DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155102	A. BUILDING -- B. WING	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	635 OAKHILL AVE PLYMOUTH, IN 46563

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/16/23 Facility Number: 000041 Provider Number: 155102 AIM Number: 100275400 At this Emergency Preparedness survey, Miller's Merry Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 131 and had a census of 58 at the time of this survey. Quality Review completed on 03/22/23	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bryan Zehr	Administrator	04/03/2023

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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	§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. You may inspect a copy at the CMS			

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	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 Standby Power Systems, 2010 edition,			

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	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 Administrator and Maintenance Director on 03/16/23 at 12:10 p.m., the generator annual fuel quality testing comments required by LSC and NFPA 110 were not followed. In the comment section of the annual fuel quality test it was recommended that the fuel be filtered due to the contamination level. Based on interview at the time of record review, the Maintenance Director stated the fuel level was low when sampled. The facility had the fuel tank filled but did not retest to confirm that the contaminate level was within the proper limit. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	E 041 The facility respectfully submits the following allegation of compliance for regulation E 041. All residents and staff have the potential to be affected by this practice. Herrman and Goetz, Inc. completed a fuel polish. This was completed 3-28-2023. Herrman and Goetz is gathering a re-sample to be sent to lab to re-check fuel quality. (Attachment I) Once sample is received back from the lab it will be forwarded to IDH LSC for compliance. To ensure ongoing compliance. Annual fuel test will be completed by Herrman and Goetz, Inc. All deficiencies will be corrected immediately. Staff was in serviced on 3-31-2023 (Attachment D).	05/05/2023
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: 03/16/23 Facility Number: 000041 Provider Number: 155102 AIM Number: 100275400	K 0000		

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	At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 131 and had a census of 58 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/22/23			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants			

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	by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4			

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	ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	The facility failed to ensure the door locking arrangements for 1 of 2 doors were installed in accordance with LSC Section 7.2.1.5.10.1(2). LSC 7.2.1.5.10.1(2) states the releasing mechanism for any latch shall be located not more than 48 inches above the finished floor. This deficient practice could affect all staff in the kitchen. Findings include: Based on observation and interview on 3/16/23 at 2:45 pm one of the exit doors from the kitchen to the corridor had a doorknob located 60 inches above the finished floor. When asked the Maintenance Director stated the doorknob was located high on the door but he was not aware that it was a code violation. This finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)	K 0222	K 222 The facility respectfully submits the following allegation of compliance for regulation K 222. All residents and staff have the potential to be affected by this practice. The doorknob to kitchen exit door was lowered to 41 inches. This was completed on 3-28-2023. (Attachment H Photos) Maintenance supervisor inspected all facility doorknob exits to ensure that all complied below 48 inches. There were no further deficiencies per inspection. Staff was in serviced on 3-31-2023 (Attachment D). To ensure on going compliance Maintenance Supervisor or Designee will complete visual inspection of doorknobs in facility ensuring they are below 48 inches. Life Safety Code Audit Tool (Attachment A) will be completed weekly for 4 weeks and monthly until 100% compliance is completed for 3 consecutive months. Results will	04/03/2023

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			be reviewed monthly by the facility QAPI Committee. All deficiencies will be corrected immediately.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility	K 0321	K 321	04/03/2023

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	failed to ensure 1 of 1 Activity storage room with large amounts of combustible storage and greater than 50 square feet was protected as a hazardous area. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Director on 03/16/23 at 3:00 p.m., the Activity storage room contained over 20 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Director agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		The facility respectfully submits the following allegation of compliance for regulation K 321. All residents and staff have the potential to be affected by this practice. Self-Closing Mechanism was added to the Activities Storage room. This was completed 3-28-2023. (Attachment H Photos) Maintenance supervisor inspected all facility rooms to ensure that all rooms with storage have self-closures. There were no further deficiencies per inspection. Staff was in serviced on 3-31-2023 (Attachment D). To ensure on going compliance Maintenance Supervisor or Designee will complete visual inspection of storage rooms in facility ensuring they have self-closures. Life Safety Code Audit Tool (Attachment A) will be completed weekly for 4 weeks and monthly until 100% compliance is completed for 3 consecutive months. Results will be reviewed monthly by the facility QAPI Committee. All deficiencies will be corrected immediately.	
K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric			

