STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING -- B. WING	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF INDIANAPOLIS	45 BEACHWAY DR INDIANAPOLIS, IN 46224

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/30/24 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Emergency Preparedness survey, Envive of Indianapolis was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 184 certified beds. At the time of the survey, the census was 96. Quality Review completed on 02/05/24 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted January 30, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 29, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gregory Otter	Executive Director	02/17/2024

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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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: a. based on review of "Emergency Generator Weekly Load Test" documentation with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, weekly emergency generator inspection documentation for January, February and March 2023 was not available for review. Based on interview at the time of record review, the Corporate Maintenance Director stated the facility has one diesel fired emergency generator and agreed weekly emergency generator inspection documentation for January, February and March 2023 was not available for review. b. based on review of "Emergency Generator Weekly Load Test" documentation with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, load testing documentation for January, February and March 2023 was not available for review. In addition, load testing documentation for load	E 0041	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *a.* Weekly and monthly generator inspections have been added to the Tels workorder system for on time reminders and documentation requirements *b.* The Director of Maintenance called Evapar and had them preform the Load bank. *c.* Evapar has preformed a fuel sample. *d.* Evapar has changed the batteries. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect all residents, staff, and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on E 041 The Generator is required to be inspected weekly and documented, Monthly load	02/29/2024

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	tests conducted weekly for the period of 04/05/23 through 01/17/24 did not indicate the actual load percentage achieved for the diesel powered generator during the test. Based on interview at the time of record review, the Corporate Maintenance Director stated the facility has one diesel fired emergency generator, load testing is documented on a weekly basis, the generator is oversized, and the facility acknowledges load testing cannot achieve at least 30 % of the name plate rating so they do not record the load percentage for each load test. The Corporate Maintenance Director stated an annual load bank test is performed but agreed supplemental load bank testing documentation for the most recent twelve month period was not available for review. c. based on review of "Fuel Analysis Report" documentation dated 12/19/22 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Corporate Maintenance Director stated the facility has one diesel fired emergency generator and agreed documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator within the most recent twelve month period was not available for review at the time of the survey. d. based on review of the emergency generator inspection contractor's "Generator Maintenance Report" documentation dated 11/21/23 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, the		test documented, along with fuel sampling yearly to ensure it will work in an emergency. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly X6. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

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	emergency generator batteries need to be replaced. The "Comments/Remarks" section of the 11/21/23 report stated, "batteries failed load test and need replaced (dated 2018)". Based on interview at time of the observations, the Maintenance Director and the Corporate Maintenance Director stated the emergency generator is tested weekly and will operate, the batteries are scheduled to be replaced on 02/05/23 but agreed emergency generator battery replacement documentation on or after 11/21/23 was not available for review. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property. The manufacturer's name plate affixed to the generator indicated it was rated at 600 kW. Documentation affixed to each of the two starting batteries indicated they were manufactured in October 2018. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference.			
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: 01/30/24	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and	

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	Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 At this Life Safety Code survey, Envive of Indianapolis 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 III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridor and in rooms 11 through 19 in the C Wing. The facility has battery operated smoke detectors in all other resident sleeping rooms. The facility has a capacity of 184 and had a census of 96 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has four detached buildings providing storage services and one detached building housing an emergency generator which were each not sprinklered. Quality Review completed on 02/05/24		executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted January 30, 2024. Please accept this Plan of Correction as the provider's credible allegation of compliance as of February 29, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included			

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	on Form CMS-2567. Based on observation and interview, the facility failed to ensure fire resistance rating labels on 1 of 12 cross corridor door sets were not painted. In addition, the facility failed to ensure 2 of 12 cross corridor door sets would self close and latch into the door frame per 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the south door in the cross corridor door set in the A Wing by Room 10 was not equipped with a fire resistance rating label. The north door in the cross corridor door set was equipped with a 3-hour fire resistance rating label. Each door in the cross corridor door set in the B Wing was equipped with a 3-hour fire resistance rating label and latching hardware to latch each door into the door frame but the door set failed to latch into the door frame when tested to close multiple times. In addition, the north door in the cross corridor door set in the D Wing by Room D8 was equipped with a 3-hour fire resistance rating label and latching hardware to latch the door into the door frame but the door failed to latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed the doors in the aforementioned cross corridor door sets would not fully self close and latch into the door frame when tested to close or were not equipped with a fire resistance rating label.	K 0100	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance repaired has repaired the doors to latch when closed. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 residents, staff, and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K100. All smoke and fire doors shall shut and latch on their own power to prevent smoke and fire from spreading. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive	02/29/2024

