STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155486	A. BUILDING -- B. WING	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/14/22 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600 At this Emergency Preparedness survey, Middletown Nursing and Rehabilitation Center was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 45 certified beds. At the time of the survey, the census was 11. Quality Review completed on 09/20/22	E 0000	This plan of correction is submitted to serve as a credible allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
E 0041 SS=C 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. The [LTC facility and the CAH] must implement emergency and standby power			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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	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. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013.			

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	(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 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 occupants. Findings include: Based on records review and interview with the Environmental Specialist and Administrator on 09/14/22 between 10:15 a.m. and 12:45 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test. This was confirmed by the Environmental Specialist, who stated he was unaware of the requirement. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m.	E 0041	**Tag E 041** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** All residents have the potential to be affected in the event that emergency power is not operating or operating correctly. Middletown Nursing and Rehabilitation runs an annual load bank to ensure the generator can tolerate the stress of the entire building and then some. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** Every 3 years Middletown Nursing will ensure that a 4 hour load bank test in conducted to ensure the generator can operate for a longer period of time in the event it is needed. Buckeye Power is due to come out and run a 1 hour load bank, so we will have to run the 4 hour test as well. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES**	12/14/2022

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			NOT RECUR: The 3 year/4 hour test will be added to the Environmental Specialist's generator testing requirements. The annual load and 4 hour test is scheduled to be completed February 2023. The Environmental Specialist and Administrator will continue to meet monthly to discuss any tests that need completed or scheduled. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** When a 3 year/4 hour load bank test is coming due, it will be discussed during the Facility's QA at least 3 months prior to date of test. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** The 4 hour load bank has been scheduled and will be completed by December 14, 2022 by Buckeye Power. The facility respectfully requests paper compliance for Tag E041.	
K 0000 Bldg. 02	A Life Safety Code Recertification and Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	This plan of correction is submitted to serve as a credible allegation of compliance in association with stated completion	

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	Survey Date: 09/14/22 Facility Number: 000343 Provider Number: 155486 AIM Number: 100289600 At this Life Safety Code survey, Middletown Nursing and Rehabilitation Center 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 facility consisted of the south wing, a one-story wing determined to be of Type V (111) construction and fully sprinkled, and the north wing, a one story wing determined to be Type II (222) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, battery operated smoke detectors in the twelve resident rooms on the North Wing (Old Hall), and hard-wired smoke detectors in the fifteen resident rooms on the South Wing (New Hall) which are electrically wired to an audible signal at the nurses' station. The facility has a capacity of 45 and had a census of 11 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 09/20/22		dates. Preparation and/or execution of this plan of correction does not constitute an admission or agreement, the provider of conclusion set facts on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state and federal law.	
K 0222 SS=E Bldg. 02	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not			

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	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 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			

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	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			
	Based on observation and interview, the facility failed to ensure 3 of 8 exit doors within the means of egress through the new addition 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. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect the current census of 11 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and	K 0222	**Tag K222** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** All residents could be affected in the event of an emergency that requires evacuation if the doors are unable to be opened. In the event of an evacuation all resident, staff and visitors must be able to open the doors even if they are locked doors. Doors must be able after 15 seconds and/or if a keypad is present the code must be accessible. Middletown Nursing and Rehab will ensure all keypads have the code visible in	10/01/2022

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	Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., the following exit doors, marked as a facility exits, were magnetically locked and could be opened by entering a four digit code but the code was not posted at the exits; 1. Two 36-inch exit doors in the new dining area. 2. The new 42-inch exit door leading to the front near the new dining addition. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)		the event of an emergency. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** The key code to all keypads will be made visible by making and label and posting above or on top of the keypads. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Environmental Specialist will create a label with the key code and post on top of or above all keypads to ensure that it is visible to all staff and visitors in the event that there is an evacuation and residents need to be removed. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During the next scheduled QAPI meeting, the posting of key codes will be discussed and ensured that it has been completed. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** The labels will completed by October 1, 2022.	

