STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING -- B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

(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: 08/29/2022 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 At this Emergency Preparedness survey, Aperion Care Tolleston Park, was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 180 certified beds. 152 beds are dually certified for Medicare and Medicaid; 28 beds are certified for Medicare only. At the time of the survey, the census was 133. Quality Review completed on 09/06/22	E 0000		
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING -- B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			

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	155580	A. BUILDING -- B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

(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
	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: During record review with the Administrator and the Maintenance Director on 08/29/22 at 2:47 p.m. the facility was unable to provide documentation that the emergency preparedness plan was reviewed in the most recent twelve months. Based on interview at the time of record review, the Administrator agreed that she was unable to locate or provide the requested documentation at the time of the survey. The finding was reviewed with the Administrator and Maintenance Director at the time of exit.	E 0004	**E004 EMERGENCY PREPAREDNESS PLAN** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. The IDT reviewed and updated the complete emergency program. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The IDT was in serviced on the emergency management requirements. A complete review of the emergency plan was added to the QAPI calendar every 12 months. IV. How the corrective	09/21/2022

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			action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/2022	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must			

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	155580	A. BUILDING -- B. WING	08/29/2022

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

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	155580	A. BUILDING -- B. WING	08/29/2022

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	reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 08/29/22 at 2:47 p.m., no documentation could be found to show the Emergency Preparedness Plan's (EPP) Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Administrator agreed that documentation to show the EEP Policies and Procedures have been reviewed or updated within the last year was not available at the time of the survey. This finding was reviewed with the Administrator	E 0013	**E0013 DEVELOPMENT OF EP POLICIES AND PROCEDURES** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. The emergency preparedness policies and procedures were reviewed and	09/21/2022

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	and Maintenance Director during the exit conference.		updated. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The IDT was in serviced on the emergency management requirements. A review and update of the emergency preparedness policies and procedures was added to the QAPI calendar every 12 months. I. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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			Date of compliance: 09/21/2022	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Communication Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 08/29/22 at 2:46 p.m., no documentation could be found to show the Emergency Preparedness Plan's (EPP) Communication Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator agreed the documentation to show the EEP Communication Plan has been reviewed or updated within the last	E 0029	E0029 DEVELOPMENT OF COMMUNICATION PLAN I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. The	09/21/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	year was not available at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		entire emergency plan was reviewed and updated by the IDT. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The IDT was in serviced on the emergency preparedness requirements. A complete review of the emergency plan was added to the QAPI calendar every 12 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The admin or designee will review the QAPI calendar monthly and check the date of the last update of the emergency preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/2022	

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E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan's (EPP) Training and Testing Plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants.	E 0036	**E036 EP TRAINING AND TESTING/*** **The facility requests paper compliance for this citation.** I. What corrective action(s) will be accomplished for those	09/21/2022

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	Findings include: Based on records review with the Administrator and Maintenance Director on 08/29/22 at 2:46 p.m., no documentation was available for review to show the Emergency Preparedness Plan's (EPP) Training and Testing Plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator agreed the documentation to show the EPP Training and Testing Plan has been reviewed or updated within the last year was not available at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. The entire emergency plan was reviewed and updated by the IDT. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The IDT was in serviced on the emergency preparedness requirements. A complete review of the emergency plan was added to the QAPI calendar every 12 months. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The admin or designee will review the QAPI calendar monthly and also check the date of the last update of the emergency	

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			preparedness plan to ensure it is reviewed at least every 12 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly x12 months or until an average of 100% compliance is achieved x12 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance: 09/21/2022	
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: 08/29/2022 Facility Number: 008505 Provider Number: 155580 AIM Number: 200064830 At this Life Safety Code survey, Aperion Care Tolleston Park 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 with a partial basement was determined to be of Type V (111) construction and	K 0000		

