STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155608	A. BUILDING -- B. WING	07/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHCARE CENTER AT WITTENBERG VILLAGE	1200 E LUTHER DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/18/22 Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820 At this Emergency Preparedness survey, Healthcare Center at Wittenberg Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 155 certified beds. At the time of the survey, the census was 91. Quality Review completed on 07/21/22	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/18/22 Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820 At this Life Safety Code survey, Healthcare	K 0000		

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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	Center at Wittenberg Village 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. The original one story building with a partial basement identified as building 01 was determined to be of Type II (000) construction and was fully sprinklered. The one story Chapel/Fellowship Hall addition identified as building 02 was determined to be Type V (000) construction and occupies a 1990 addition to the facility. The facility is surveyed as two buildings due to different construction types. The building is partially protected by a 150 kW diesel powered emergency generator. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 91 at the time of this survey. All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered. Quality Review completed on 07/21/22			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in			

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	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 1 of 7 hazardous areas such as a soiled linen rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with LSC 7.2.1.8. This deficient practice could affect 13 residents, staff and visitors in the vicinity of the Soiled Utility room in 300 hall. Findings include:	K 0321	Observed soiled linen door was repaired to close and latch into the frame A review of all self- close doors was completed to ensure that they were self-closing and able to latch into the door frame. Any identified concerns were immediately repaired. Maintenance team members have	08/09/2022

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	Based on observation with the Director of Building Services and Maintenance Supervisor during a tour of the facility from 2:20 p.m. to 3:40 p.m. on 07/18/22, the corridor door to the Soiled Linen room in the 300 Hall which contained more than 64 gallons of storage was equipped with a self-closing device but the door failed to fully close and latch into the door frame when tested three separate times. When swinging to close, the door slowed down enough that it stopped on the latching side and would not positively latch into the frame. Based on interview at the time of observation, the Maintenance Supervisor agreed the corridor door to the aforementioned hazardous area failed to self-close and latch into the door frame. This finding was reviewed with the Administrator and Director of Building Services at the exit conference. 3.1-19(b)		been educated on the requirement to ensure that all self-close doors latch into the frame. Monthly rounding to test all self-close doors to ensure they latch into the door frame will be completed by the Maintenance Director or designee. Any concerns related to the aforementioned testing will be submitted to the QAPI Committee for a review on a monthly basis to ensure continued compliance.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____			

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	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 record review and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents and staff in the facility. Findings include: Based on review of the sprinkler contractor's "Inspection & Testing" documentation dated 04/19/2022, 01/26/2022, 11/01/2021 and 07/28/2021 with the Director of Building Services and Maintenance Supervisor during record review from 10:50 a.m. to 12:00 p.m. and 12:30 p.m. to 2:20 p.m. on 07/18/2022, monthly sprinkler gauge inspection documentation for August, September, October and December 2016; and February, March, May, June and July 2022 was not available for review. Based on interview at the time of record review, the Maintenance Supervisor confirmed that monthly gauge inspection	K 0353	Monthly sprinkler system inspection was completed of the wet system on 7/27/22 and documented accordingly. The dry system inspection documentation was observed and found to be in compliance on the day of the survey. The facility is confident that there are no like circumstances. The maintenance team has been educated on the monthly inspection and documentation requirement for the wet and dry sprinkler systems. The Maintenance Director or designee will complete monthly checks of the sprinkler systems to ensure the inspections are completed and documented accordingly. Any concerns related to the aforementioned inspections and documentation will be submitted to the QAPI Committee on a monthly basis to ensure continued compliance.	08/09/2022

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	documentation for the aforementioned periods was not available for review at the time of the survey. This finding was reviewed with the Administrator and Director of Building Services at the exit conference. 3.1-19(b)			
K 0363 SS=D 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			