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			We respectfully request for paper compliance for Tag K222.	
K 0271 SS=E Bldg. 02	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7			
	Based on observation and interview, the facility failed to ensure 2 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 10 residents and staff using the New Dining Room. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., the exit discharge from the New Dining Room, had a large new concrete pad which terminated into a gravel alleyway, which led to a gravel parking lot. Where the concrete pad met the alleyway there was a 5-7 inch drop off not providing a level surface free of obstructions leading to the common way. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m.	K 0271	**Tag K 271** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** In the event that there is an evacuation of residents that requires the use of the two 36 inch door, the alleyway leading to the staff parking lot would be hazardous and difficult to push a resident in a wheelchair to safety. Middletown Nursing and Rehab plans to use asphalt or concrete to create a smooth pathway to the staff parking lot. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** All residents need to be safe during an evacuation, and have a smooth surface to a public area. All exit doors have a smooth	12/14/2022

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	3.1-19(b)		surface leading to a public area. Exit doors and their surfaces leading to a public area will be monitored quarterly to ensure no new cracks or rough areas that could be hazardous. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Environmental Specialist will monitor all surfaces to ensure safe passage to a public area in the event that there is an evacuation. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During quarterly QA meetings the Environmental Specialist will discuss any issues that present itself and needs immediate correction. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** We will plan to have this project completed by December 14, 2022. We respectfully request paper compliance for Tag K 271.	
K 0321 SS=E Bldg. 02	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire			

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	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 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 2 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 10 residents, as well as staff and visitors. Findings include:	K 0321	**Tag K 321** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Using a resident room, even empty, as a storage room can be very hazardous to all residents.	11/01/2022

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	Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., the following was noted: A) Room 116, greater than 50 square feet, contained a number of combustible storage items, such as, paper, chairs, beds and furniture. The corridor door to this room was not equipped with a self-closing device. B) Room 11, greater than 50 square feet, had at least 3 beds and 4 chairs and other combustible items. The room not equipped with a self-closing device or self-closing hinges. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)		Resident rooms should never be used as storage. The rooms will be cleared out and only specified items will be permitted in the resident rooms. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** If non-storage rooms are being used as storage, it takes away from new potential admissions, and in the event there is a fire the items in the room will only add to the flames. All staff and contract staff will be re-educated on using resident rooms as storage. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Environmental Specialist and Administrator will do random walk-thru's, and in the event an item is in a resident room that does not belong, it will be immediately thrown away. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During quarterly QA meetings the Environmental	

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			Specialist will notify of any items, if any, has had to be discarded. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Resident rooms turned into storage rooms will be cleared out by November 1. We respectfully request paper compliance for Tag K 321.	
K 0324 SS=E Bldg. 02	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			
	1. Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood system in 1 of 1 Kitchen. NFPA 96, 11.1.4 states instructions for manually operating the fire extinguishing system shall be	K 0324	**Tag K 324** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE**	12/14/2022

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	posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect staff in the kitchen and 25 residents in the dining room. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., the kitchen contained a UL 300 hood system and a K-class fire extinguisher with posted instructions. Based on interview, the Day Cook at the appliance was asked; what is the correct response if there was a grease fire underneath the hood. The employee replied, "throw flour on it." The employees failed to indicate activating the UL 300 hood extinguishing system and using the correct fire extinguisher for a hood grease fire. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 2. Based on observation and interview, the facility failed to maintain the roll up serving door from the cooking facility that serve 30 or more residents to ensure cooking facilities are protected and not open to the corridor/dining hall. This deficient practice affects 40 residents in the dining hall. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., the roll up serving door from the kitchen into the dining hall did not terminate on a counter or other hard surface. The aforementioned door		**DEFICIENT PRACTICE:** All residents have the potential to be affected in the event that there is a fire in the kitchen. All kitchen staff must be knowledgeable with putting out any type of kitchen fire; and all doors must seal appropriately to avoid smoke from seeping into other rooms. All kitchen staff will be re-educated on proper use of fire extinguishers and the overhead door will be sealed properly. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** If there is a kitchen fire and no kitchen staff know how to properly extinguish a fire it could potentially affect residents and staff. The kitchen staff will be re-educated by the dietary manager. The overhead door not sealing property could affect anyone in the adjoining area if smoke leaks thru the door. The door will be sealed properly. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** All staff in the kitchen will be re-educated and randomly questioned for the next 60 days by the Dietary Manager. The Environmental Specialist will	

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	hung free on the wall and had approximately a 4-inch gap near the bottom through which smoke could travel. The Environmental Specialist stated that he was unaware of plans to install counters near the roll up door. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)		add a stop for the overhead door to sit on when closed. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** The Administrator and Dietary Manager will ensure that all new staff and current staff are properly trained during hire and annual facility training. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** This deficiency will be completed by December 14, 2022. We respectfully request paper compliance for Tag K324.	
K 0341 SS=E Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8			