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APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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	fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors. Battery powered smoke detectors are located in the North and South wing resident rooms; the PCU resident rooms are equipped with hard wired smoke detectors. The facility is protected by a 30-kW natural gas generator and a 45-kW diesel generator. The facility has 180 certified beds. 152 beds are dually certified for Medicare and Medicaid; 28 beds are certified for Medicare only. At the time of the survey, the census was 133. All areas where the residents have customary access were sprinklered. A detached wood equipment storage shed was unsprinklered. Quality Review completed on 09/06/22			
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155580	A. BUILDING 01 B. WING	08/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE TOLLESTON PARK	2350 TAFT ST GARY, IN 46404

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	sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.			
	Based on observation and interview, the facility failed to maintain the building construction type of the facility. This deficient practice could affect at least 10 residents, staff and visitors within the facility. Findings include: Based on observations on 08/29/22 during a tour of the facility at 1:52 p.m. with the Maintenance Director, there was an approximate six foot long by one foot wide section of drywall missing on the ceiling along the exterior wall in the electrical room across the corridor from Medical Records. This missing drywall exposed the wood ceiling joists and roof decking above. Based on interview at the time of observation, the Maintenance	K 0161	**K161 BUILDING CONSTRUCTION TYPE AND HEIGHT** **The facility requests paper compliance for this citation**. I. Immediate actions taken for those residents identified: The Maintenance Director will replace the six foot long by one-foot-wide section of drywall No resident or staff was found to	09/21/2022

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	Director confirmed that the building construction was not maintained due to the aforementioned missing drywall on the ceiling. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		be affected by this alleged deficiency. II. How the facility identified other residents: The facility observed all other hallway and egresses to ensure that the same deficient practice did not occur in other areas Visitors, staff, and residents that reside at the community have the potential to be affected by the alleged deficient practice. III. Measures put into place/ System changes: The Maintenance Director will make rounds weekly to ensure building structure is intact and document findings on the preventative maintenance log IV. How the corrective actions will be monitored: The administer or designee will review the preventative maintenance log monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will	

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			identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/2022	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General 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 staff interview, the facility failed to maintain the means of egress free from obstructions in 2 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment	K 0211	**K211 MEANS OF EGRESS** **The facility requests paper compliance for this citation.** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 15 residents, staff and	09/21/2022

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	This deficient practice could affect approximately 15 residents, staff and visitors. Findings include: Based on observations made with the Maintenance Director on 08/29/22 during a tour of the facility between 12:45 p.m. and 2:45 p.m. the following was noted: a) there was a bed being stored in the egress corridor by resident room 327. The bed was also observed in the corridor by room 327 at this location during an inital walk thru from 10:20 a.m. to 10:35 a.m. b) a roll on type floor scale was sitting the floor near resident room 231. Across the corridor from the floor scale was a multi shelf cart for linen storage, reducing the corridor width to four and a half feet. Based on an interview with the Maintenance Director at the time of the observations, he agreed that there was storage in the egress corridors in the above mentioned locations. This finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		visitors had the potential to be affected by this alleged deficient practice. The linen cart was relocated to a more appropriate area. The bed was moved out of the corridor. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The staff will be in serviced on maintaining a free, unobstructed corridor in case of an emergency. The maintenance director or designee will complete walking rounds 5 days a week to ensure the corridors remain unobstructed and record the results on the preventative maintenance log. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The administer or designee will audit all corridors weekly and the maintenance directors daily log to ensure the corridors remain unobstructed. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends	

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			or patterns and make recommendations to revise the plan of correction as indicated. Compliance: 09/21/2022	
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 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 Based on record review, observation 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 14.2.1.2.2 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	K 0345	**K345 FIRE ALARM SYSTEM** **The facility requests paper compliance for this citation.** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice	09/21/2022