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	These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		Director to the QAPI committee for further recommendations.	
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 1. Based on observation and interview, the facility failed to ensure 2 of 7 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 40 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 8:50 a.m. to 9:05 a.m. on 01/30/24, a wheeled wheelchair weigh scale was stored in the A Wing corridor near Room A1. The weigh scale projected four feet into the eight foot wide corridor. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the wheeled wheelchair weigh scale was still stored in	K 0211	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *1.* The Director of Maintenance has removed all furniture/ obstructions to allow egress *2. All key knobs were removed from resident rooms* **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 40 residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to**	02/29/2024

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	the A Wing corridor near Room A1. In addition, furniture was stored in the east exit vestibule of the C Wing which interfered with exit access. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned means of egress were not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure corridor doors to 2 of over 60 resident sleeping rooms were not provided with a lock on the door which required a key to unlock from the corridor. This deficient practice could affect four residents and staff. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the corridor door to resident sleeping Room C20 and D15 was equipped with a lock on the door handle which required a key to unlock from the corridor side of the door. The door lock had a twist mechanism to unlock the door on the room side of the door. The exit from the room could also be through a shared restroom with the adjoining resident sleeping room. Based on interview at the time of the observations, the Corporate Maintenance Director stated the rooms were recently renovated, the rooms were probably		**ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K211 maintaining a clear path of egress for emergency evacuation purposes. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

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	used for renovation supplies and the contractor probably has the key to unlock the door, the contractor forgot to change out the lock and agreed the aforementioned means of egress were not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of			

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

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	155077	A. BUILDING 01 B. WING	01/30/2024

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	Based on observation and interview, the facility failed to ensure the means of egress through 2 of 10 doors was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. LSC Section 7.2.1.5.3 states locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the corridor door set in the C Wing by Room C2 was equipped with magnetic locking devices to keep the doors closed when the door set was in the fully closed position. The door set could be released to open by entering a code at the keypad by Room C2 but the code was not posted at the keypad. The corridor door set at the entrance to the D Wing from the center lobby was also equipped with magnetic locking devices when the door set was in the fully closed position. The door set could be released to open by entering a code at the keypad but the code was not posted. Based on interview at the time of the observations, the Corporate Maintenance Director stated the D Wing houses residents with the clinical diagnosis to be in a secure but agreed the code to release the door set to open by the entrance to the D Wing and at the C Wing exit by Room C2.	K 0222	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Maintenance Director has placed the code next to each keypad **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 resident, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K222 maintaining the posting of the code at each keypad required to allow egress in the event of an emergency **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	02/29/2024

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	These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) 1. Based on observation and interview; the facility failed to install exit signage in 1 of 5 wings in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 states exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the entrance to the D Wing at	K 0293	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *1*. The Director of Maintenance replaced the missing exit signage. *2*. Not an exit signage placed on proper door. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 residents, staff, and visitors. **3: What measures will be put into place or what systemic changes will be made to**	02/29/2024

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	the corridor door set by Room D3 was not marked as a facility exit with an exit sign. Based on interview at the time of the observations, the Corporate Maintenance Director stated the D Wing had recently been renovated, the exit sign may not have been put back in place after the renovation and agreed the path of egress was not obvious with the corridor door set closed. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 doors to the outside of the facility in the D Wing Activities Room was not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8th's inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 5 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the exit door to the courtyard in the D Wing Activities Room was not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observations, the		**ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K293. The requirments of exit signage along with the importance of marking No exit doors. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

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	Maintenance Director and the Corporate Maintenance Director stated the door to the courtyard is not an exit to the public way and agreed the aforementioned door to the courtyard did not have a NO EXIT sign posted. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)			
K 0321 SS=E 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 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			

