STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING -- B. WING	07/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(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 completed by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/05/2022 Facility Number: 000369 Provider Number: 155530 AIM Number: 100275190 At this Emergency Preparedness survey, South Shore Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 100 certified beds. At the time of the survey, the census was 86. Quality Review completed on 07/12/22	E 0000		
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: 07/05/2022 Facility Number: 000369 Provider Number: 155530 AIM Number: 100275190 At this Life Safety Code survey, South Shore	K 0000		

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

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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	Health & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The building is fully protected by a 200 kW diesel-powered generator. The facility has a capacity of 100 with a census of 86 at the time of the survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage. Quality Review completed on 07/12/22			
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			

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	permitted on each door and provisions shall be made for the rapid removal of occupants 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			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 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 Based on observation and Interview, the facility failed to ensure 1 of 7 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect at least 6 residents and staff that would use the exit by resident room 312. Findings include: Based on observation with the Maintenance Director and Administrator on 07/05/22 at 2:23	K 0222	K222 NFPA 101 – EGRESS DOORS **This facility requests paper compliance for this citation.** *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. This facility asks for a desk review of this citation.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** The identified back exit door near room 312 has been adjusted so that when the 15 second delayed egress is	07/27/2022

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	p.m., the exit door by room 312 was equipped with a 15 second delayed egress. When the exit door was tested, the irreversible process to release the lock was not initiated. The door did release from the magnetic lock when the code on the keypad was pressed. Based on interview at the time of observation, the Maintenance Director tried several times to activate the delay egress and stated the delayed egress is not working properly and will need to be repaired. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		activated works properly. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** This alleged violation had the potential to affect residents and visitors and staff on all units . The identified door has been adjusted. Maintenance verified that all doors with a 15 second delay are working properly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** In service will be done with Maintenance designee regarding the importance of making sure that all egress doors that have 15 second delay are working properly. A log verifying all doors in the facility with a 15 second delayed egress will be tested weekly for 3 months. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**. The log will be presented to the QAPI committee at QAPI meetings for review for compliance for 3 months or determined to be compliant by the committee. **Date systemic changes will be completed: July 27, 2022**	

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K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 1 of 1 central storage corridor doors to a hazardous area enclosure was self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 24 residents and staff in one smoke compartment. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 07/05/22 at 2:30 p.m., the Central Supply room was over 50 square feet in size, containing large amounts of combustible supplies, and the door with self-closing device; but the door was held open by a cardboard box. The door being propped open would prevent the door from self-closing upon activation of the fire alarm. Based on interview at the time of observation, the Maintenance Director agreed the door to Central Supply contained combustible storage, was	K 0223	**K223 NFPA 101 DOORS WITH SELF-CLOSING DEVICES** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. **1) Immediate actions taken**	07/27/2022

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	greater the 50 square feet, and the door was held open with a cardboard box. The cardboard box was removed and the door self-closed into the frame. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**for those residents identified:** There were no residents cited in regard to this regulation. The cardboard box was removed and the door self-closed into the frame.. **2) How the facility identified other residents:** Residents who reside at and staff that work at the facility have the potential to be affected by the alleged deficient practice. Maintenance toured the facility and assured there were no obstruction in any doors to restrict them from closing. **3) Measures put into place/ System changes:** The medical records staff and maintenance staff will be re-educated about automatic door closures by the Maintenance Director/designee by 7/24/2022. Random audits will be completed on automatic door closures by the Maintenance Director/designee weekly for 3 months to ensure compliance. The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:**	

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			· The Executive Director will review the Automatic Door Closure audits monthly. · The results of these audits will be reviewed in QAPI Meeting until 100% compliance is achieved. The QAPI Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Compliance by: 7/27/2022	
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 5 of over 40 battery operated smoke alarms installed in resident sleeping rooms were not over ten years old in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect over 30 residents, staff, and visitors in the vicinity of Rooms 203, 207, 504 and employee breakroom.	K 0300	K300 NFPA 101 – Protection – other Smoke Detectors The facility requests paper compliance for this citation. *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of*	07/27/2022

