STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155839	A. BUILDING -- B. WING	11/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUMMIT HEALTH AND LIVING	701 S MAIN ST SUMMITVILLE, IN 46070

(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: 11/02/23 Facility Number: 000373 Provider Number: 155839 AIM Number: 100288730 At this Emergency Preparedness survey, Summit Health and Living was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 34 and had a census of 32 at the time of this survey. Quality Review completed on 11/08/23 The requirements of 42 CFR, Subpart 483.73 are Not Met as evidenced by:	E 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Health & Living that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Health & Living. The facility requests the following plan of correction be considered its allegation of compliance.	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anastasia Key
TITLE: HFA
(X6) DATE: 11/23/2023

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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	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.			

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	(2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Supervisor (MS) on 11/02/23 at 09:15 a.m., the subsistence needs documentation for the emergency preparedness program was incomplete. Documentation for temperatures to protect resident health safety and for safe and sanitary storage of provisions was not available for review. Based on interview at the time of records review, the MS and Administrator stated the aforementioned policies could not be found. This finding was reviewed with the Corporate Compliance Nurse and MS during the exit conference.	E 0015	Facility failed to include in our policy how residents would be cared for during events of extreme heat or cold. A policy addendum was added to reflect this information. It has been added to all Disaster Books in the facility. Staff was educated on this during our monthly all staff meeting, 11/22/23. Disaster books will continue to be reviewed yearly and updated as needed.	11/22/2023
E 0041 SS=F	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power			

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Bldg. --	§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 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			

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	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 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,			

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	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. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	1. Based on records review and interview, the facility failed to implement the emergency power system 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 with the Administrator and Maintenance Supervisor (MS) on 11/02/23 at 12:10 p.m., the generator annual fuel quality testing was completed but documentation was not available at the time of the survey. Based on interview at the time of record review, the MS stated the fuel quality test was completed but they had not received the report yet. 2. Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities	E 0041	Prior to Life Safety survey, Buckeye completed a 2-hour annual generator load bank test. Buckeye was contacted during Life Safety survey on November 2, 2023, to schedule a 4-hour load bank test. Buckeye came out November 6, 2023, and completed the 4-hour generator test. Results were received on November 7, 2023.	11/06/2023

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	Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Administrator and Maintenance Supervisor (MS) from 9:05 a.m. to 12:35 p.m. on 11/02/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the MS stated documentation of supplemental load testing for four hours within the most recent three-year period was not available for review. Based on observations with the MS during the facility tour, the emergency generator was confirmed to be diesel powered. These findings were reviewed with the Corporate Compliance Nurse and MS at the exit conference.			

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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: 11/02/2023 Facility Number: 000373 Provider Number: 155839 AIM Number: 100288730 At this Life Safety Code survey, Summit Health and Living was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type II000 construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery powered smoke detectors in the resident sleeping rooms. The facility has a capacity of 34 and had a census of 32 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 11/08/23	K 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Summit Health & Living that the allegations contained in the survey report are accurate or reflect accurately the provision of care and service to the residents at Summit Health & Living. The facility requests the following plan of correction be considered its allegation of compliance.	
K 0211 SS=E	NFPA 101 Means of Egress - General			

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Bldg. 01	Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit doors from the kitchen only contained one latching mechanism to release the door and open. LSC 7.2.1.5.10 states a latch or other fastening device on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect staff in the kitchen. Findings include: Based on observation with the Maintenance Supervisor (MS) on 11/02/23 at 12:55 p.m., the kitchen exit door to the Dining room was equipped with two latching devices, a latching door turn knob and a separate deadbolt lock. Based on interview at the time of observation, the MS agreed the kitchen exit door was equipped with two latching devices. This finding was reviewed with the Corporate Compliance Nurse and MS during the exit conference.	K 0211	The kitchen “exit door” to the dining room was equipped with 2 latching devices, a latching door turn knob and a separate deadbolt lock. The locking door turn knob was replaced on November 13, 2023 with a door knob without a lock. The door now only has one locking mechanism. Additionally, all other doors were checked by the maintenance supervisor, no other doors were found to have two locking mechanisms.	11/13/2023

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	3.1-19(b)			
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8			
	Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm control units, located in an area that was continuously occupied, was provided with annunciation readily accessible to responding personnel to facilitate an efficient response to the fire situation. 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 and Signaling Code. NFPA 72, 2010 Edition, Section 10.16.3.1 states all required annunciation means shall be readily accessible to responding personnel. Section 10.16.3.2 states all required annunciation means shall be located as required by the authority having jurisdiction to facilitate an efficient response to the fire situation. Section 10.12.5 states the trouble signal(s) shall be located in an area where it is likely to be heard Annex A is not a part of the requirements but is	K 0341	The fire alarm control is currently in the mechanical room and not in a location that is continuously occupied. Elwood Fire was contacted on November 3, 2023, and a quote was obtained to add an annunciator to an area that is observed 24/7. This will be placed at the nurse’s station and the entire system will be updated. It is scheduled to be installed on 11/27/23. Once placed, all staff will be trained regarding operation and when the Maintenance Supervisor and Administrator need to be contacted.	11/27/2023