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	Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. 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, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., in the main lobby corridor there was a smoke detector located within 3 feet of an air supply where air flow would prevent proper operation of the detector. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)	K 0341	**Tag K341** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** All residents and staff have the potential of being affected by this deficiency if the smoke detectors are not working properly. If there is air flow pushing smoke away from the detector if may delay the detector and prevent a timely notification and evacuation. The smoke detector will have to be moved to prevent this from occurring. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** The Environmental Specialist will ensure that there are no other smoke detectors are within 3 feet of any airflow supply. If there is any new air supplies added within the facility, the Environmental Specialist will ensure there is enough space between the supply and smoke detector. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The smoke detector will be moved. Grunau is	12/14/2022

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			scheduled to be in the facility prior to January 1, 2023, so we will have them move the smoke detector. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** The Environmental Specialist will work with Grunau to ensure that any new smoke detectors installed are placed properly. If there is any more problems the Department Heads will discuss the issues with the Environmental Specialist during our quarterly QA meetings. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Granua is scheduled to be here October 17, 2022 and plan to correct deficiency. The deficiency will be corrected no later than December 14, 2022. We respectfully request paper compliance for Tag K341.	
K 0345 SS=C Bldg. 02	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			

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	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			
	Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: Based on records review and interview with the Environmental Specialist and Administrator on 09/14/22 between 10:15 a.m. and 12:45 p.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection conducted on 08/15/22. Based on interview at the time of records review, the Environmental Specialist stated a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection was not conducted.	K 0345	**Tag K 345** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** If the fire alarm is not working during an emergency it could affect all residents, staff and visitors within the building. Even though it is a smart system and the facility conducts monthly fire drills we understand the value of visually inspecting the alarm panel by professionals. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** The fire alarm system will be visually inspected by Granua when they are here for everything else. Granua is scheduled to be in the facility prior to January 1, 2023. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Environmental Specialist will set up biannual	12/14/2022

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	This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)		visual inspections with Granua to keep this deficiency from recurring. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During facility quarterly QA meetings the Environmental Specialist will inform everyone in the meeting if an inspection is coming up or has been missed due to Granua not showing up. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Granua is scheduled to be in the facility October 17, 2022, and plan to have deficiency corrected by December 14, 2022. We respectfully request paper compliance for Tag K 345.	
K 0353 SS=F Bldg. 02	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 and interview, the facility failed to maintain automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 5.3.1.1.1.6 states dry sprinklers that have been in service for 10 years shall be replaced or representative samples shall be tested and then retested at 10-year intervals. NFPA 25, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review and interview with the Environmental Specialist and Administrator on 09/14/22 between 10:15 a.m. and 12:45 p.m., deficiencies were noted for the facility's sprinkler system. The "Deficiencies Summary" section of	K 0353	**Tag K 353** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Sprinkler systems working improperly or at least not in proper order could affect residents in the event of a fire. Granua is scheduled to be in the facility by October 17, 2022 and they will inspect the sprinkler systems. Also, the sprinkler box will be order at the same time. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** The Environmental Specialist will inform and setup with Granua to inspect the sprinkler system every 10-15 years. During the inspection they will ensure all components of the sprinkler system is in place. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Administrator	12/14/2022

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the 08/15/2022 sprinkler system inspection report stated, "have all dry sprinklers known to be more than 10-15 years old been replaced or a sample tested? No sign or knowledge of replacement or sample tested." Based on interview at the time of record review, the Environmental Specialist stated the facility was unaware of the current status regarding this reported deficiency.

This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m.

3.1-19(b)

2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility.

Findings include:

and Environmental Specialist will work together to make sure these inspections are done on time.

HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Administrator and Environmental Specialist will meet bi-annually to ensure that all annual and extended inspections are being met.

BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED: The inspection will be completed October 17, 2022, and Granau will give us the results as soon as possible. We expect to have the deficiency completed by December 14, 2022.

We respectfully request paper compliance for Tag K 353.