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	Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm panel was protected. NFPA 72, National Fire Alarm and Signaling Code Section 10.15 states in areas that are not continuously occupied, automatic smoke detection shall be provided at the location of each fire alarm control unit(s), notification appliance circuit power extenders, and supervising station transmitting equipment to provide notification of fire at that location. Exception: Where ambient conditions prohibit installation of automatic smoke detection, automatic heat detection shall be permitted. Annex A is not a part of the requirements but is included for informational purposes only. A.10.15 states the fire alarm control unit(s) that are to be protected are those that provide notification of a fire to the occupants and responders. The term fire alarm control unit does not include equipment such as annunciators and addressable devices. Requiring smoke detection at the transmitting equipment is intended to increase the probability that an alarm signal will be transmitted to a supervising station prior to that transmitting equipment being disabled due to the fire condition. CAUTION: The exception to 10.15 permits the use	K 0341	K 341 The facility respectfully submits the following allegation of compliance for regulation K 341. All residents and staff have the potential to be affected by this practice. Smoke Detector will be connected to the fire alarm system in the Main Mechanical Room to protect fire alarm panel. This will be completed by B A Solutions (Attachment E). Estimated time of completion is 4-7-2023. To ensure ongoing compliance this smoke detector will be added to our list of units on our quarterly inspection by Safe Care. All deficiencies found by Safe Care will be corrected immediately. Staff was in serviced on 3-31-2023.	04/07/2023

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	of a heat detector if ambient conditions are not suitable for smoke detection. It is important to also evaluate whether the area is suitable for the control unit. Where the area or room containing the control unit is provided with total smoke-detection coverage, additional smoke detection is not required to protect the control unit. Where total smoke-detection coverage is not provided, the Code intends that only one smoke detector is required at the control unit even when the area of the room would require more than one detector if installed according to the spacing rules in Chapter 17. The intent of selective coverage is to address the specific location of the equipment. Location of the required detection should be in accordance with one of the following: (1) Where the ceiling is 15 feet in height or less, the smoke detector should be located on the ceiling or the wall within 21 feet of the centerline of the fire alarm control unit being protected by the detector in accordance with 17.7.3.2.1. (2) Where the ceiling exceeds 15 feet in height, the automatic smoke detector should be installed on the wall above and within 6 feet from the top of the control unit. This deficient practice could affect all occupants. Findings include: Based on observation with the Maintenance Director and Administrator on 03/16/23 at 1:35 p.m., the fire alarm panel located in the main mechanical room was not protected by a smoke detector connected to the fire alarm system. Based on an interview at the time of observation, the Maintenance Supervisor confirmed the main mechanical room was not continuously occupied and a smoke alarm was not connected to the fire alarm system for protection of the fire alarm panel.			

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	This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)			
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to ensure 1 of 1 kitchen walk-in refrigerator was provided with adequate coverage. NFPA 13, 2010 edition, Section 8.7.5.1.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. This deficient practice could affect 2 staff in the kitchen.	K 0351	K351 The facility respectfully submits the following allegation of compliance for regulation K 351. All residents and staff have the potential to be affected by this practice. Facility has obtained quote to have Sprinkler head was moved to the center of the walk-in	04/04/2023

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	Findings include: Based on observation with the Maintenance Director on 03/16/23 at 2:40 p.m., in the kitchen there was only one sprinkler head in the walk-in refrigerator. Only part of the area was covered by the sprinkler due to the sprinkler placement 12 feet from one wall. The coverage area is 7.5 feet on each side of the sprinkler. Based on interview at the time of observation, the Maintenance Director stated he was unaware there was a problem with the sprinkler installation in the walk-in refrigerator. The finding was reviewed with the Administrator and the Maintenance Director at the exit conference. 3.1-19(b)		refrigerator. This created coverage area of 7.5 feet in the refrigerator. (Attachment J) Maintenance Supervisor inspected facility to ensure that there were no further deficiencies. This was completed 3-28-2023. Staff was in serviced on 3-31-2023 (Attachment D) To ensure on going compliance Maintenance Supervisor or Designee will complete visual inspection of sprinkler heads in the facility ensuring they have the proper coverage of 7.5 ft. Life Safety Code Audit Tool (Attachment A) will be completed weekly for 4 weeks and monthly until 100% compliance is completed for 3 consecutive months. Results will be reviewed monthly by the facility QAPI Committee. All deficiencies will be corrected immediately.	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)			

