STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING -- B. WING	06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 06/22/21 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 At this Emergency Preparedness survey, Saint Anthony was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 189 certified beds. At the time of the survey, the census was 167. Quality Review on 06/25/21 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The facility requests desk compliance	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			

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	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of the facility's "Emergency & Disaster Preparedness" plan on 06/22/21 between 9:05 a.m. to 1:00 p.m. with the Plant Operations Director present, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. The emergency plan available has not been reviewed within the past 12 months. Based on interview at the time of record review, the Plant Operations Director said the facility has not had its entire emergency preparedness program reviewed by the facility within the most recent twelve month period because of the COVID 19 Pandemic. This finding was reviewed with the Plant Operations Director at the time of exit.	E 0004	The facility requests desk compliance E004 1.1 The Emergency & Disaster Preparedness plan was immediately updated. 1.2 All documentation has been updated pertaining to Emergency and Disaster Preparedness for the last 12 months. 1.3 The Director of Plant Operations has reviewed and updated its entire emergency	07/15/2021

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			preparedness program for the facility to ensure compliance. In-serviced on Development Emergency Preparedness Plan review and update annually has been completed (Attachment #1). 1.4 The Director of Plant Operations will continue to update Emergency and Disaster Preparedness on an annual basis and will be available in the Director of Plant's office.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures,			

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	based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and			

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	updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and updated their emergency preparedness policies and procedures at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's "Emergency & Disaster Preparedness" plan on 06/22/21 at 12:50 p.m. with the Plant Operations Director, the emergency plan available did not have a review date during the past 12 month period with the last date of review currently listed as 04/2019. Based on interview at the same time as record review the Plant Operations Director agreed there was no update provided for the Emergency & Disaster Preparedness plan within the last twelve months because of the COVID 19 Pandemic.	E 0013	The facility requests desk compliance E 013 1.1 The Emergency & Disaster Preparedness plan was immediately updated. 1.2 All documentation has been updated pertaining to Emergency and Disaster Preparedness for the last 12 months. 1.3 The Director of Plant Operations has reviewed and updated its entire emergency	07/15/2021

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	This finding was reviewed with the Plant Operations Director at the time of exit.		preparedness program for the facility to ensure compliance. In-serviced on Development of Emergency Preparedness Plan and Policies and Procedures has been completed (Attachment #2). 1.4 The Director of Plant Operations will continue to update Emergency and Disaster Preparedness on an annual basis.	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC			

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	facilities]. Based on record review and interview, the facility failed to maintain an emergency preparedness communication plan that complies with Federal, State, and local laws that were reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the "Emergency & Disaster Preparedness" plan with the Plant Operations Director during record review at 12:50 p.m. on 06/22/21, documentation for a complete emergency program reviewed by the facility within the most recent twelve month period was not available for review. The most recent update was 04/2019. Based on interview at the time of record review, the Plant Operations Director stated the Emergency & Disaster Preparedness plan, which includes a communication plan, had not been reviewed and updated within the last twelve months due to the COVID 19 Pandemic. This finding was reviewed with the Plant Operations Director at the time of exit.	E 0029	The facility requests desk compliance E 029 1.1 The Emergency & Disaster Preparedness plan was immediately updated. 1.2 All documentation has been updated pertaining to Emergency and Disaster Preparedness for the last 12 months. 1.3 The Director of Plant Operations has reviewed and updated its entire emergency preparedness program for the facility to ensure compliance. In-serviced on Emergency Communication Procedure has been completed (Attachment #3).	07/15/2021

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			1.4 The Director of Plant Operations will continue to update Emergency and Disaster Preparedness on an annual basis.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program			

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	must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and			