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	other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 90 resident room doors to the corridor would close completely and latch into the door frame. This deficient practice could affect 2 residents and staff. Findings include: Based on observation with the Director of Building Services on 07/18/22 during a tour of the facility between 2:20 p.m. and 3:40 p.m., the corridor door of resident room #713 failed to close and latch into the frame after three attempts. Based on interview at the time of observation, the Director of Building Services confirmed the aforementioned door as not latching into the door frame and stated that latch appears to be malfunctioned and would have work performed on the door. This finding was reviewed with the Administrator and Director of Plant Operations at the exit conference. 3.1-19(b)	K 0363	Room 713 door has been repaired and tested to latch positively into the frame. A review of all resident room doors was completed to ensure that they were able to positively latch. Any identified concerns were immediately repaired. Maintenance team members have been educated on the requirement to ensure that all resident room doors latch into the frame. Monthly rounding to test 2 resident room doors in each hallway monthly to ensure they positively latch into the door frame will be completed by the Maintenance Director or designee. Any concerns related to the aforementioned testing will be submitted to the QAPI Committee for review on a monthly basis to ensure continued compliance.	08/09/2022

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to ensure 6 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff, and visitors in the facility. Findings include: Based on record review of the documentation entitled "Fire Drill" with the Maintenance Supervisor on 07/18/22 from 10:50 a.m. to 12:00 p.m. and 12:30 p.m. to 2:20 p.m., the documentation for the following fire drills failed to include the verification of transmission of the fire alarm signal to the monitoring station: a) 01/27/22 at 1:00 p.m. b) 03/30/22 at 4:00 a.m. c) 04/07/22 at 12:00 p.m. d) 06/13/22 at 4:00 p.m.	K 0712	A fire drill was conducted at 10:22am on 8/1/22. This drill included verification of the transmission of the signal to the alarm company. A copy of this event is included as an attachment. The Maintenance team members were educated related to the requirements that all fire drills require the verification of the fire alarm signal to the monitoring company in fire drills conducted between 6:00am and 9:00pm. The Maintenance team members were also educated related to the requirements that fire drills are to be conducted at least quarterly on each shift. An audit of the fire drill paperwork will be conducted monthly by the Maintenance Director to ensure that these practices are being followed. Any concerns related to the	08/09/2022

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	e) 07/07/22 at 12:00 p.m. f) 10/14/21 at 1:00 p.m. Based on interview at the time of record review, the Maintenance Supervisor confirmed that the aforementioned fire drills did not document the verification of transmission of the fire alarm signal to the monitoring station. 2. Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill" forms with the Director of Building Services and Maintenance Supervisor on 07/18/2022 from 10:50 a.m. to 12:00 p.m. and 12:30 p.m. to 2:20 p.m., there was no documentation for a second shift fire drill in the first quarter of 2022. Additionally, there was no documentation for a second shift fire drill in the fourth quarter of 2021. Based on interview at the time of record review, the Maintenance Supervisor stated the facility had changed the drill schedule and those two drills must have been missed. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		aforementioned audit will be submitted to the QAPI committee for review on a monthly basis.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric			

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	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 maintain a complete written record of monthly generator load testing for 1 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving	K 0918	The generator load test was completed on July 27, 2022 and was documented accordingly. The documentation included actual load percentage which was	08/09/2022

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	the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 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 occupants. Findings include: Based on record review with the Director of Building Services and Maintenance Supervisor on 07/18/22 from 10:50 a.m. to 12:00 p.m. and 12:30 p.m. to 2:20 p.m., documentation for October, November 2021 monthly load testing was not available for review. Additionally, January, February, and June 2022 monthly load testing was not available for review at the time of the survey. Based on an interview at the time of record review, the Maintenance Supervisor confirmed documentation of a monthly generator load test of the aforementioned time period was not available for review. 2. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the		in the desired range. The facility has 1 diesel powered generator and is confident that there are no like concerns. The facility maintenance staff has been educated on the requirements for generator testing. The generator testing form has been updated to include the actual load percentage. The Director of Maintenance or designee will review generator testing log monthly to ensure the testing is completed appropriately and load percentage is included in the documentation. Any concerns related to the aforementioned testing will be submitted to the QAPI committee on a monthly basis to ensure continued compliance.	