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	155102	A. BUILDING 01 B. WING	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S MERRY MANOR	635 OAKHILL AVE PLYMOUTH, IN 46563

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	Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 2 of 2 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 03/16/23 at 2:05 p.m., an unsealed penetration, where a flexible conduit was installed, was discovered in the attic smoke barrier by room 83. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned smoke barrier contained an unsealed penetration. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0372	K 372 The facility respectfully submits the following allegation of compliance for regulation K 372. All residents and staff have the potential to be affected by this practice. Penetration found on inspection was sealed by Maintenance Supervisor and Corporate Consultant. This was completed on 3-28-2023. (Attachment H Photos) Maintenance supervisor inspected all facility firewalls to ensure that there were no unsealed penetrations. There were no further deficiencies per inspection. Staff was in serviced on 3-31-2023 (Attachment D). To ensure on going compliance Maintenance Supervisor or Designee will complete visual inspection of fire walls in facility ensuring there are no unsealed penetrations. Life Safety Code Audit Tool (Attachment A) will be completed weekly for 4 weeks and monthly until 100% compliance is completed for 3 consecutive months. Results will be reviewed monthly by the facility QAPI Committee. All deficiencies will be corrected immediately.	04/03/2023
K 0712 SS=F	NFPA 101 Fire Drills			

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Bldg. 01	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7			
	Based on record review and interview, the facility failed to ensure 2 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 9:00 p.m. and 6:00 a.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on records review with the Maintenance Director and Administrator on 03/16/23 at 10:30 a.m., the fire drill forms for third shift drills indicated transmission of signal was not tested for the fire drill completed on 05/20/22 at 4:00 am. There also was a silent fire drill documented on 07/26/22 at 8:00 pm which is not within the time frame of the regulation. Based on interview at the time of record review, the Maintenance Director stated he did not transmit the signal the next day for the fire drill completed on 05/20/22 and the silent drill on 07/26/22 was not within the time frame of the regulation.	K 0712	K 712 The facility respectfully submits the following allegation of compliance for regulation K 712. All residents and staff have the potential to be affected by this practice. Maintenance Supervisor and designee were in serviced on NFPA 101 K-712 requirements for fire drills. This was completed 3-31-2023 (Attachment F). All staff was in serviced 3-31-2023. (Attachment D) To ensure on going compliance Maintenance Supervisor or Designee will complete fire drills alternating times, varying conditions, and at least quarterly on each shift. Facility Fire Alarm Audit Tool (Attachment G) will be completed monthly until 100% compliance is completed for 12 consecutive months. Results will be reviewed monthly by the facility QAPI	04/03/2023

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	This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Committee. All deficiencies will be corrected immediately.	
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure access and working space was maintained for 1 of 1 electrical panels in main mechanical room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the workspace shall permit at least a	K 0911	K 911 The facility respectfully submits the following allegation of compliance for regulation K 911. All residents and staff have the potential to be affected by this practice. All items that were being stored in front of electrical panel in main mechanical room were removed by Maintenance Supervisor and Corporate Consultant. This was completed on 3-28-2023. (Attachment H Photos) Maintenance supervisor inspected all facility rooms that house electrical panels to ensure that there was no storage in front of any electrical panels. Maintenance Supervisor also added red tape to signify 3 ft. clearance in front of the electrical panels. There were no further	04/03/2023

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	90-degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a height of 61?2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could any residents in the area of the mechanical room. Findings include: Based on observations during a tour of the facility with the Maintenance Director and the Administrator on 03/16/23 at 1:30 p.m., an electrical panel in the main mechanical room was block from access with items stored in front of the panels. Based on interview at the time of the observations, the Maintenance Director agreed items were stored within the working space in front of the electrical panel. 3.1-19(b)		deficiencies per inspection. Staff was in serviced on 3-31-2023 (Attachment D). To ensure on going compliance Maintenance Supervisor or Designee will complete visual inspection of electrical panels in facility ensuring there is nothing being stored in front of electrical panels. Life Safety Code Audit Tool (Attachment A) will be completed weekly for 4 weeks and monthly until 100% compliance is completed for 3 consecutive months. Results will be reviewed monthly by the facility QAPI Committee. All deficiencies will be corrected immediately.	
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			