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	procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the "Emergency & Disaster Preparedness" plan on 06/22/21 at 12:50 p.m. with the Plant Operations Director, there was documentation available to show the facility had an emergency preparedness training and testing program, however, there was no documentation to show that the training and testing program has been reviewed and updated within the past twelve months. The last available review date was 04/2019. Based on interview at the time of record review, the Plant Operations Director stated the Emergency & Disaster Preparedness plan had not been updated within the last twelve months due to the COVID 19 Pandemic. This finding was reviewed with the Plant Operations Director at the exit conference.	E 0036	E 036 1.1 The Emergency & Disaster Preparedness plan was immediately updated. 1.2 All documentation has been updated pertaining to Emergency and Disaster Preparedness for the last 12 months. 1.3 The Director of Plant Operations has reviewed and updated its entire emergency preparedness program for the facility to ensure compliance. In-serviced on Emergency Preparedness training and testing has been completed (Attachment #4). 1.4 The Director of Plant Operations will continue to update Emergency and Disaster Preparedness on an annual basis.	07/15/2021

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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: 06/22/21 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 At this Life Safety Code survey, Saint Anthony 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 three story facility with a partial basement, was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and battery operated smoke-detectors in resident rooms. The building is partially protected by a 100 kW diesel powered emergency generator. The facility has the capacity for 189 and had a census of 144 at the time of this survey. Quality Review on 06/25/21	K 0000	The facility requests desk compliance	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation			

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	2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Third floor D Wing Nurse's Station in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 18 residents in the Third floor D Wing smoke compartment. Findings include: Based on observation with the Plant Operations Director on 06/22/21 at 1:43 p.m., the Third floor D Wing Nurse's Station had a missing escutcheon. Based on interview at the time of	K 0351	The facility requests desk compliance K 351 1.1 The Third Floor D Wing nurse's Station missing escutcheon was repaired immediately.	07/15/2021

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	observation, the Plant Operations Director confirmed the escutcheon was missing and had an assistant replace the escutcheon prior to survey exit. This finding was reviewed with the Plant Operations Director at the exit conference. 3.1-19(b)		1.2 The Director of Plant operations had an assistant replace the escutcheon and an in-serviced was completed on sprinkler system-installation (Attachment # 5) 1.3 No other escutcheons were observed that needed replacement. Presence of escutcheons audits will be added to daily preventative maintenance schedule for six (6) months to ensure compliance. The Director of Plant Operations/designee will monitor on a daily basis. Any identified concerns relating to escutcheon will be corrected as observed. 1.4 The Director of Plant Operations/designee will report monthly audit findings to the QAPI Committee meeting monthly for	

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	155214	A. BUILDING 01 B. WING	06/22/2021

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			(6) months beginning July 15, 2021. The QAPI Committee will monitor data presented for any items for trends and determine if further auditing is warranted.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in two areas throughout the facility. 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 tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 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	K 0353	The facility requests desk compliance K 353 1.1 On Third Floor by A wing 1/2	07/15/2021

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	affect up to 43 residents and staff. Findings include: Based on observations with the Plant Operations Director on 06/22/21 during a tour of the facility from 1:00 p.m. to 3:10 p.m.; the following was noted: a.) a 1/2 inch hole in a suspended ceiling tile of the third floor A wing corridor by the nurse's station and resident rooms 309-A and 310-A. b.) a 1/2 inch hole in a suspended ceiling tile of the third floor D wing corridor by resident room 384-A. Based on interview at the time of observation, the Plant Operations Director stated the ceiling mounted Wi-Fi units in the corridors were recently repositioned and the holes had not been repaired. This finding was reviewed with the Plant Operations Director at the time of exit. 3.1-19(b)		hole in a suspended ceiling tile and room 309-A, 310-A and 384-A. Due to Wi-Fi mounts holes was repaired. 1.2 The Director of Plant operations has completed the hole repairs and a whole Facility inspection with no other areas found to have holes. 1.3 The Director of Plant Operations in-serviced the Plant Operations staff (Attachment # 7). The Plant Director will audit and monitor on a daily basis. Any identified concerns related to holes in ceiling tiles will be corrected as observed. 1.4 The Director of Plant Operations/designee will report monthly audit findings to the QAPI Committee meeting monthly for	

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			(6) months beginning July 15, 2021. The QAPI Committee will monitor data presented for any items for trends and determine if further auditing is warranted.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by 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			