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	Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., there was one spare sprinkler cabinet in the riser room that included 10 spare sprinklers which were not in their own protected slot. They were stored loose in the cabinet and not secured in holders. Based on interview at the time of the observation, the Environmental agreed the spare sprinkler cabinet had spare sprinklers not in protected slots and stated another box would be needed. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)			
K 0361 SS=E Bldg. 02	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1			
	Based on observation and interview, the facility failed to ensure 1 of 1 offices with a pass-through window greater than 20 square inches met the requirements of spaces open to the corridor. LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically	K 0361	**Tag K 361** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Middletown Nursing and Rehabilitation Center will have Granau add another smoke detector in the “copy room”.	12/14/2022

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MIDDLETOWN NURSING AND REHABILITATION CENTER	131 S 10TH ST MIDDLETOWN, IN 47356

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	supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. LCS 19.3.6.5.1 states miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20 inches squared (0.015 m2). (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficient practice could affect staff and up to 10 residents. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., the Copy Room had pass-through window was not protected by electrically supervised automatic smoke detection. Based on interview at the time of observation, the Environmental Specialist agreed the window was greater than 20 square inches and the copy room was not provided with electrically supervised automatic smoke detection. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)		**HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** This could affect residents in the event that a fire starts in the “copy room”, because there is nothing to detect the smoke. The fire could spread to other parts of the building without detecting smoke soon enough. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** When Granua comes into the Facility by October 17, 2022, and we will have them install another smoke detector in the “copy room”. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** The Administrator and Environmental Specialist will do a walk thru prior to Granau coming to the facility to make sure there is not anything extra we need to have them do. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Granua will be in the facility October 17, 2022, and	

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	155486	A. BUILDING 02 B. WING	09/14/2022

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			have deficiency completed no later than December 14, 2022. We respectfully request paper compliance for Tag K 361.	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by 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			

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	resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 7 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 8 residents. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m. the following was observed; (1) the corridor door to Room 116 had 2 holes approximately ½ inch each near the knob which penetrated completely through the door. (2) Resident Room # 7, 8, 9, 18, 19 did not close and latch positively into the door frame, the door panels were sagging and prohibiting the door from closing and latching. (3) The Snack Room, equipped with a self-closing device, failed to self-close and latch. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)	K 0363	**Tag K 363** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** The holes in the door of room 116 could potentially allow smoke to enter in the event of a fire and affect a resident possibly residing in the room. The panels on the doors have gradually slid down and fixed. Residents could be affected by the snack room in the event that there is a fire if the door had not latched properly. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** In the event that there is smoke in the building all doors must be properly sealed and closed to prevent smoke inhalation. The holes in the door will be filled in and repaired. The panels are being removed, so it does not prevent the doors from closing properly. The self-closing latch on the snack room door is	12/14/2022

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			be adjusted to close more easily. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** All staff will be permitted to notify the Environmental Specialist in the event they notice a door not working properly. These are all doors and rooms that nursing, housekeeping and dietary staff may enter and notice an issue. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During quarterly QA meetings if the staff notices any new issues, it will immediately be brought to the Environmental Specialist's attention if it has not already been done. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Room 116 will be completed by October 31, 2022; The panels will all be removed by December 14, 2022; and the snack room door will be fixed by October 31, 2022. We respectfully request paper compliance for Tag K 363.	
K 0374 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 02	Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. NFPA 101 2012 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch. This deficient practice could affect 10 residents in two smoke compartments Finding include: Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., the smoke barrier doors leading into the new dining room had a 1/3 inch gap between the doors when closed. Based on an interview at the time of observation, the Environmental Specialist agreed there was a gap larger than 1/8 inch between the smoke doors when closed.	K 0374	**Tag K 374** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Smoke leaking thru any fire door has to potential to affect residents residing in the facility. Middletown Nursing and Rehab will add a smoke barrier strip in between the fire doors. This will help prevent smoke inhalation in the event of a fire from either side of the smoke doors. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** If smoke is able to leak thru any fire door it of course could affect residents residing in	12/14/2022

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	This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)		the area. During fire drill the Environmental Specialist will continue to ensure fire doors close and seal properly when fire alarm is pulled. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Environmental Specialist will inspect all fire doors during our monthly drills and if there is an issue, he will coordinate with the Administrator and order any necessary parts, and/or contact a contractor if needed. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During our quarterly QA meetings we will discuss any ongoing issues including open surveys or potentially upcoming surveys and ensure everything is getting into working order. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** This deficiency will be completed by December 14, 2022. We respectfully request paper compliance for Tag K 374.	