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	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 record review and interview, the facility failed to ensure non-hospital grade electrical receptacles at resident sleeping rooms were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all residents. Findings include: Based on records review on 03/16/23 at 11:30 a.m., the documentation presented showing the last time the electrical receptacles in resident sleeping rooms were tested was incomplete. Based on	K 0914	K 914 The facility respectfully submits the following allegation of compliance for regulation K 914. All residents and staff have the potential to be affected by this practice. Date on the Documentation for Electrical Receptacles was reformatted to show the proper month, day and year (Attachment B). This was completed by the Maintenance Supervisor and Corporate Consultant. Maintenance supervisor re inspected all facility resident sleeping rooms to insure all electrical receptacles were tested (Attachment C). This was completed on 3-30-2023. All deficiencies were repaired immediately during inspection. Staff was in serviced on 3-31-2023 (Attachment D). To ensure on going compliance Maintenance Supervisor or Designee will	04/03/2023

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	interview at the time of the records review, the Maintenance Director stated that all the electrical receptacles in the resident sleeping rooms were not hospital-grade and the inspection had been done. The documentation provided did not have a title or dated year, therefore the year it was completed could not be verified. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		complete visual inspection of all facility resident sleeping rooms. Life Safety Code Audit Tool (Attachment A) will be completed weekly for 4 weeks and monthly until 100% compliance is completed for 3 consecutive months. Results will be reviewed monthly by the facility QAPI Committee. All deficiencies will be corrected immediately	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a			

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	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 follow the recommendations of the annual fuel quality test performed on August 30, 2022, for 1 of 1 facility diesel powered generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on records review with the Maintenance Director on 03/016/23 at 12:20 p.m., the documentation of the annual fuel quality test for the diesel generator was abnormal and recommended the fuel be filtered to remove particulates. Based on interview at the time of records review, the Maintenance Director stated the tank was low when tested and that was the reason the test was abnormal. The facility had the	K 0918	K 918 The facility respectfully submits the following allegation of compliance for regulation K 918. All residents and staff have the potential to be affected by this practice. Herrman and Goetz, Inc. completed a fuel polish. This was completed 3-28-2023. Herrman and Goetz is gathering a re-sample to be sent to lab to re-check fuel quality. (Attachment I) Once sample is received back from the lab it will be forwarded to IDH LSC for compliance. To ensure ongoing compliance. Annual fuel test will be completed by Herrman and Goetz, Inc. All deficiencies will be corrected immediately. Staff was in serviced on 3-31-2023 (Attachment D).	05/05/2023

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	fuel tank filled to correct the problem but did not retest to see if it resolved the problem. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw.	K 0920	K 920 The facility respectfully submits the following allegation of compliance for regulation K 920.	04/03/2023

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	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 up to 5 residents in the Maintenance office area. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 03/16/23 at 3:02 p.m., a refrigerator and a microwave (high power draw equipment) were plugged into and supplied power by a power strip in the Maintenance office. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was supplying power to high power draw equipment. 3.1-19(b)		All residents and staff have the potential to be affected by this practice. Power strip was removed by Maintenance Supervisor and Corporate Consultant. This was completed on 3-28-2023. (Attachment H Photos) Maintenance supervisor inspected all facility resident rooms, offices, and storage rooms to ensure that there were no power strips in use with (high power draw equipment). There were no further deficiencies per inspection. Staff was in serviced on 3-31-2023 (Attachment D). To ensure on going compliance Maintenance Supervisor or Designee will complete visual inspection of all facility resident rooms, offices, and storage rooms to ensure that there were no power strips in use with (high power draw equipment). Life Safety Code Audit Tool (Attachment A) will be completed weekly for 4 weeks and monthly until 100% compliance is completed for 3 consecutive months. Results will be reviewed monthly by the facility QAPI Committee. All deficiencies will be corrected immediately.	