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	Director on 08/29/22 from 10:35 a.m. to 12:45 p.m., the fire alarm report dated 02/21/2022 by the facility's fire alarm vendor indicated the annunciator located at the South Unit Nurse's station failed inspection and was 'falling off the wall'. The fire alarm report dated 08/15/2022 stated the annunciator panel failed inpection and was 'falling off the wall'. During a tour of the facility with the Maintenance Director on 08/29/22 from 12:45 p.m. to 2:45 p.m., the fire alarm annunciator at the South Unit Nurse's station had black electrical tape wrapped around the device. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for one week and was unable to show documentation that repairs had been made. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents had the potential to be affected by this alleged deficient practice. The the annunciator panel will be installed properly to the wall. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The maintenance director will be inserviced on properly reviewing the fire inspection reports and requesting repairs. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The administrator or designee will review the fire inspection records quarterly or when available to ensure suggested repairs are completed timely and document the results on the fire system repair audit tool. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive	

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			months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/2022	
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 observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any	K 0353	**K353 SPRINKLER SYSTEM-MAINTENANCE AND TESTING** **The facility requests paper compliance for this citation.** I. What corrective action(s) will be accomplished for those	09/21/2022

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	sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 08/29/22 at 1:34 p.m., there were two spare sprinkler cabinets at the risers located in Mechanical room across the corridor from the Director of Nursing office. There were a total of 10 sprinklers either laying loose on top of the cabinets or inside the cabinets not in protected slots. Additionally, there were no spare sidewall sprinklers in the cabinets. During a tour with the Maintenance Director, sidewall sprinklers were observed installed in the facility. Based on interview at the time of the observations, the Maintenance Director stated he had been on the job one week, and was unaware that the spare sprinklers were not properly stored and there were not any spare sidewall sprinkler heads. 2. 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		residents found to have been affected by the deficient practice. All residents and staff had the potential to be affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents, staff, and visitors have the potential to be affected by this alleged deficient practice. An inspection of the sprinklers and the sprinkler cabinet was completed. An additional sprinkler cabinet was ordered to ensure compliance. All 10 sprinkler were stored properly in the protective slots. The Maintenance Director completed a dry and wet sprinkler system gauge inspection III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The sprinkler system maintenance and testing schedule was added to the preventive maintenance log. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.	

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	is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. 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, staff, and visitors. Findings include: Based on review of the sprinkler system inspection reports for the most recent twelve month period with the Maintenance Director 08/29/2022 from 10:35 a.m. to 12:45 p.m., weekly dry sprinkler system gauge inspection documentation for 48 weeks of the most recent 52 week period was not available for review. Monthly wet sprinkler system gauge inspection documentation for 8 months of the most recent 12 month period was also not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for 8 months of the most recent 12 month period was not available for review. The sprinkler inspection reports dated 06/14/2022, 03/22/2022, 12/15/2021 and 09/28/2021 indicated the facility has 2 Dry type and 1 Wet type sprinkler systems. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for one week and could not locate any documentation for the sprinkler system gauge and control valve		The administrator or designee will audit the maintenance log monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance:09/21/2022	

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	inspection documentation for the aforementioned weekly and monthly periods at the time of the survey. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0355 SS=D Bldg. 01	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 ensure 1 of 2 portable fire extinguishers in the electrical room by the Social Services Office was installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice was not in a resident care area but could affect staff in the electrical room. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/29/22 at 1:34 p.m., a discharged ABC portable fire extinguisher located in the Electrical room by the Social	K 0355	**K355 PORTABLE FIRE EXTINGUISHERS** **The facility requests paper compliance for this citation.** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The discharged fire extinguisher was discarded appropriately. No residents were affected by this alleged deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be	09/21/2022

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	Services Office was sitting on the floor. Based on interview at the time of observation, the Maintenance Director agreed the extinguisher was sitting on the floor not mounted. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		identified and what corrective action(s) will be taken. Staff had the potential to be affected by this alleged deficient practice. The discharged fire extinguisher was discarded appropriately. The ABC portable fire extinguishers were all inspected. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The maintenance director will audit the portable fire extinguishers weekly to ensure they are inspected at least monthly and record the results of audit on the preventive maintenance log. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The administrator or designee will review the maintenance log monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make	