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	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 4 of over 15 hazardous areas such as combustible storage rooms/spaces (over 50 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the main dining room was being utilized for storage of combustible materials and was open to the corridor. Combustible supplies were stored on over 10 wooden pallets in the room along with furniture and supplies stockpiled from areas being renovated in the facility. In addition, panels installed on the ceiling of the B Wing combustible supply storage room for a water leak repair had become partially detached which exposed the attic above. Resident sleeping rooms B19 and D1 had been converted to combustible supply storage rooms as part of the facility renovation. The corridor door to each of the two rooms was not equipped with a self closing or automatic closing device. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed the aforementioned hazardous areas were	K 0321	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has had the dining room emptied of all construction/combustible materials. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 residents, staff, and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K321. Hazardous areas such as combustible storage rooms/spaces (over 50 square feet) must be separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing.	02/29/2024

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	not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	
K 0324 SS=D 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 and interview, the facility failed to ensure 1 of 1 kitchen fire suppression systems was inspected semiannually. NFPA 96,	K 0324	**1: What corrective action(s) will be accomplished for those residents found to have been**	02/29/2024

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	2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices, hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect over two staff and visitors in the kitchen. Findings include: Based on review of the kitchen range hood fire suppression system inspection contractor's "Kitchen Fire Suppression Report"" documentation dated 05/23/23 and 01/05/24 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, it was greater than seven months in between semiannual kitchen exhaust system inspections conducted within the most recent twelve month period. Based on interview at the time of record review, the Maintenance Director and the Corporate Maintenance Director agreed it was greater than seven months in between semiannual kitchen exhaust system inspections conducted within the most recent twelve month period. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		**affected by the deficient practice?** The Director of Maintenance has contacted Elwood fire protection and scheduled future timely inspections **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 2 residents, staff, and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K324. Kitchen hood suppression systems are to be inspected semiannually to ensure safety and proper operations **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

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K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 8:50 a.m. to 9:05 a.m. on 01/30/24, the main fire alarm control panel for the facility in the Maintenance Office was in the trouble mode and was silenced. Based on interview at the time of the initial walk through, the Maintenance Director stated dust from the contractor's current renovation of the facility was setting off the fire alarm system regularly. In addition, the main water line for the facility, which is off the property, is scheduled to be shut down for repairs today and so the fire alarm system was put on the test	K 0345	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *1.* The Director of Maintenance has called Elwood Fire Protection to clear the trouble from the panel and ensure normal operations. *2.* Elwood has inspected the missed smoke dectors in rooms C11 to C 19 *3.* Elwood has preformed a sensivity test on smoke dectors in rooms C11 to C 19 **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect all residents, staff, and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	02/29/2024

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	mode and silenced but he did not know why the system trouble light was illuminated. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the main fire alarm control panel for the facility was still in the trouble mode and was silenced. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director stated the fire alarm is operable and would function but the facility is working with the fire alarm system monitoring company to determine why the panel is in the trouble mode. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Table 14.4.5 at 15.(h) states fire alarm system smoke detectors shall be functional tested annually. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect over 20 residents, staff and visitors in the C Wing.		The Director of Maintenance has been educated by the Executive Director on K345 Fire Alarm must be in proper working order, proper time and no trouble or faults indicated. All smoke dectors are required to be inspected per code. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. To ensure correct information on fire panel display. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

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	Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Report" documentation dated 01/05/24 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, smoke detector testing documentation within the most recent twelve month period for smoke detectors installed in resident sleeping rooms C11 through C19 was not available for review. The 01/05/24 testing documentation did include six areas in the C Wing but it did not include the resident sleeping rooms. Based on interview at the time of record review, the Corporate Maintenance Director stated the facility is undergoing renovation, the contractor may not have tested the C Wing resident sleeping room smoke detectors because of the renovation but agreed other fire alarm system smoke detectors in the C Wing were tested on 01/05/24 and agreed annual testing documentation for fire alarm system smoke detectors installed in resident sleeping rooms C11 through C19 within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the C Wing is currently occupied by residents. Fire alarm system smoke detectors are installed in resident sleeping rooms C11 through C19. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)			

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	3. Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect over 20 residents, staff and visitors in the C Wing. Findings include: Based on review of the fire alarm system inspection contractor's "Fire Alarm Report" documentation dated 10/17/23 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, smoke detector sensitivity testing documentation for smoke detectors installed in resident sleeping rooms C11 through C19 was not available for review. The 10/17/23 sensitivity testing documentation did include six areas in the C Wing but it did not include the resident sleeping rooms. Based on interview at the time of record review,			

