STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING -- B. WING	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT CHRISTIAN VILLAGE	6685 EAST 117TH AVENUE CROWN POINT, IN 46307

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/17/2023 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 At this Emergency Preparedness survey, Crown Point Christian Village was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility is certified for 145 beds, and is set up for 144. Eighty-seven beds are dually certified for Medicare and Medicaid. Twenty-six are certified for Medicare only. At the time of the survey, the census was 93. Quality Review completed on 05/22/23	E 0000	Please consider this plan of correction as Crown Point Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our Residents solely as a requirement of the provision of the Federal and State Law. Please accept this evidence in lieu of an onsite post survey re-visit for recertification and state licensure.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deb Mills	Interim Administrator	06/02/2023

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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	*[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop			

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	exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct			

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	exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:			

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	(i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

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	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,			

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	facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires			

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	activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual,			

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	facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.			

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	(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to provide complete documentation for the community or facility-based exercises to test the Emergency Preparedness Plan (EPP). The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	**It is the policy of Crown Point Christian Village to follow all federal, state and local guidelines, laws and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility manager, employee, agents or other individuals. The response to the alleged insufficient practice cited in this statement does not constitute agreement with the insufficiency. The preparation, submission and implementation of this plan of correction will serve as credible allegation of compliance.**	06/17/2023

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	a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., a table-top exercise report was able to be reviewed, but no documentation of a community-based or facility-based exercise could be provided at the time of record review. Based on interview at the time of record review, the Maintenance Director stated he was unsure whether the facility had conducted a community or facility-based exercise within the past year and was unable to be provide documentation during record review. This finding was reviewed with the Maintenance Director and the Executive Director during the exit conference.		**E039** **Corrective actions which were done for the residents found to have been affected by the deficient practice:** *Documentation of a facility-based exercise titled, Active Shooter Awareness & Response was located and serves as the 2nd required annual exercise.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents have the potential to be affected.* **The measures the facility will take and systems the facility will alter to ensure that the deficient practice will not reoccur:** *The community will continue to annually conduct 2 exercises to test the Emergency Preparedness Plan.* **Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and deficient practice will not recur:** *Findings of the two annual exercises will be reported to the QAPI Committee for one year. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.*	

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E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. 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.			

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	482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain 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,			

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	2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. 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 Maintenance Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., the facility generator lacked the 4-hour generator exercise and fuel quality analysis required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated they were unaware of the required 4-hour generator exercise and further stated that the fuel analysis had not been conducted within the last 12 months. The findings were reviewed with the Executive	E 0041	**E041** **Corrective actions which were done for the residents found to have been affected by the deficient practice:** *A four-hour continuous run under load test for the emergency generator was conducted 6/1/23; Also, a diesel generator fuel quality test was completed by vendor 5/31/23; awaiting results.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents have the potential to be affected.* **The measures the facility will take and systems the facility**	06/17/2023

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	Director and Maintenance Director at the exit conference.		**will alter to ensure that the deficient practice will not reoccur:** *A four-hour continuous run under load test for the emergency generator will be scheduled every 36 months with documentation and a diesel generator fuel quality test will be scheduled annually, with documentation in the work order system.* **Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and deficient practice will not recur:** *Annual and 36-month generator tests findings will be reported to QAPI Committee. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.*	
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: 05/17/2023 Facility Number: 001198 Provider Number: 155637 AIM Number: 100471000 At this Life Safety Code survey, Crown Point	K 0000	Please consider this plan of correction as Crown Point Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of	

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	Christian 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. This facility was located on the west side of the first floor and the entire lower level of a two story building. The facility was determined to be of Type II (111) construction and was fully sprinklered. The Healthcare Occupancy includes the atrium area of the second floor as it was not separated by a two-hour barrier. No residents use the second floor. The facility has a fire alarm system with hard wired smoke detection in the corridors, in spaces open to the corridors and hard wired single-station detectors in resident rooms. The building is protected by a 150 kW diesel-powered generator which provides emergency power. The facility is certified for 145 beds, and is set up for 144. Eighty-seven beds are dually certified for Medicare and Medicaid. Twenty-six are certified for Medicare only. At the time of the survey, the census was 93. All areas where the residents have customary access were sprinklered. The detached waste water treatment plant, fire system pump house and equipment storage garages were unsprinklered. Quality Review completed on 05/22/23		correction reflects a desire to continuously enhance the quality of care and services provided to our Residents solely as a requirement of the provision of the Federal and State Law. Please accept this evidence in lieu of an onsite post survey re-visit for recertification and state licensure.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained			

