STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING -- B. WING	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLONIAL NURSING HOME	119 N INDIANA AVE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/20/2023 Facility Number: 000360 Provider Number: 155733 AIM Number: 100290370 At this Emergency Preparedness survey, Colonial Nursing Home was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 55 certified beds. At the time of the survey, the census was 35. Quality Review completed on 07/24/23	E 0000	/b> =”” b=””> =”” b=””> =”” b=””> =”” b=””>	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Short	Administrator	08/21/2023

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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	155733	A. BUILDING -- B. WING	07/20/2023

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	forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs 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.			

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	155733	A. BUILDING -- B. WING	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 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			

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	155733	A. BUILDING -- B. WING	07/20/2023

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	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 Regional Director on 07/20/23 between 09:59 a.m. and 12:05 p.m., the generator lacked certain monthly load testing and weekly visual checks required by LSC and NFPA 110. Based on interview at the time of record review, the Regional Director stated that the Maintenance Director position had been recently filled and monthly and weekly inspection were not conducted during the missing times. The findings were reviewed with the Regional Director at the exit conference.	E 0041	E041 (F) Hospital CAH and LTC Emergency Power It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; • All residents could potentially be harmed by the alleged deficient practice. A generator testing occurred on 07/31/2023 How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; • All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the generator testing was conducted on 07/31/2023. Additional education was provided to the Maintenance Director to ensure testing is being completed 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 reviewed policy and procedure on Generator Testing	08/15/2023

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			protocol • A performance improvement tool has been developed to monitor monthly load testing and weekly visual checks How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. By what date the systemic changes will be made: August 15, 2023	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey were conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/20/2023 Facility Number: 000360	K 0000	/b> **="" b="">** **="" b="">** **="" b="">** **="" b="">**	

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	Provider Number: 155733 AIM Number: 100290370 At this Life Safety Code survey, Colonial Nursing Home 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. Colonial Nursing Home is a two-story building with a basement of Type V (000) construction that was built at three different times. The original building was constructed in 1906 with additions constructed in 1986 and 1994. The building is fully sprinklered and there is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The facility has 55 certified beds. All 55 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 35. All areas where the residents have customary access and areas providing facility services were sprinklered. Quality Review completed on 07/24/23			
K 0161 SS=F 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			

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	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 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 was not an acceptable type of construction as required by NFPA 101 - 2012 edition, Sections 19.1.6.1, 4.5.8 and NFPA 220 - 2012 edition, Section 4.1, 4.1.1 and Table 4.1.1. This deficient practice could affect all 35 residents. Findings include:	K 0161	/b> It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those***	08/15/2023

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	Based on observation with the Regional Director on 07/20/2023 during a tour of the facility from 12:10 p.m. to 2:12 p.m., observation of the unprotected wood structure revealed that the type of construction of the building was Type V (000) and the building was two stories. Type V (000) is not an acceptable type of construction for a two-story existing healthcare building. This finding was confirmed by the Regional Director at the time of discovery. 3.1-19(b)		***residents found to have been affected by the deficient practice;*** **· An independent company, RTM, completed an FSES review in 2021 and determined all the Interstitial spaces of the basement levels and 2nd floor will require the installation of smoke and heat detectors. The new smoke detection system was installed as well as a sprinkler system in 2023 by Safecare.** **· A new FSES score will be completed on 8/7/2023. This has been scheduled at the earliest date possible. The new FSES should reflect the new system that will be a passing score.** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice but none were identified . Administration will review FSES documentation and will review annually as needed.** ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;***	

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			·The IDT reviewed CMS guidelines on Use of fire safety evaluation system (FSES) **·A performance improvement tool has been developed to monitor that FSES and its accuracy** ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.** ***By what date the systemic changes will be made:*** ***08/15/2023***	
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility	K 0225	K225 Stairways and Smokeproof	08/15/2023