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	the Corporate Maintenance Director stated the facility is undergoing renovation, the contractor may not have sensitivity tested the C Wing resident sleeping room smoke detectors because of the renovation but agreed other fire alarm system smoke detectors in the C Wing were sensitivity tested on 10/17/23 and agreed sensitivity testing documentation for fire alarm system smoke detectors installed in resident sleeping rooms C11 through C19 within the most recent two year period was not available for review. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the C Wing is currently occupied by residents. Fire alarm system smoke detectors are installed in resident sleeping rooms C11 through C19. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the 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			

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	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, observation and interview; the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 1 of 4 quarters. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition. NFPA 25, Section 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, Section 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. NFPA 25, Section 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. NFPA, 25 Section 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. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler System Test Report" documentation dated 05/25/23, 08/03/23 and 01/05/24 with the Executive Director, the Maintenance Director and the Corporate	K 0353	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *1*. The Director of Maintenance has contacted Elwood fire protection and scheduled future timely compliant inspections 2. All ceiling holes have been repaired and all missing tiles were replaced. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect all residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K353. Sprinkler inspections must be conducted quarterly and documented. All ceiling penetrations must be sealed to prevent the passage of smoke and fire. **4: How the corrective action**	02/29/2024

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	Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, no fourth quarter (October, November, and December) 2023 sprinkler system inspection report documentation was available for review. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the sprinkler system inspection contractor had affixed a hanging tag to the facility's two dry sprinkler system risers located in the Laundry Room indicating fourth quarter 2023 water flow alarm inspection and testing was performed by the contractor on 12/18/23. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed it had been more than 90 days in between quarterly sprinkler system inspection and testing on 08/03/23 and 12/18/23. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ceiling smoke barriers. 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 deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 20 residents,		**will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

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	staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the following was noted in the ceiling smoke barrier: a. numerous suspended ceiling tiles were missing in the main dining room. b. two suspended ceiling tiles were missing in the dietary office in the kitchen. c. the attic access panel was not in place in the B Wing short hall water heater room. In addition, there were numerous gaps in between drywall panels installed on the ceiling in the room which exposed the attic above. d. panels installed on the ceiling of the B Wing storage room for a water leak repair had become partially detached which exposed the attic above. e. a three inch in diameter hole was noted in the ceiling of the room open to the corridor near the C Wing exit door vestibule where a former smoke detector had been installed. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed the aforementioned openings in the ceiling did not maintain ceiling construction. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)			
K 0363 SS=E	NFPA 101 Corridor - Doors			

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Bldg. 01	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 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			

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	devices, etc. Based on observation and interview, the facility failed to ensure 2 of over 60 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the latching plate and latching mechanism on the corridor door to resident sleeping Room C22 was loose and partially detached from the door which prevented the door from fully closing and latching into the door frame when tested to close multiple times. In addition, a circular gap was noted around the door handle for the corridor door to the D Wing Housekeeping Employees room which would not resist the passage of smoke. Based on interview at the time of the observations's, the Corporate Maintenance Director agreed the corridor door to resident Room C22 had an impediment to closing and latching into the door frame and each of the two doors would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has repaired this door. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K363 fire doors must shut and latch to prevent smoke and fire from spreading. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	02/29/2024
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 01	Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 2 of 12 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 40 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the cross corridor door set in the B Wing short hall and in the D Wing by Room D17 each swing to close in the same direction and were equipped with a door closing coordinator but the coordinator did not function properly which caused the door in the door set with the astragal to remain propped open against the	K 0374	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has replaced the door coordinator and the door now shuts properly **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could over 40 residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K374 All fire and smoke doors must close fully to	02/29/2024

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	coordinator and caused a gap of greater than 1/8 inch when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed the aforementioned cross corridor smoke barrier door sets did not fully close when tested to close multiple times and would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		prevent smoke and fire from spreading. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6.This audit will be placed into the Tels system for scheduled reminders and documentation. `Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	
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 Based on observation and interview, the facility failed to ensure 3 of over 100 electrical fixtures were protected in accordance with LSC 19.5.1.1. NFPA 70, National Electric Code, 2011 Edition, Article 406.5, states receptacles shall be enclosed so that live wiring terminals are not exposed to contact. 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. This deficient practice could affect over 10 residents, staff and visitors.	K 0511	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has replaced the broken GFCI outlet and replaced missing outlet covers. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what**	02/29/2024

