.1-19(b)		Plant Operations with the appropriate key. The key was placed behind the nurse's station in its original location. The Director of plant operations was educated by the Executive Director on K341 Fire Alarm System Installation as it pertains to NFPA 70, National Electric code and NFPA72 National Fire alarm code referencing sections 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 and Signaling code section 10.10.1, 10.10.3: 10.10.7. The director of plant operation will visually inspect the fire panel weekly x3 months to ensure fire panel is locked and key is made available in the event it is needed. Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved. This deficient practice could affect all occupants. Compliance date 08/01/24	
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	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 2 of 2 automatic sprinkler systems. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 24, 5.3.4 states the freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solutions if necessary. Section 5.3.4.1 states solutions shall be in accordance with Table 5.3.4.1(a) and Table 5.3.4.1(b). Section 5.3.4.3.2 states if the test results indicate an	K 0353		08/20/2024

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	incorrect freeze point at any point in the system, the system shall be drained, the solution adjusted, and the systems refilled. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the facility's quarterly sprinkler system inspection reports on 07/30/24 at 10:41 a.m. with the Director of Plant Operations and Senior Director of Plant Operations present, the quarterly sprinkler report dated 09/11/23 stated "Anti-freeze failed freeze test during inspection" for both the Riser Right and Riser Left. The antifreeze temperature for the Propylene solution in Riser Left was -1F and Riser Right was 3F. Based on interview at the time of record review, the Director of Plant Operations said there was no documentation showing the acceptable freeze point of the anti-freeze in the two systems. The Director of Plant Operations contacted the sprinkler inspection vendor and produced an email dated 07/30/24 at 11:17 a.m. that stated, in part, 'The remaining deficiencies are being prepared to quote so we can keep the facility in compliance. I will get those quotes out to you to have the services completed as soon as possible.' 2. Based on Record review, observation and interview, the facility failed to ensure 7 of 7 sprinkler system gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states			

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	gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review with the Director of Plant Operations and Senior Director of Plant Operations on 07/30/24 at 11:40 a.m., the Internal Deficiency Report from the 05/23/24 Semi-Annual sprinkler system inspection stated, 'gauges need replaced', 'KFS will need to replace (7) Sprinkler water gauges at the risers that are out of date'. The date of gauges was recorded as '06/2019' in the gauges section of the report. Based on observation during a tour of the facility from 12:13 p.m. to 2:05 p.m. on 07/30/24, the facility has supervised wet sprinkler systems and had a total of seven and water pressure gauges with a manufacture date of 2019 listed on the face of each sprinkler system gauge. No recalibration date information was affixed to the sprinkler system gauges. Based on interview at the time of the observations, the Director of Plant Operations stated he did not believe sprinkler system gauges had been recalibrated within the most recent five year period and acknowledged documentation of sprinkler system gauge replacement or recalibration was not available for review for each of 7 sprinkler system gauges which were more than five years old. 3. Based on observation, and interview; the facility failed to ensure all sprinkler heads in the facility loaded with lint were cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of			

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	Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect ten residents and staff in two smoke compartments. Findings include: Based on observations with the Senior Director of Plant Operations and Director of Plant Operations during a tour of the facility from 12:13 p.m. to 2:05 p.m. on 07/30/24, the following was noted: a) the sprinkler located in resident room 106 was covered with lint and/or dust. b) the sprinkler located in the clean laundry room was covered in lint and/or dust. c) the sprinkler located by the washers in the laundry room was covered in lint and/or dust. Based on interview at the time of observations, the Director of Plant Operations agreed the aforementioned automatic sprinklers were loaded with lint and cleaned with sprinklers before survey exit.			

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	These findings were reviewed with the Executive Director, Senior Director of Plant Operations and Director of Plant Operations at the exit conference. 3.1-19(b)			
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 ensure 1 of 1 portable fire extinguisher in the corridor outside resident room 208 were kept in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 1-6.3 states Fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of a fire. Preferable they shall be located along normal paths of travel, including exits from areas. This deficient practice could affect as many as 28 residents, 6 staff and 2 visitors on 200 Hall. Findings include: Based on observation during a tour of the facility with Director of Plant Operations and Senior Director of Plant Operations on 07/30/24 at 1:02 p.m., the ABC portable fire extinguisher located in the corridor by resident room #208 was obstructed by a patient lift Hoyer device. Based on interview at the time of observation, the Director of Plant Operations confirmed the fire extinguisher was obstructed and not readily accessible, and moved the Hoyer lift from in front of the fire extinguisher	K 0355	K355 – Portable Fire Extinguisher Immediate Intervention The Director of Plant Operations has removed the Hoyer Lift immediately, blocking the ABC Fire Extinguisher located on the 200 hall, near 208 The Director of Plant Operations was educated by the Executive Director NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, 1-6.3. The Director of Plant Operations will audit all fire extinguishers to remain free of obstructions, allowing them to be accessible and immediately available in the event of a fire, twice weekly for one month, weekly for one month. Results of this audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines	08/01/2024