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	failed to provide and maintain exit stairs and exit stair enclosures in accordance with NFPA 101 - 2012 edition, Sections 19.2, 19.2.1, 19.2.2.3, 7.1.3.2, 7.1.3.2.1, 7.1.3.2.3, 7.1.10, 7.1.10.1, 7.2.2, 7.2.2.1, 7.2.2.1.1, 7.2.2.3.3, 7.2.2.3.3.1, 7.2.2.3.3.4, 7.2.2.2, 7.2.2.2.1, 7.2.2.2.1.1, 7.2.2.5.3, 7.2.2.5.3.1, 7.2.2.5.3.2, 7.7.3, 7.7.3.4, 7.2.2.3.6, 7.2.2.3.6.1, 7.2.2.3.6.2, 8.2 and Table 7.2.2.2.1.1 (b). This deficient practice could affect approximately 6 of the 35 residents. Based on observations with the Regional Director on 07/20/2023 during a tour of the facility from 12:10 p.m. to 2:12 p.m., the following was discovered: a) the exit stair by room 201 was not enclosed in fire rated construction. The door to the stair did not have fire resistance rating. b) the stair by room 201 consisted of metal open-grate walking surfaces. The landing and all of the stair treads were metal open-grate where there was 1/4 inch piece of metal and a 1 inch gap between the 1/4 inch metal pieces. This building is a healthcare occupancy. c) the stair by room 201 continued down from the upper landing 24 risers to the bottom of the stair without an intermittent landing. The approximately 15 foot distance exceeded the allowable maximum 12 foot distance between landing. d) the stair by room 201 only had a 30 inch clear width and not the required minimum 36 inch clear width. These findings were confirmed by the Regional Director at the times of discovery and exit conference. 3.1-19(b)		Enclosures It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** **· Requesting compliance with alleged deficiency through the Life Safety Equivalency granted through the FSES is completed and a passing score is achieved. These stairs would only be used in an emergency situation, i.e. fire evacuation by using the fire sled and these stairs do reach the sidewalk downstairs for egress to outside the building.** **· Installation occurred from an independent contractor, Safe Care of all additional work needed to be upgrade the smoke detection system. Total coverage smoke detection included the installation of automatic smoke detection in all rooms, halls, storage areas, basements, attic, lofts, space above suspended ceilings, and other subdivisions and accessible spaces as well as the inside of all closets, elevators, shafts, ,enclosed stairways, dumb waiter shafts,**	

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			and chutes. The fires system panel was updated as well by Safe Care as well. The facility will have an updated FSES on 08/07/2023 to reflect the updated system. ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice but none were identified. Administration will review FSES documentation and will review annually as needed.** ***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 reviewed CMS guidelines on Use of fire safety evaluation system (FSES)** **·A performance improvement tool has been developed to monitor that FSES and its accuracy** ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality**	

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			Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made: 8/15/2023***	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on records review and interview, the facility failed to ensure 8 of 8 battery backup lights were tested monthly. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0291	**K291 (F) Emergency Lighting** It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** **·All residents could potentially be harmed by the alleged deficient practice but**	08/15/2023

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	Based on an observation during a tour of the facility with the Regional Director on 07/20/23 between 09:59 a.m. and 12:05 p.m., documentation of monthly 30 second test for May 2023 and June of 2023 for all battery powered emergency lights were not available for review. Based on an interview at the time of record review, the Regional Director stated that the Maintenance Director position had been recently filled and the inspections had not been conducted during the transitioning. This finding was reviewed with the Regional Director during the exit conference. 3.1-19(b)		**none were identified. A emergency battery testing occurred on 08/01/2023** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the emergency lighting were conducted on 08/01/2023.** **·Additional education was provided to the Maintenance Director to ensure testing is being completed.** ***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 reviewed emergency testing protocol** **·A performance improvement tool has been developed to monitor emergency lighting testing** ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality**	

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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
			Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made: 8/15/2023***	
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide 1 of 1 correct written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants.	K 0346	**K346 (F) Fire Alarm System-Out of Service** It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those***	08/15/2023