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	Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, one of the two wall mounted electrical outlet boxes in the C Wing nurse's station pantry was cracked and chipped which exposed the internal parts of the outlet. The cover plate was also missing for the wall mounted outlet box near the head of the resident bed in Room D3. In addition, the cover plate for the wall mounted light switch inside resident sleeping room D21 by the corridor door was missing. The resident sleeping rooms in the C Wing and D Wing were occupied by residents. Based on interview at the time of the observations, the Corporate Maintenance Director stated the two resident rooms had been recently renovated, the contractors failed to reinstall the cover plates and agreed the aforementioned three electrical fixtures were exposed and not protected. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		**corrective action will be taken.** This deficient practice could affect all residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K511 all electrical fixtures must be protected in accordance with LSC 19.5.1.1. to prevent accidental access. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	
K 0712 SS=C 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			

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	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 1. Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on the first shift for 3 of 4 quarters. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, first shift fire drills conducted within the most recent twelve month period on 04/07/23, 07/28/23 and 10/11/23 were conducted at, respectively, 8:30 a.m., 8:00 a.m. and 8:00 a.m. Based on interview at the time of record review, the Maintenance Director and the Corporate Maintenance Director stated the facility operates three shifts per day and agreed the aforementioned first shift fire drills were not conducted at unexpected times under varying conditions. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) and 3.1-51(c) 2. Based on record review and interview, the facility failed to document all staff who participated in quarterly fire drills on the third shift	K 0712	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *1*. The Director of Maintenance has scheduled random times for future drills. *2*. Moving forward the director of maintenance will have partisapants sign the back of the actual drill sheet. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect all residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K712 fire drill must be random and unannounced. All participants must sign to document the were trained **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?**	02/29/2024

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	for 1 of 4 quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. LSC Section 19.7.1.8 states employees of health care occupancies shall be instructed in life safety procedures and devices. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Drill Report" documentation with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, documentation for the third shift fire drill conducted at 3:00 a.m. on 03/20/23 did not include the staff who participated in the fire drill. Based on interview at the time of record review, the Maintenance Director and the Corporate Maintenance Director stated the facility operates three shifts per day and agreed documentation for the aforementioned third shift fire drill did not include all staff who participated in the fire drill. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) and 3.1-51(c)		The Director of Maintenance will perform monthly review X6. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable			

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	liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on record review, observation and interview; the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 2 of 2 outdoor areas where smoking was taking place. This deficient practice could affect over 5 residents, staff and visitors. Findings include: Based on review of smoking policy documentation with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from	K 0741	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has cleaned up the cigarette butts in both areas. Ashtray and metal closing can will be in each smoking location. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect	02/29/2024

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	9:10 a.m. to 12:45 p.m. on 01/30/24, assessed residents and staff are allowed to smoke in designated outdoor smoking areas. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, over 20 cigarette butts were strewn on the ground outside the facility by the D Wing Activity Room. Cigarette butts were also deposited into a flower pot which contained combustible trash outside the D Wing Activity Room. In addition, over 20 cigarette butts were strewn on the ground outside the staff breakroom exit door near the outdoor resident smoking area outside the facility by the main dining room exit door. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed cigarette butts were deposited on the ground at the aforementioned two locations and were not consistently deposited into the ashtrays and metal containers with self-closing cover devices which were provided at these two outdoor location where smoking was taking place. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		over 5 residents, staff and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K741 We must ensure smoking materials are deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform weekly review X8. This audit will be placed into the Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container			

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	capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7			
	Based on observation and interview, the facility failed to ensure unattended trash receptacles stored in 1 of 7 means of egress were stored in a room protected as a hazardous area in accordance with Section 19.7.5.7. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of resident sleeping Room C22. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, two separate unattended 20 gallon capacity receptacles were partially filled with trash and were stored next to one another in the corridor outside Room C22. The combined capacity of the receptacles exceeded 32 gallons. Based on interview at the time of the observations, the Maintenance Director stated the trash receptacles are stored in the corridor and agreed the aforementioned receptacles were not being stored in a room protected as a hazardous area when unattended. These findings were reviewed with the Executive	K 0754	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance removed the trash containers from the hall. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 residents, staff and visitors **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K754 Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be	02/29/2024