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	compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 100 resident room doors to the corridor were maintained in accordance with LSC Section 19.3.6.3. Section 19.3.6.3.5 states that corridor doors shall be provided with a means for keeping the door closed. Section 19.3.6.3.10 states that doors shall not be held open by devices other than those that release when the door is pushed or pulled. This deficient practice could affect staff and up to 19 residents. Findings include: Based on observation with the Plant Operations Director during a tour of the facility on 06/22/21 at 2:15 p.m., the corridor door to Resident Room 232-A on B Wing of the second floor did not latch into the frame after several attempts. Based on interview at the time of observation, the door of room 232-A not latching when closed was acknowledged by the Plant Operations Director. This finding was reviewed with the Plant Operations Director at the exit conference. 3.1-19(b)	K 0363	The facility requests desk compliance K 363 1.1 The corridor door to Resident Room 232-A on B wing 2nd floor was repaired to make sure it latches. 1.2 Upon facility inspection no other door was observed to have issues regarding positively latching of the doors.	07/15/2021

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			1.3 The latch has been repaired by the facility. The Director of Plant Operations/designee will monitor on a daily basis. Presence of positive latching to door closing will be added to monthly door audit and preventative maintenance schedule for six (6) months to ensure compliance. 1.4 The Director of Plant Operations in-serviced the Plant Operations staff (Attachment # 8) on proper corridor-doors closing as well as removal of any impediment, which would not allow proper latching of doors. Presence of impediments to door closing will be added to monthly door audit and preventative maintenance schedule for six (6) months to ensure compliance. (Attachment # 9). The Director of Plant Operations/designee will report monthly audit findings to the QAPI Committee meeting monthly for six (6) months beginning July 15, 2021. The QAPI Committee will monitor data presented for any items for trends and determine if further auditing is warranted.	

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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 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			

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	consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 7 of 52 weeks. 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, 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. Findings include: Based on record review with the Plant Operations Director on 06/22/21 at 11:15 a.m., the last documented weekly generator visual inspection was 05/03/2021. Based on an interview at the time of record review, the Plant Operation Director acknowledged weekly visual inspections of the generator had not been documented since 05/03/2021. He further stated that the staff member who performed the visual inspections recently retired and the weekly inspections must have been mistakenly added to the monthly testing. This finding was reviewed with the Plant Operations Director at the exit conference.	K 0918	The facility requests desk compliance K 918 1.1 The Director of Plant Operation initiated required inspection and testing of weekly inspections for the generator. 1.2 Inspection and testing will be corrected immediately. 1.3 The Director of Plant Operations in-serviced Plant Operation staff on the required 52 week inspections for the generator and testing in accordance with LLC. The Emergency Power supply should be inspected weekly and exercised monthly. The Director	07/15/2021

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	3.1-19(b)		of Plant Operations in-serviced the Plant Operations staff (Attachment # 10). 1.4 The Director of Plant Operations/designee will report monthly audit Findings to the QAPI Committee meeting monthly for six (6) months beginning July 15, 2021. The QAPI Committee will monitor data presented for any items for trends and determine if further auditing is warranted.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed			

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	wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 Therapy area did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects as many as 3 residents, 2 staff. Findings include: Based on observation with the Plant Operations Director during a tour of the facility on 06/22/21 at 2:48 p.m., a laptop was powered by being plugged into a power strip that was plugged into another power strip which was plugged into the wall. Based on interview at the time of observation, the Plant Operations Director acknowledged the power strip plugged into another power strip as being in use within the Therapy area. This finding was reviewed with the Plant Operations Director at the time of exit. 3.1-19(b)	K 0920	The facility requests desk compliance K 920 1.1 The power strip plugged into another power strip was removed. 1.2 Upon Facility Inspection no other power strips were observed to be used. 1.3 The Director of Plant Operations in-serviced the Plant	07/15/2021

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			Operations staff (Attachment # 11) on proper power cords and extension cords as well as removal of any power strips plugged in another. The Director of Plant Operations/designee will monitor on a daily basis. Presence of daily inspections and monthly audit and preventative maintenance schedule for six (6) months to ensure compliance. 1.4 The Director of Plant Operations/designee will report monthly audit findings to the QAPI Committee meeting monthly for six (6) months beginning July 15, 2021. The QAPI Committee will monitor data presented for any items for trends and determine if further auditing is warranted.	