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	Findings include: Based on observations with the Maintenance Director and Administrator on 07/05/22 during a tour of the facility from 1:15 p.m. to 2:45 p.m., manufacturer's documentation affixed to the battery operated smoke alarms installed above the doors in resident sleeping rooms 203, 207 and 504 indicated each device was manufactured 12/31/2011, 11/12/2011 and 01/05/2011 respectively. Additionally, the battery operated smoke alarms installed above the doors of the Employee Breakroom and Central Supply indicated each device was manufactured 01/05/2011 and 01/06/2011. Based on interview at the time of each observation, the Maintenance Director agreed the aforementioned smoke alarms were more than ten years old. These findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. Room 203, 207, 504, employee break room and central supply were identified. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Maintenance Director has been educated on the protocols of smoke detector usage and that detectors do not remain in service longer than 10 years from the date of manufacture. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A log was developed to record all battery-operated smoke detector locations and manufacture dates. This log will be presented to the Administrator for review and compliance. Audit results will be presented to the QAPI committee. **How the corrective action(s)**	

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	155530	A. BUILDING 01 B. WING	07/05/2022

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance will present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 7/27/2022**	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility	K 0353	K353 =NFPA 101 – Sprinkler	07/27/2022

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	failed to maintain the ceiling construction throughout the facility. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect at least 8 residents and staff near the locker room. Findings include: Based on observation with the Maintenance Director and Administrator during a tour of the facility from 1:15 p.m. to 2:45 p.m. on 07/05/22, the following was noted: a) 1"-2" area surrounding metal conduits penetrating lay in ceiling tile in the janitor closet across the corridor from Unit 3 nurse station was not firestopped b) 2"-3" area surrounding piping running up through lay in ceiling tile in the lockerroom across the corridor from Unit 4 shower room was not firestopped. These penetrations through the ceilings exposed the space above and could delay the activation of the sprinklers installed in the rooms. Based on interview at the time of observations, the Maintenance Director confirmed the penetrations in the aforementioned areas. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		System – Penetrations The facility requests paper compliance for this citation. *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. Areas identified were janitors closet across the corridor from Unit 3 nurses station and the Employee locker room across the corridor from unit 4 shower room. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Facility has sealed the penetrations in the aforementioned areas and the areas have been fire stopped. Facility utilized a UL rated fire stop system to fire stop	

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			the penetration. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance will track and inspect and audit areas in the facility that have penetrations in the ceiling and seal and firestop these areas. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance will present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QA and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 7/27/2022**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed were	K 0511	K511 – NFPA – Utilities – Gas and Electric	07/27/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/05/2022

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	maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:15 p.m. to 2:45 p.m. on 07/05/22, an electrical junction box without a cover and with exposed wiring was noted in the space above the drop ceiling by the cross corridor doors at Unit 2. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned electrical junction box location was not provided with a cover. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		The facility requests paper compliance for this citation. *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Cover plates were installed on the electrical junction box in the space above the drop ceiling by the cross-corridor doors at Unit 2. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance staff were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 01 B. WING	07/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			in-serviced on the protocols of keeping electrical junction boxes maintained in a safe operating condition. Maintenance surveyed the facility and assured all other electrical boxes have a plate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance will present any reported non-compliance of secured electrical junction boxes to the QAPI Committee until 100% compliance has been achieved for 2 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 7/27/2022**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.			

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	155530	A. BUILDING 01 B. WING	07/05/2022

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	19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 1 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.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, staff, and visitors in the facility. Findings include: Based on record review of the documentation entitled "Fire Drill Form" with the Maintenance Director on 07/05/22 from 9:50 a.m. to 1:15 p.m., the documentation for the drill conducted on 02/07/2022 at 4:00 a.m. failed to include the verification of transmission of the fire alarm signal to the monitoring station. This drill was conducted as a silent drill, but the verification of transmission of the fire alarm signal to the monitoring station was not conducted later the next day. Based on interview at the time of record review, the Maintenance Director indicated at that time was unaware of the requirement. He further stated that now he was aware of the need to document the verification of transmission of the fire alarm signal to the monitoring station. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	K712 – NFPA 101 - Fire Drills *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Fire drills are logged as to type of drill (silent, pull station activated or event), shift, time and date. Drills that are conducted between 9:000 PM and 6 A.M., a coded announcement may be used instead of audible alarms and a verification of transmission of the fire alarm signal to the monitoring station will be conducted later that day.	07/27/2022