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	Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		located in a room protected as a hazardous area when not attended. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform weekly review X8. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	
K 0791 SS=F Bldg. 01	NFPA 101 Construction, Repair, and Improvement Operati Construction, Repair, and Improvement Operations Construction, repair, and improvement operations shall comply with 4.6.10. Any means of egress in any area undergoing construction, repair, or improvements shall be inspected daily to ensure its ability to be used instantly in case of emergency and compliance with NFPA 241. 18.7.9, 19.7.9, 4.6.10, 7.1.10.1 Based on observation and interview, the facility failed to ensure the means of egress in adjoining construction, repair and improvement operations comply with LSC 19.7.9.1. LSC Section 19.7.9.1 states construction, repair, and improvement operations shall comply with 4.6.10. LSC Section 19.7.9.2 states the means of egress in any area undergoing construction, repair, or improvements shall be inspected daily for compliance with	K 0791	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance will check and document for clear egress in construction areas while construction is taking place.	02/29/2024

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	7.1.10.1 and shall also comply with NFPA 241, Standard for Safeguarding Construction, Alteration, and Demolition Operations. LSC Section 4.6.10.1 states buildings, or portions of buildings, shall be permitted to be occupied during construction, repair, alterations, or additions only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternative life safety measures acceptable to the authority having jurisdiction are in place. LSC Section 7.1.10.1 states the means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the A Wing was currently undergoing facility renovation. The B Wing, C Wing and D Wing renovations were mostly completed. All wings were marked as an exit with an exit sign. Based on interview at the time of the observations, the Executive Director stated facility renovations began in the Spring of 2023. Based on interview at the time of the observations, the Corporate Maintenance Director stated the facility might have daily egress check documentation in Direct Supply TELS but it was not available for review at the time of the survey. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit		**2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 residents, staff and visitors **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K791. We must ensure the means of egress in adjoining construction, repair and improvement operations comply with state regulations **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform weekly review X8. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

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	conference. 3.1-19(b)			
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 1 of 1 D Wing electrical rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect over 20 residents, staff and visitors in the D Wing. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director	K 0911	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance will cleared the areas in front of all breaker panels. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 residents, staff and visitors **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K911. We must clear unobstructed access to breaker panels at all times.	02/29/2024

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	during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, picture frames were stored under two wall mounted electrical panels in the Electrical Panel Location room in the D Wing. The flooring underneath the electrical panels was painted to indicate no storage should be in the working space under and in front of the panels but the items were stored in the painted area working space. Based on interview at the time of the observations, the Corporate Maintenance Director stated the D Wing had been recently renovated and agreed picture frames were stored within three feet of the working space in front of electrical panels in the D Wing Electrical Panel Location room. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly review X6. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	
K 0914 SS=E Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which			

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	activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles that failed annual testing in 3 of over 60 resident rooms were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles, whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 6 residents and staff. Findings include: Based on review of "Receptacle Tests - Annual" documentation dated 10/01/23 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, electrical receptacles in resident sleeping Room	K 0914	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Maintenance has replaced the mentioned receptacles with hospital grade. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 6 residents, staff and visitors **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K914 When changing out receptacles in resident areas, it is required to use hospital grade receptacle. **4: How the corrective action will be monitored to ensure the deficient practice will not recur**	02/29/2024

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	B1, B4 and B8 failed annual testing and were replaced. Based on interview at the time of record review, the Maintenance Director stated the electrical receptacles which failed 10/01/23 were replaced but he could not ensure that they were replaced with hospital-grade receptacles. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, all electrical receptacle locations in resident sleeping rooms B1, B4 and B8 were not hospital-grade. Based on interview at the time of the observations, the Corporate Maintenance Director agreed the receptacle locations in the three resident sleeping rooms were not hospital-grade. These findings were not reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		**i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform an annual outlet audit and replace with hospital grade receptacles moving forward. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	
K 0918 SS=F 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 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			

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	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)			
	1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 12 weeks of the most recent 52 week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, Section 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors.	K 0918	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** *1.*The Director of Maintenance documented all weekly inspections since that date and is not in the Tels system weekly. *2.*The Director of Maintenance called Evapar and had them preform the Load bank. *3.* Evapar has preformed a fuel sample 4. Evapar has changed the batteries. **2: How other residents having the potential to be affected by**	02/29/2024

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	Findings include: Based on review of "Emergency Generator Weekly Load Test" documentation with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, weekly emergency generator inspection documentation for January, February and March 2023 was not available for review. Based on interview at the time of record review, the Corporate Maintenance Director stated the facility has one diesel fired emergency generator and agreed weekly emergency generator inspection documentation for January, February and March 2023 was not available for review. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to exercise the generator for 12 of 12 months and failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. NFPA 110, Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating.		**the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect all residents, staff, and visitors. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on K918 The Generator is required to be inspected weekly and documented, Monthly load test documented, along with fuel sampling yearly to ensure it will work in an emergency. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly X6. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations.	