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	in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, Section 14.4.5.3.1 states smoke detector sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., no documentation for a smoke detector sensitivity test was available for review. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned condition and confirmed no other documentation was available for review. This finding was reviewed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)	K 0345	**K345** **Corrective actions which were done for the residents found to have been affected by the deficient practice:** *Smoke detector sensitivity test completed with documentation 6/1/23; Annual fire alarm inspection completed 6/1/23-awaiting report; Painter's tape removed from identified smoke detector upon discovery 5/17/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents have the potential to be affected.* **The measures the facility will take and systems the facility will alter to ensure that the deficient practice will not reoccur:** *1.Smoke detector sensitivity test scheduled with documentation every two years, in the work order system; 2. Fire alarm system visual inspection scheduled semi-annually with documentation in the work order system; 3. Annual fire alarm inspection scheduled with documented*	06/17/2023

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	2. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., no documentation was provided regarding a visual inspection of the fire alarm system six months prior to the annual fire alarm inspection. Based on interview at the time of records review, the Maintenance Director acknowledged the aforementioned condition and stated a semi-annual inspection could not be located. This finding was reviewed with the Maintenance Director and Executive Director at the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems		*inspection report; 4. Smoke detectors to be inspected at least quarterly for anything covering detectors.* **Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and deficient practice will not recur:** *Findings will be reported quarterly to the QAPI Committee for 6 months. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.*	

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	was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., documentation for an annual fire alarm inspection report was unable to be located at the time of the survey. Based on an interview at the time of record review, the Maintenance Director stated that they had contacted the alarm company and they have not forwarded the report to the facility at the time of the survey and agreed documentation could not be provided. This finding was reviewed with the Maintenance Director and Executive Director during the exit conference. 3.1-19(b) 4. Based on record review, observation and interview; the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, 14.2.1.2.1 states the requirements of Section 10.19 shall be applicable when a system is impaired. Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all clients, staff, and visitors. Findings include:			

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	Based on observation during a tour of the facility with the Maintenance Director on 05/17/23 between 12:55 p.m. and 2:45 p.m., the hardwire smoke detector located in the mechanical room near resident room 278 had painters tape covering the smoke detector. This deficiency can hinder the operation of the fire alarm and delay activation. Upon interview at the time of observation, the Maintenance Director stated they were unaware of the covered smoke detector. The tape was removed at observation. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the	K 0353	**K353**	06/17/2023

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	facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., there was no monthly inspection of the wet pipe sprinkler system's gauges and valves for the past 12 months. During an interview at the time of record review, the Maintenance Director stated inspections are usually visual and not written down on record. Findings were discussed with the Executive Director and Maintenance Director at exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA		**Corrective actions which were done for the residents found to have been affected by the deficient practice:** *A wet pipe sprinkler system gauges and valves inspection was completed with documentation 5/30/23; a quarterly sprinkler system inspection is scheduled for 6/9/23, during which the 2/18/23 quarterly inspection identified deficiencies will be corrected including, the sprinkler system supervisory switch repair; a legible sprinkler riser hydraulic nameplate was securely, attached 6/2/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents have the potential to be affected.* **The measures the facility will take and systems the facility will alter to ensure that the deficient practice will not reoccur:** *Monthly wet pipe sprinkler system gauges and valves inspections are scheduled with documentation, in the work order system; any future, quarterly sprinkler system inspection deficiencies will be timely corrected.* **Quality Assurance Plans to monitor facility performance to ensure corrections are**	

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	25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review of "Sprinkler Inspection - Quarterly Inspection" documentation dated 02/08/23 with Maintenance Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., under the deficiency recap on page four of the report, it was noted that the hydraulic nameplate for the sprinkler riser was not legible and securely attached to the riser. Furthermore, two other deficiencies were noted. The supervisory switch for the sprinkler system did not pass testing. Based on interview at the time of record review, the Maintenance Director acknowledged there was no written documentation available to show the sprinkler system had been repaired since the last inspection on 02/08/23. The deficiencies were also noted in sprinkler reports from 11/02/22 and 08/04/22. Findings were discussed with the Maintenance Director and Executive Director at exit conference.		**achieved and deficient practice will not recur:** *Monthly & quarterly inspections findings will be report to the QAPI Committee for 6 months. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.*	

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K 0363 SS=D Bldg. 01	3.1-19(b) NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	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 2 of 17 resident room corridor doors on the southwest wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 4 residents in rooms 275 and 278. Findings include: Based on observation with the Maintenance Director on 05/17/23 between 12:55 p.m. and 2:45 p.m., the corridor door to resident rooms 275 and 278 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director agreed that the door failed to latch into the frame. The doors were able to be adjusted at the time of observation. The finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**K363** **Corrective actions which were done for the residents found to have been affected by the deficient practice:** *Both affected door latches were adjusted to properly function. All resident room corridor doors were inspected by maintenance 5/25/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents have the potential to be affected.* **The measures the facility will take and systems the facility will alter to ensure that the deficient practice will not reoccur:** *All resident room corridor doors will be inspected and adjusted (if necessary) monthly and scheduled in work order system.* **Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and deficient practice will not recur:** *Maintenance staff to monthly monitor, log, repair/adjust as*	06/17/2023