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			Maintenance staff were in-serviced on the regulations of verification of transmission of the fire alarm signal to the monitoring station. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A log sheet was developed for maintenance to summarize date/time/type of drills and verification of transmission of fire alarm signal to the monitoring station. This log sheet will be presented to the QAPI committee each month for review and recommendations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance will present a monthly summary of audits to the Quality Assurance Committee until 100% compliance has been achieved for 12 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 7/27/2022**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing			

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	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 program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 6 of the last 12 months. 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	K 0918	K918 – NFPA – Electrical systems – Essential Electrical system. The facility requests paper compliance for this citation. *This plan of Correction is the*	07/27/2022

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	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. Chapter 6.4.4.2 of 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 record review with the Maintenance Director on 07/05/22 at 11:55 a.m., documentation for July 2021 and October 2021 through February 2022 load testing was not available for review. Based on an interview at the time of record review, the Maintenance Director stated he was hired about nine months ago and as far as he knew, there was no other monthly generator load testing documentation available for review at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 26 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the		*facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. Maintenance Director will continue to maintain monthly and weekly generator load testing documentation which includes record of inspection, performance exercising period and if needed repairs. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Inspections will be scheduled weekly and monthly, and results	

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	155530	A. BUILDING 01 B. WING	07/05/2022

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	generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Maintenance Director on 07/05/22 from 9:50 a.m. to 1:15 p.m.., documentation for weekly generator testing between 07/05/2021 to 01/06/2022 was not available for review. Based on an interview at the time of record review, the Maintenance Director stated he was hired about nine months ago and as far as he knew, there were no other weekly generator testing available for review at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		of inspections will be recorded and filed on inspection tool. In service will be done for maintenance designee to make sure that generator logs for weekly and monthly logs and tests are done and to present to the QAPI committee for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance will present summary of audit to the Quality Assurance Committee, along with the next scheduled inspection window. Results of these inspections will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 7/27/2022**	
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			

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	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 nurses' station did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects up to 8 residents, 6 staff near the Unit 3 nurses station area. Findings include: Based on observation made with the Maintenance Director on 07/05/22 during a tour of the facility between 1:45 p.m. and 2:45 p.m.; a power strip was in use in the Assistant Director of Nursing's office with a refrigerator plugged into it. Based on interview at the time of each observation, the Maintenance Director confirmed the instance of power strip usage and stated the refrigerator would be moved and plugged into the wall. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.	K 0920	K920 – NFPA 101 – Electrical Equipment – power cords and extension cords The facility requests paper compliance for this citation. *This plan of Correction is the facility's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice:** No residents were identified in this citation. **How other residents having the potential to be affected by the**	07/27/2022

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	3.1-19(b)		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this alleged deficient practice. The power strip was removed from the Assistant director of nursing's office and the refrigerator was plugged directly into the outlet. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A walk through of facility was completed with no other multi-plug outlets or surge protectors used out of compliance. Facility staff, Department Supervisors and Therapy were in-serviced on the regulations involving extension cords, multi-plug outlets and surge protectors in the Long-Term Care facility. Staff will continue to observe all areas for non-compliance and note any concerns on a Maintenance request form so proper electrical needs are addressed. Maintenance request logs will be presented to the QAPI committee for review. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Maintenance will present a monthly summary of	

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			audits to the Quality Assurance Committee until 100% compliance has been achieved for 3 consecutive months. Results of the audits will be reviewed in QAPI and plan will be adapted or adjusted as needed to maintain compliance. **Date systemic changes will be completed: 7/27/2022**	