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	Findings include: Based on record review with the Regional Director on 07/20/23 between 09:59 a.m. and 12:05 p.m., documentation of a written fire watch policy in the event of the fire alarm system outage/impairment was not able to be located. Based on interview at the time of record review, the Regional Director stated that the facility does have a fire watch policy in place, but the documentation was unable to be reviewed at the time of the survey. Findings were discussed with the Regional Director at exit conference. 3.1-19(b)		***residents found to have been affected by the deficient practice;*** **·All residents could potentially be harmed by the alleged deficient practice, but none were identified. A written policy for fire watch policy was put into place on 07/31/2023.** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the fire watch policy was conducted on 07/31/2023.** **· 1:1 education was provided to the Maintenance Director to ensure fire watch policy was in place and available** ***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 reviewed the fire watch policy** **·A performance improvement tool has been developed to monitor the fire watch policy is in place** ***How the corrective actions will be monitored to ensure the***	

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			deficient practice does not recur; **A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.** ***By what date the systemic changes will be made: 8/15/2023***	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source			

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	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to 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 Regional Director on 07/21/23 between 09:59 a.m. and 12:05 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 Regional Director stated that they had recent changes with Maintenance Directors and have been in the process of transitioning, so inspections were not done. However, other documentation of a monthly gauge & valve inspection were unable to be located at the time of survey. Findings were discussed with the Regional	K 0353	K353 (F) Sprinkler System-Maintenance and Testing It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** **·All residents could potentially be harmed by the alleged deficient practice but none were identified. The facility checked the pipe sprinkler system's gauges and valves on 08/01/2023** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the pipe sprinkler system's gauges and valves on 08/01/2023.** **·1:1 education was provided to the Maintenance Director to ensure the pipe sprinkler**	08/15/2023

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	Director at exit conference. 3.1-19(b)		**system's gauges and valves are checked** ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;*** **·A performance improvement tool has been developed to monitor pipe sprinkler system's gauges and valves are being checked** ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.** ***By what date the systemic changes will be made: 8/15/2023***	

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K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the	K 0354	**K354 (F) Sprinkler System- Out of Service** It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** **·All residents could potentially be harmed by the alleged deficient practice. A written policy for fire watch policy was put into place on 07/31/2023** ***How other resident having the potential to be affected by the same deficient practice will be***	08/15/2023

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	facility. Findings include: Based on record review with the Regional Director on 07/20/23 between 09:59 a.m. and 12:05 p.m., no documentation of a written fire watch policy in the event of a sprinkler impairment or outage was able to be located at the time of record review. Based on interview at the time of record review, the Regional Director stated that the facility does have a fire watch policy and documentation could have been misplaced and acknowledged documentation was unable to be found during the survey. Findings were discussed with the Regional Director at exit conference. 3.1-19(b)		***identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the fire watch policy was conducted on 07/31/2023.** **· 1:1 education was provided to the Maintenance Director to ensure fire watch policy was in place and available** ***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 reviewed the fire watch policy** **·A performance improvement tool has been developed to monitor the fire watch policy is in place** ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately**	

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			corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made: 8/15/2023***	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 7 of 7 fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of	K 0761	It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** **·All residents could potentially be harmed by the alleged deficient practice but none were identified. An inspection of the 7 fire doors was conducted on 08/01/2023** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the 7 fire doors was conducted**	08/15/2023

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	either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Regional Director on 07/20/23 between 09:59 a.m. and 12:05 p.m., no documentation of an annual inspection for the (7) fire door assemblies was available for review. Based on observation during the tour between 12:10 p.m. and 2:12 p.m., there are (7) one hour fire door assembly in the two stair wells. Based on interview at the time of records review and observation, the Regional Director stated the annual fire door inspection could have been conducted, but documentation could not be		**on 08/01/2023** **· 1:1 education was provided to the Maintenance Director to ensure all 7 fire doors are checked annually** ***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 reviewed fire door checklist** **·A performance improvement tool has been developed to monitor the fire door checks** ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.** ***By what date the systemic***	