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	manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on review of generator load testing documentation with the Director of Building Services and Maintenance Supervisor from 10:50 a.m. to 12:00 p.m. and 12:30 p.m. to 2:20 p.m. on 07/18/22, the load information to show the actual load percentage for the diesel powered generator was not documented. Based on interview at the time of record review, the Director of Building Services confirmed that the load percentage for the diesel generator was not documented on a monthly basis. 3. Based on record review and interview, the facility failed to ensure a complete written record of weekly inspections for the generator was maintained for 4 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			

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	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 Director of Building Services and Maintenance Supervisor on 07/18/22 from 10:50 a.m. to 12:00 p.m. and 12:30 p.m. to 2:20 p.m., documentation for the weekly generator inspections for the weeks of 9/27/2021, 10/13/2021, 10/25/2021, 11/22/2021 and 11/29/2021 was not available for review. Based on an interview at the time of record review, the Director of Building Services confirmed no documentation for weekly generator inspections was available for review for the aforementioned time periods. These findings were reviewed with the Administrator and Director of Building Services at the exit conference. 3.1-19(b)			
K 0920 SS=D 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			

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	155608	A. BUILDING 01 B. WING	07/18/2022

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	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 Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including power strips were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during	K 0920	The exam table and laptop were removed from the power strip and plugged directly into the wall outlet. A rounding of the resident care environment was completed to observe household appliances and office equipment. Any like concerns were resolved immediately. Team members were educated related to the requirement for household or office appliances to be plugged directly into the wall rather than a power strip. A monthly audit of the resident care/office areas will be completed by the Maintenance Director or designee to ensure any household or office appliances are plugged directly into the wall rather than a	08/09/2022

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	examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect at least 5 residents and staff in the Therapy room. Findings include: Based on observations with the Director of Building Services during a tour of the facility from 2:20 p.m. to 3:40 p.m. on 07/18/2022, an exam bed and a laptop computer mounted to a mobile pole were plugged into a power strip in the Physical Therapy room. The UL listing of the power strip could not be determined. Based on interview at the time of the observation, the Director of Building Services agreed power strip was being used in the patient care vicinity for PCREE and non-PCREE and as a substitute for fixed wiring at the aforementioned location. This finding was reviewed with the Administrator and Director of Building Services at the exit conference. 3.1-19(b)		power strip. Any concerns related to the aforementioned audit will be submitted to the QAPI committee for review on a monthly basis.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/18/22	K 0000		

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	155608	A. BUILDING 02 B. WING	07/18/2022

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	Facility Number: 000515 Provider Number: 155608 AIM Number: 100290820 At this Life Safety Code survey, Healthcare Center at Wittenberg Village 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. The original one story building with a partial basement identified as building 01 was determined to be to be of Type II (000) construction and was fully sprinklered. The one story Chapel/Fellowship Hall addition identified as building 02 was determined to be Type V (000) construction and occupies a 1990 addition to the facility. The facility is surveyed as two buildings due to different construction types. The building is partially protected by a 150 kW diesel powered emergency generator. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Resident rooms are equipped with battery powered smoke detectors. The facility has a capacity of 155 and had a census of 91 at the time of this survey. All areas of resident access are sprinklered. A detached grounds maintenance shed was unsprinklered. Quality Review completed on 07/21/22			

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K 0355 SS=E Bldg. 02	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect all portable fire extinguishers in the facility each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire	K 0355	The cited fire extinguishers were inspected and documented as such. All facility fire extinguishers were inspected and documented as such. The maintenance team members were provided education related to the requirement for fire extinguishers to be inspected on a monthly basis as well as the location of said fire extinguishers. The Maintenance Director or designee will conduct audits of 10 random fire extinguishers per month to ensure that inspections are completed and documented appropriately. Any concerns related to the aforementioned audits will be submitted to the QAPI Committee for review on a monthly basis to ensure continued compliance.	08/09/2022

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	extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect residents and staff using the Chapel and Fellowship Hall. Findings include: Based on observation during a tour of the facility with the Director of Building Services and Maintenance Supervisor on 07/18/22 from 2:20 p.m. and 3:40 p.m., the annual inspection tags on two ABC fire extinguishers located in the Fellowship Hall lacked documentation of recent monthly inspections for May and June 2022. Based on interview at the time of observations during the tour, the Director of Building Services confirmed the lack of monthly inspection documentation and stated that he would speak with the night shift personnel who perform and document the inspections. This finding was reviewed with the Administrator and Director of Building Services at the exit conference. 3.1-19(b)			