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			needed and report findings monthly to QAPI Committee for 6 months. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.	
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 Based on record review and interview, the facility failed to conduct fire drills on each shift for 4 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 Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., all 12 required fire drill documentation was unable to be located. Based on interview at the time of record review, the Maintenance Director stated that all fire drills are documented in a	K 0712	**K712** **Corrective actions which were done for the residents found to have been affected by the deficient practice:** *Identified 12 missing fire drills documentation was located in a different office, after the survey.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents have the potential to be affected.* **The measures the facility will take and systems the facility**	06/17/2023

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	computer software 'TELS' and handwritten, but the binder containing all of the documentation could not be found during the survey. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b) 3.1-51(c)		**will alter to ensure that the deficient practice will not reoccur:** *Regularly scheduled & documented fire drills will continue and be retained in a Maintenance Office binder.* **Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and deficient practice will not recur:** *Fire drills summary will be reported monthly to QAPI Committee for 6 months. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.*	
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this			

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	manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at 86 of 86 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 05/17/23 between 12:55 p.m. and 2:45 p.m., the facility's 86 resident sleeping rooms contained four to eight non-hospital-grade electrical receptacles. Based on records review between 10:01 a.m. and 12:52	K 0914	**K914** **Corrective actions which were done for the residents found to have been affected by the deficient practice:** *All identified resident room non-hospital-grade electrical receptacles were numbered and tested 5/26, 5/30, 5/31/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents have the potential to be affected.* **The measures the facility will take and systems the facility will alter to ensure that the deficient practice will not reoccur:** *All identified resident room, non-hospital-grade electrical receptacles were numbered and scheduled for annual testing with a documentation log in the work order system.* **Quality Assurance Plans to monitor facility performance to**	06/17/2023

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	p.m., no documentation was available to show electrical receptacles in resident sleeping rooms were tested annually. Based on interview at the time of the observation and records review, the Maintenance Director confirmed all of the electrical receptacles in the resident sleeping rooms were not hospital-grade and stated annual testing per NFPA 99, Receptacle Testing requirements has not been completed. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		**ensure corrections are achieved and deficient practice will not recur:** *Annual findings will be reported to QAPI Committee. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.*	
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			

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	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 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: During records review with the Maintenance Director on 05/17/23 between 10:02 a.m. and 12:52 p.m., documentation of a four hour run test for the emergency generator conducted within the last 36 months was not provided for review. Based on interview at the time of records review, the Maintenance Director stated a four hour continuous run under load was not conducted in	K 0918	**K918** **Corrective actions which were done for the residents found to have been affected by the deficient practice:** *A four-hour continuous run under load test for the emergency generator was conducted with documentation 6/1/23; Also, a diesel generator fuel quality test was completed with documentation 5/31/23; awaiting results.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents have the potential to be affected.* **The measures the facility will take and systems the facility will alter to ensure that the deficient practice will not reoccur:** *A four-hour continuous run under*	06/17/2023

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	the past 36 months. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 05/17/23 between 10:01 a.m. and 12:52 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the Maintenance Director stated the facility does have a diesel generator but was unaware of the fuel quality testing requirements and did not have the fuel tested. The Maintenance Director later confirmed that a fuel analysis had not been performed within the past year. This finding was reviewed with the Executive		*load test for the emergency generator will be scheduled every 36 months with documentation and a diesel generator fuel quality test will be scheduled annually, with documentation in the work order system.* **Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and deficient practice will not recur:** *Annual and 36-month generator tests findings will be reported to QAPI Committee. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.*	

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	Director and Maintenance Director 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 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 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring.	K 0920	**K920** **Corrective actions which were done for the residents found to have been affected by the deficient practice:** *Identified refrigerator and microwave were removed. An*	06/17/2023

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	This deficient practice could affect approximately 15 staff and residents. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 05/17/23 between 12:55 p.m. and 2:45 p.m., a refrigerator (high power draw equipment) and microwave (high power draw equipment) was plugged into and supplied power by a power strip in the Social Services office near room 265. Based on interview at the time of observation, the Maintenance Director acknowledged power strip was supplying power to the high power appliances and would take care of the issue. Findings were discussed with the Maintenance Director and Executive Director at exit conference. 3.1-19(b)		*inspection was conducted for prohibited extension cords and power strip use 5/25/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *All residents and offices have the potential to be affected.* **The measures the facility will take and systems the facility will alter to ensure that the deficient practice will not reoccur:** *Monthly rounding inspections for prohibited extension cords and power strip use will be conducted by staff.* **Quality Assurance Plans to monitor facility performance to ensure corrections are achieved and deficient practice will not recur:** *Any deficiencies and corrections will be reported monthly to QAPI Committee for 6 months. The QAPI Committee will determine the need for continued or additional corrective actions to maintain compliance.*	