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	provided at the time of the survey. Findings were discussed with the Regional Director at exit conference. 3.1-19(b)		***changes will be made: 8/15/2023***	
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 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 29 of 29 resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition,	K 0914	It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures.	08/15/2023

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	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 Regional Director on 07/20/23 between 12:10 p.m. and 2:12 p.m., the facility's 29 resident sleeping rooms contained four to six non-hospital-grade electrical receptacles. Based on records review between 09:59 a.m. and 12:05 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 Regional 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 could have been conducted within the past 12 months, but was unable to find documentation. Findings were discussed with the Regional Director at exit conference.		***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** **·All residents could potentially be harmed by the alleged deficient practice. A inspection of electrical receptacles conducted on 08/04/2023** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the electrical receptacles conducted on 08/04/2023** **· 1:1 education was provided to the Maintenance Director to ensure all electrical receptacles are being inspected** ***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 reviewed policy on electrical receptacles.** **·A performance improvement tool has been developed to monitor the electrical receptacle testing**	

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	3.1-19(b)		***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.** ***By what date the systemic changes will be made:*** ***8/15/2023***	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with			

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	NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 2 of 12 months and weekly inspection for 8 of 52 weeks. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Chapter 6.4.4.2 of	K 0918	It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** **·All residents could potentially be harmed by the alleged deficient practice. A inspection of electrical receptacles conducted on**	08/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155733	A. BUILDING 01 B. WING	07/20/2023

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	NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Regional Director on 07/20/23 between 09:59 a.m. and 12:05 p.m., no documentation was available for the month of May and June of 2023 to show the generator set in service was exercised at least once monthly, for a minimum of 30 minutes. Also, the generator weekly inspection log showed the last weekly inspection was conducted on 05/19/23 and no other weekly inspections were conducted since. Based on an interview at the time of record review, the Regional Director stated that the Maintenance Director position had recently been filled and the inspections were not conducted during the time of transitioning. The findings were reviewed with the Regional Director during the exit conference. 3.1-19(b)		**08/04/2023** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice. An audit of the electrical receptacles conducted on 08/04/2023** **· 1:1 education was provided to the Maintenance Director to ensure all electrical receptacles are being inspected** ***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 reviewed policy on electrical receptacles.** **·A performance improvement tool has been developed to monitor the electrical receptacle testing** ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance**	

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			Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. ***By what date the systemic changes will be made: 8/15/2023***	
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			

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	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 3 of 3 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. This deficient practice could affect approximately 5 residents and staff. Findings include: Based on observations during a tour of the facility with the Regional Director on 07/20/23 between 12:10 p.m. and 2:12 p.m., a refrigerator (high power draw equipment) and microwave (high power draw equipment) was plugged into and supplied power by an extension cord in the Admissions/Activities Office. Furthermore, resident room 201 contained a power strip that supplied power to a minifridge. Additionally, the power strip used for the minifridge was daisy chained into another power strip. Based on interview at the time of record review, the Regional Director agreed that there were misused power strips and removed the extension cord and power strips upon observation. Findings were discussed with the Regional Director at exit conference. 3.1-19(b)	K 0920	**K920- Electrical Equipment-Power Cords and Extensions** It is the practice of this facility that we ensure that residents are free from misappropriation/exploitation based on developed policies and procedures. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** **·All noncompliant extension cords and power strips were removed from all rooms in the facility** ***How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;*** **·All residents residing in the facility could potentially be affected by the alleged deficient practice but none were identified.** **·An audit of the power strips and extension cords was conducted on 08/03/2023.** **· 1:1 education was provided to the Maintenance Director to ensure facility is free from extension cords and power strips**	08/15/2023

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			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 reviewed the power strip and extension cord policy** **·A performance improvement tool has been developed to monitor noncompliant power strips and extension cords** ***How the corrective actions will be monitored to ensure the deficient practice does not recur;*** **A performance improvement tool has been initiated that randomly audits. This Quality Assurance Audit Tool will be completed by the Maintenance Director/Designee Weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.** ***By what date the systemic changes will be made:*** ***8/15/2023***	