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	included for informational purposes only Section A.10.16.3 states the primary purpose of fire alarm system annunciation is to enable responding personnel to identify the location of a fire quickly and accurately and to indicate the status of emergency equipment or fire safety functions that might affect the safety of occupants in a fire situation. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on observations with the Maintenance Supervisor (MS) on 11/02/23 at 01:00 p.m., the main fire alarm control unit was in the mechanical room an area not continuously occupied. Based on interview at the time of the observations, the MS agreed the main Fire Alarm panel was not in an area continuously occupied and stated there is no remote annunciator in the continuously occupied areas of the building. The finding was reviewed with the Corporate Compliance Nurse and MS during the exit conference. 3.1-19(b)			
K 0500 SS=E Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility	K 0500	Boiler permits were expired.	11/27/2023

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	failed to ensure 2 of 2 fuel fired water heaters had current inspection certificates to ensure the water heaters were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect staff in the vicinity of the mechanical room. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor (MS) on 11/02/23 at 01:10 p.m., the two hot water heaters in the mechanical room had permits that expired on 06/24/21. Based on interview at the time of the observation, the MS stated the inspection for the water heaters was completed but they have not received the permits. These findings were reviewed with the Corporate Compliance Nurse and the MS at the exit conference. 3.1-19(b)		Travelers Insurance was contacted starting on November 7, 2023, to give an updated inspection. Inspection is scheduled for 11/27/23. Once completed, updated permits will be placed on boilers. It was added to TELS to be checked prior to inspection in 2 years.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 20 ground fault circuit interrupter (GFCI) was properly maintained for	K 0511	The electrical receptacle in the employee breakroom was within 5 ft from the sink and when tested	11/13/2023

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	protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect staff in the employee break area.. Findings include: Based on observation with the Maintenance Supervisor (MS) on 11/02/23 at 01:20 p.m. when the electric receptacle located 5 feet from the sink in the employee break area was tested with a GFCI tester the electric receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the MS agreed the electric receptacle 5 feet from the sink was not GFCI protected.. This finding was reviewed with the Corporate Compliance Nurse and the MS during the exit conference. 3.1-19(b)		with the GFCI tester the receptacle failed to trip and did not break the electrical current. It was replaced with a GFCI on November 13, 2023.The maintenance supervisor checked the entire building for outlets near a water source that would require a GFCI receptacle, and no others were found.	
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.			

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	155839	A. BUILDING 01 B. WING	11/02/2023

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	19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Maintenance Supervisor (MS) on 11/02/23 at 10:30 a.m., the following shifts were missing documentation of a completed fire drill: a) A first shift fire drill in the second quarter of 2023. b) The first shift fire drills in the third quarter of 2023. Based on interview at the time of record review, the Maintenance Director agreed the drills mentioned were not completed. 3.1-19(b) 3.1.51(c)	K 0712	On November 10, 2023, the Maintenance Supervisor was reeducated that fire drills must be completed quarterly on each shift and 2 hours apart from previous drill. A schedule was made by the Maintenance Supervisor and Administrator. These were added to TELS. Drills will be reviewed monthly by the administrator. All residents and staff could be affected by this deficient practice.	11/10/2023
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			

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	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 records review and interview, the facility failed to implement the emergency power system 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 with the Administrator and Maintenance Supervisor (MS) on 11/02/23 at 12:10 p.m., the generator annual fuel quality testing was completed but documentation was not	K 0918	Harvest Land Co-Op completed the annual generator fuel test. We did not have the report at the time of the survey. Harvest Land Co-Op was contacted during the Life Safety survey on November 2, 2023, and was told our fuel results could take up to 2 weeks for results. Harvest Land Co-Op was contacted again on November 16, 2023, and was told we would receive our test results by mail or e-mail. At this time, we have not received the results.	11/06/2023

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	available at the time of the survey. Based on interview at the time of record review, the MS stated the fuel quality test was completed but they had not received the report yet. 2. Based on record review, observation, and interview; the facility failed to document 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Administrator and Maintenance Supervisor (MS) from 9:05 a.m. to 12:35 p.m. on 11/02/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator was not available for review. Based on interview at the time of record review, the MS stated documentation of supplemental		Buckeye completed a 2-hour annual generator load bank test. Buckeye was contacted during Life Safety survey on November 2, 2023, to schedule a 4-hour load bank test. Buckeye came out November 6, 2023, and completed the 4-hour generator test. Results were received on November 7, 2023. Follow up 4-hour generator testing for every 3 years, the next 4-hour generator test will be in November of 2026, and it was added to TELS.	

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	load testing for four hours within the most recent three-year period was not available for review. Based on observations with the MS during the facility tour, the emergency generator was confirmed to be diesel powered. These findings were reviewed with the Corporate Compliance Nurse and MS at the exit conference. 3.1-19(b)			