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	Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator Weekly Load Test" documentation with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, load testing documentation for January, February and March 2023 was not available for review. In addition, load testing documentation for load tests conducted weekly for the period of 04/05/23 through 01/17/24 did not indicate the actual load percentage achieved for the diesel powered generator during the test. Based on interview at the time of record review, the Corporate Maintenance Director stated the facility has one diesel fired emergency generator, load testing is documented on a weekly basis, the generator is oversized and the facility acknowledges load testing cannot achieve at least 30 % of the name plate rating so they do not record the load percentage for each load test. The Corporate Maintenance Director stated an annual load bank test is performed but agreed supplemental load bank testing documentation for the most recent twelve month period was not available for review. Based on observations with the Maintenance			

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	Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property. The manufacturer's name plate affixed to the generator indicated it was rated at 600 kW. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to ensure an annual fuel quality test was performed for the facility's diesel fuel fired emergency 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 NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. 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, staff and visitors. Findings include: Based on review of "Fuel Analysis Report" documentation dated 12/19/22 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, documentation of an annual fuel quality test for			

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	the facility's diesel fuel fired emergency generator within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Corporate Maintenance Director stated the facility has one diesel fired emergency generator and agreed documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator within the most recent twelve month period was not available for review at the time of the survey. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property. The manufacturer's name plate affixed to the generator indicated it was rated at 600 kW. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b) 4. Based record review, observation and interview; the facility failed to ensure 1 of 1 emergency generators was kept in reliable operating mode in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Section 8.3.1 states the Emergency Power Supply Systems (EPSS) shall be maintained to ensure that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. This deficiency could affect all residents, staff and visitors. Findings include:			

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	Based on review of the emergency generator inspection contractor's "Generator Maintenance Report" documentation dated 11/21/23 with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during record review from 9:10 a.m. to 12:45 p.m. on 01/30/24, the emergency generator batteries need to be replaced. The "Comments/Remarks" section of the 11/21/23 report stated "batteries failed load test and need replaced (dated 2018)". Based on interview at time of the observations, the Maintenance Director and the Corporate Maintenance Director stated the emergency generator is tested weekly and will operate, the batteries are scheduled to be replaced on 02/05/23 but agreed emergency generator battery replacement documentation on or after 11/21/23 was not available for review. Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, the facility has one diesel fired emergency generator located outside the building on the northeast side of the property. Documentation affixed to each of the two starting batteries indicated they were manufactured in October 2018. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)			
K 9999 Bldg. 01	State Findings	K 9999	**1: What corrective action(s) will**	02/29/2024

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	3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(a) The facility must be designed, constructed, equipped and maintained to protect the health and safety of residents, personnel, and the public. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to provide smoke detectors in 2 of over 60 resident sleeping rooms. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Maintenance Director during a tour of the facility from 1:10 p.m. to 3:50 p.m. on 01/30/24, all resident sleeping rooms were equipped with a smoke detector except resident sleeping Room B22 and D9. The facility was currently being renovated but resident rooms B22 and D9 were occupied by residents. Based on interview at the time of the observations, the Maintenance Director and the Corporate Maintenance Director agreed resident sleeping Room B22 and D9 were not provided with a smoke detector. These findings were reviewed with the Executive Director, the Maintenance Director and the Corporate Maintenance Director during the exit conference. 3.1-19(b)		**be accomplished for those residents found to have been affected by the deficient practice?** The Maintenance Director has installed/reinstalled any/all smoke detectors in all resident rooms. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** This deficient practice could affect over 20 residents, staff and visitors **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The Director of Maintenance has been educated by the Executive Director on the requirement to maintain any/all in-room safety designed equipment designed to protect the health and safety of residents. Personnel and the public. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** The Director of Maintenance will perform monthly X6 audits or resident rooms. This audit will be placed into the Tels system for scheduled reminders and documentation. Results of these reviews will be presented by the Executive	

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			Director to the QAPI committee for further recommendations.	