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			recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/2022	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect at least 10 residents, staff and visitors. Findings include: Based on observations made with the Maintenance Director on 08/29/22 during a tour	K 0374	**K374 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER** **The facility requests paper compliance for this citation.** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this deficient practice. II. How other residents having	09/21/2022

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(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
	the facility from 12:45 p.m. to 2:45 p.m., the smoke barrier doors in the Lobby area leading to the South unit failed to fully close and latch when tested on three separate attempts leaving a one-inch gap when closed at the fullest. Based on an interview at the time of observation, the Maintenance Director agreed that the doors failed to fully close stating that the astragal was installed on the wrong side of the door which stopped the doors from latching. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. At least 10 residents, staff and visitors had the potential to be affected by this alleged deficient practice. All barrier doors were inspected to ensure proper closure. The barrier door listed on the 2567 was the only doors not to close properly and were adjusted. The astragal was installed properly. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. All barrier doors will be inspected monthly to ensure proper closure. The results of the inspection will be documented on the preventative maintenance log. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The administrator will audit the maintenance log monthly to ensure doors are inspected and functioning properly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90%	

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	155580	A. BUILDING 01 B. WING	08/29/2022

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			compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/2022	
K 0531 SS=D Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review and interview, the facility failed to maintain testing of 1 of 1 staff elevator firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance	K 0531	**K531 ELEVATORS** **The facility requests paper compliance for this citation.**	09/21/2022

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	with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice would affect staff that use the elevator. Findings include: Based on record review with the Maintenance Director on 08/29/22 at 12:30 p.m., the monthly testing for the elevator firefighter recall for the staff elevator was missing 11 of the last 12 months. Documentation dated 06/09/2022 of monthly firefighter recall testing was performed during the annual service of the elevator. Based on interview at the time of record review, the Maintenance Director stated he had been on the job for one week and could not located the missing monthly tests at the time of the survey. This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)		I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this deficient practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All residents and staff had the potential to be affected by this alleged deficient practice. The Firefighter Recall Testing is completed monthly and documented on the OTIS Log of Monthly Elevator testing. The Maintenance Director was in-serviced on how to perform the recall testing on 9/13/22 by OTIS. I. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The Maintenance Director was in-serviced on how to perform the recall testing on 9/13/22 by OTIS. The Maintenance Director will complete recall testing monthly and document on the log. IV. How the corrective	

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			action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The administrator or designee will audit the monthly elevator testing log monthly to ensure compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 09/21/2022	
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			

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	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 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 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	K 0918	**K918 ELECTRICAL SYSTEMS-ESSENTIAL ELECTRIC SYSTEM** **The facility requests paper compliance for this citation.** I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this alleged deficient practice II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	09/21/2022

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	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 Maintenance Director from 10:35 a.m. to 12:45 p.m. on 08/29/22, the load information to show the actual load percentage for the diesel powered generator was documented as "ok". Based on interview at the time of record review, the Maintenance Director stated he had been on the job for one week and agreed the monthly generator load documentation did not show the actual load percentage. 2. Based on record review and interview, the facility failed to ensure a 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 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 Maintenance		action(s) will be taken. All residents have the potential to be affected by this alleged deficient practice. Generators were inspected and passed inspection. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The maintenance director was in serviced on inspecting generators weekly. The maintenance director will document the required generator inspections on the generator log IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The administrator or designee will audit the generator log weekly to ensure compliance The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Director on 08/29/22 from 10:35 a.m. to 12:45 p.m., the last documented weekly generator inspection was dated 08/02/2022 for both the Diesel fired generator and the Natural Gas generator. Based on an interview at the time of record review, the Maintenance Director stated he had been on the job for one week and no other weekly generator inspection documentation was available for review at the time of the survey. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Date of compliance: 09/21/2022	