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	upon observation. This finding was reviewed with the Executive Director, Senior Director of Plant Operations and Director of Plant Operations at the exit conference. 3.1-19(b)		substantial compliance has been achieved. This deficient practice could affect as many as 28 residents, 6 staff and 2 visitors on 200 hall. Date of Compliance 08/01/24	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct 1 of 3 fire drills for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all visitors, staff and residents. Findings include: Based on records review with the Director of Plant Operations and Senior Director of Plant Operations on 07/30/24 from 9:30 a.m. to 12:13 p.m., there was no documentation for a fire drill conducted on second shift of the fourth quarter of	K 0712		08/01/2024

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	2023. Based on interview, the Senior Director of Plant Operations stated two third shift drills were conducted in the fourth quarter of 2023 and no second shift drill was conducted. This finding was reviewed with the Executive Director, Senior Director of Plant Operations and Director of Plant Operations at the exit conference. 3.1-19(b) 3.1-51(c)			
K 0781 SS=D Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on record review, observation, and interview; the facility failed to enforce the portable space heater policy to ensure heaters were inspected and did not exceed 212 degrees for 1 of 1 portable space heaters used in staff areas. This deficient practice could affect staff in the 300 Hall nurse station restroom. Findings include: Based on records review with the Director of Plant Operations on 07/30/24 at 2:10 p.m., the space heater policy permits space heaters not exceeding 212 degrees in non-patient care or non-patient treatment areas. Based on observation at 1:25 p.m., an unplugged space heater was under the sink in the staff restroom by the 300 Hall nurse station. There was no affixed label on the portable	K 0781	K - 781- Portable Space Heaters Immediate Intervention The Director of Plant Operations immediately threw the space heater away. DPO did a search of the entire campus to see if there were more space heaters in the building. DPO was trained by the Executive Director that space heaters are not allowed in the facility. The Director of Plant Operations will audit the building one time per week for foru weeks for one month	08/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155772	A. BUILDING 01 B. WING	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COBBLESTONE CROSSINGS HEALTH CAMPUS	1850 E HOWARD WAYNE DR TERRE HAUTE, IN 47802

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	space heater ensuring the heater does not exceed 212 degrees. Based on interview at the time of observation and records review, the Director of Plant Operations stated space heaters are allowed in staff areas per policy and confirmed the portable space heater in the restroom did not indicate if the heating element does not exceed 212 degrees and removed the space heater from the restroom. The finding was reviewed with the Executive Director, Senior Director of Plant Operations and Director of Plant Operations during the exit conference. 3.1-19(b)		for space heaters. Results of the audit will be presented by the Executive Director to the QAPI committee for further recommendations and continue until the Quality Assurance Team determines substantial compliance has been achieved. Compliance Date 08/01/2024	
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 wiring of a structure. Extension cords used			

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	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 power strips 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. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect at least four residents and staff in the therapy room. Findings include: Based on observation with the Director of Plant	K 0920	**K 920** Electrical Equipment – Power cords and Extension cords **Immediate Intervention** The Director of Plant Operations removed the radio from the unapproved power strip and removed the unapproved power strip. Director of plant operations was educated by the executive director on K920 NFPA101 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 UL60601-1. 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. The Director of Plant Operations and Executive Director will verify non approved devices are not in use once per week X 3 months followed by once per month X 3. The Executive Director will present the results of visual inspection through the QAPI committee for further recommendations and will continue until QAPI team	08/01/2024

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	Operations and Senior Director of Plant Operations during a tour of the facility from 12:13 p.m. to 2:05 p.m. on 07/30/24, a radio was plugged into and powered by a power strip sitting on a counter in therapy within four feet of the resident treatment area. The UL listing of the power strip could not be determined. Based on interview at the time of the observation, the Director of Plant Operations agreed a power strip was being used in the patient care vicinity for non-PCREE and as a substitute for fixed wiring at the aforementioned location in the facility and removed the power strip. This finding was reviewed with the Executive Director, Senior Director of Plant Operations and Director of Plant Operations during the exit conference. 3.1-19(b)		determines substantial compliance has been achieved. This deficient practice could affect at least four residents and staff in the therapy room. Compliance Date 08/01/24	