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K 0918 SS=F Bldg. 02	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 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 an annual fuel quality test	K 0918	**Tag K 918** **WHAT CORRECTIVE ACTION(S)**	12/14/2022

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	was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review and interview with the Environmental Specialist and Administrator on 09/14/22 between 10:15 a.m. and 12:45 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. The facility has 1 generator, which is diesel-fired. Based on interview at the time of records review, the fuel quality testing for the diesel-fired generator could not be located and the Environmental Specialist stated that this test was not something he was aware he needed. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99		**WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Middletown Nursing and Rehab Center will have Schaffer Oil test our fuel quality annually. Even though our generator runs weekly and a load monthly, any fuel that sets for too long could affect the performance of the generator engine; and in return affect residents during an emergency. The 4 hour load bank test will be scheduled to be completed with the annual 1 hour test. **HOW OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** Poor fuel quality could affect an engine to run improperly, so Schaffer oil will be scheduled annually to check our fuel quality. The Environmental Specialist will coordinate with the Administrator weekly to discuss any tests that are coming up or anything that may have been missed and needs to be rescheduled. This includes the annual load bank as well as the 4 hour/3 year test. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Environmental	

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	Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems (EPS) shall be tested at least once within every three years. For a diesel-powered EPS, loading shall be not less than 30 percent of the nameplate kWrating of the EPS. A supplemental load bank shall be permitted to be used to meet or exceed the 30 percent requirement. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Environmental Specialist and Administrator on 09/14/22 between 10:15 a.m. and 12:45 p.m., the facility provided documentation for testing of the emergency generator, however could not provide documentation of a three year 4 hour test. This was confirmed by the Environmental Specialist, who stated he was unaware of the requirement. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)		Specialist will coordinate with the Administrator weekly to discuss any tests that are coming up or anything that may have been missed and needs to be rescheduled. This includes the annual load bank as well as the 4 hour/3 year test. The Administrator will keep checking emails to see if there are any new regulations that Life Safety has implanted. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During quarterly QA meetings the Environmental Specialist will discuss with the team any tests that are scheduled and any issues that have been noticed and need fixed. **BY WHAT DATE THE SYSTEMIC CHANGES WILL BE COMPLETED:** Fuel test was completed September 14, 2022 (See Attachment), and the 4 hour/3 year load bank test has been scheduled and will be completed by December 14, 2022. We respectfully request paper compliance for Tag K 918.	
K 0920 SS=E Bldg. 02	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and			

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	Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	1. Based on observation and interview, the facility failed to ensure power strips in therapy met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 6 residents. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and	K 0920	**Tag K 920** **WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Having powerstrips in resident areas could potentially affect residents. Powerstrips must have a certain UL number and still be monitored closely. Middletown Nursing has a no powerstrip policy for resident areas. Powerstrips will be removed and if needed hard-wired plugs will be installed. **HOW OTHER RESIDENTS**	12/14/2022

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	Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., the therapy area had a power strip inside the patient care vicinity for electrical equipment items including computers that lacked a UL rating of 1363A or 60601-1 label on the power strip. This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 3 staff. Findings include: Based on observations during a facility tour and interview with the Environmental Specialist and Administrator on 09/14/22 between 12:45 p.m. and 3:15 p.m., in the therapy area a power strip was being used to power a dorm-style refrigerator (high power draw equipment). This finding was acknowledged by the Environmental Specialist and Administrator at the time of discovery and again at the exit conference at 4:15 p.m. 3.1-19(b)		**HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE WILL BE IDENTIFIED AND WHAT CORRECTIVE ACTIONS WILL BE TAKEN:** All staff, especially therapy staff, will be trained on the powerstrip policy and powerstrips will be removed. The Environmental Specialist will do a walk thru in resident areas to ensure no powerstrips are being used. **WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR:** The Environmental Specialist or appointee will do a weekly walk thru to ensure no powerstrips are in use in resident areas. Also, housekeeping, nursing and dietary staff will be made aware to say something if they see powerstrips as well. **HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE:** During quarterly QA meetings the Environmental Specialist will remind all department heads on the use of powerstrips as well as report any powerstrips that have been found. **BY WHAT DATE THE SYSTEMIC**	

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			CHANGES WILL BE COMPLETED: This deficiency will be completed by December 14, 2022. We respectfully request paper compliance for Tag K 920.	