STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155702	A. BUILDING -- B. WING	01/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE PERU	1850 WEST MATADOR ST PERU, IN 46970

(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 State Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/29/18 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Emergency Preparedness survey, Aperion Care Peru was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 92 and had a census of 69 at the time of this survey. Quality Review completed on 02/02/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	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	

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

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	155702	A. BUILDING -- B. WING	01/29/2018

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E 0015 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director and the Executive Director on 01/28/17 at 10:20 a.m., the facility's Emergency Preparedness plan provided did not address the loss of sewage and waste disposal in an emergency. Based on interview at the time of records review, the Executive Director agreed the plan did	E 0015	**E015 Subsistence needs for staff and patients** **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 for those residents identified:** The facility policy was updated to include all components set forth by subsistence needs for staff and patients whether they evacuate or shelter in place include, but not limited to the following: 1. Food ,water, medical and pharmaceutical supplies. 2. Alternate sources of energy to maintain, a temperature to protect patient health and safety and for the safe and sanitary	02/28/2018

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	not address the loss of sewage and waste disposal in an emergency		storage of provisions. 3. Emergency lighting 4. Fire protection ,extinguishing and alarm systems 5. Sewage and waste disposal **2) How the facility identified other residents:** All residents could be affected **3) Measures put into place/ System changes:** Staff will be in-serviced on the emergency preparedness manual, manuals will be placed at all nurses stations for accessibility to staff **4) How the corrective actions will be monitored:** Revised policy will be reviewed at the QAA monthly meeting and will obtain Medical Directors signature. Policy will be reviewed and updates as necessary and annually. **5) Date of compliance: 02/28/2018**	
E 0036 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could	E 0036	**E036 Training and testing** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation	02/28/2018

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	affect all occupants. Findings include: Based on record review with the Maintenance Director and Executive Director on 01/29/18 at 10:25 a.m., the facility's Emergency Preparedness plan provided did not contain a written emergency preparedness training and testing program. Based on interview at the time of records review, the Executive Director stated there was a emergency preparedness training and testing program but it was not written into the plan.		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 for those residents identified:** The facility revised emergency preparedness to include training and testing program **2) How the facility identified other residents:** All residents could be affected **3) Measures put into place/ System changes:** Staff will be in serviced on the emergency preparedness to include training and testing program. Facility will conduct a mock training. **4) How the corrective actions will be monitored:** Revised policy will be review at the monthly QAA meeting and will obtain medical Directors signature. Policy will be reviewed	

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E 0037 SS=C Bldg. --	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings Include: Based on record review with the Maintenance Director and Executive Director on 01/29/18 at 10:28 a.m., the facility did not provide initial or annual emergency preparedness training for staff. Based on interview at the time of records	E 0037	and updated as needed and annually **5) Date of compliance: 2/28/2018** **E037** **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 for those residents identified:** The facility revised emergency preparedness to include training and testing program **2) How the facility identified other residents:**	02/28/2018

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	review, the Executive Director stated initial or annual training has not been conducted.		All residents could be affected **3) Measures put into place/ System changes:** Staff will be in serviced on the emergency preparedness to include training and testing program. Facility will conduct mock training with current staff. Executive Director will contact outside services/volunteers regarding facility's emergency preparedness and their roles Volunteers such as ambulance transport, long term care facilities and assisted living close to facility New staff will be trained on the manual during orientation, and a mock evacuation after 120 days of employment. **4) How the corrective actions will be monitored** Revised policy, training and results of testing program will be review at the monthly QAA meeting until facility has reached an acceptable goal of completion by the QAA team. Policy will be reviewed and updated as needed and annually. **5) Date of compliance: 2/28/2018**	
E 0039 Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the	E 0039	**E039**	02/28/2018

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	emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants.		**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 for those residents identified:** The facility has completed a table top exercise that includes a group discussion led by a facilitator, using a narrated clinically-relevant emergency scenario and prepared questions designed to challenge an emergency plan. **2) How the facility identified other residents:** All residents could be affected **3) Measures put into place/ System changes:** Staff in be in serviced on the table top scenario findings to improve on clinically-relevant emergency. Facility will conduct another mock	

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	Findings include: Based on record review with the Maintenance Director and Executive Director on 01/29/18 at 10:29 a.m., the facility's was unable to provide documentation that two annual exercises were conducted for the last 12 months. Based on interview at the time of records review, the Executive Director stated the drills were not conducted.		emergency training within 30 days of initial training. New staff will be trained on the manual/mock evacuation during orientation by executive director/designee. **4) How the corrective actions will be monitored:** Exercise scenario and results will be reviewed at QAA monthly meeting. Plan will be reviewed and updated as necessary and annually. Staff drills will be completed annually thereafter. **5) Date of compliance: 2/28/2018**	
E 0041 SS=C Bldg. --	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance 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 record review with the Maintenance Director and the Executive Director on 1/29/18 at 10:34 a.m., the monthly load test and weekly checks did not	E 0041	**E041 LTC Emergency Power** **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	02/28/2018

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	comply with testing in NFPA 101. The generator log form showed missing monthly load test and weekly checks for the time period of February 2017 to December 2017. Based on interview at the time of record review, the Maintenance Director agreed 11 months of testing was missing.		required by the provisions of federal and state law. **1) Immediate actions taken for those residents identified:** The facility had completed an audit prior to life safety survey and hired a new maintenance Director. The monthly load lest/weekly checks was completed immediately with the maintenance director by Safe Care. **2) How the facility identified other residents:** All residents are affected **3) Measures put into place/ System changes:** Maintenance director was in-service on the mandated generator load/weekly checks. Monthly/weekly maintenance logs were updated. Executive director will request logs monthly to check for compliance. Any logs found to be non-compliant will be addressed immediately including disciplinary action up to termination **4) How the corrective actions will be monitored:** Maintenance logs and results will be reviewed at QAA meeting monthly for 6 months and quarterly thereafter if 100% complaint.	

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/29/18 Facility Number: 003130 Provider Number: 155702 AIM Number: 200386750 At this Life Safety Code survey, Aperion Care Peru was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and hard wired smoke detectors in all resident	K 0000	**5) Date of compliance: 2/28/2018** 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	

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	rooms. The facility has a capacity of 92 and had a census of 69 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 02/02/18 - DA			
K 0163 SS=E Bldg. 01	NFPA 101 Interior Nonbearing Wall Construction Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5 Based on observation and interview, the facility failed to ensure 1 of 1 interior separation walls to the 300 hall were comprised of noncombustible or limited combustible materials for a Type II building. This deficient practice could affect 35 residents in the one smoke compartment. Findings include:	K 0163	**K163 Interior nonbearing wall construction** **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	02/28/2018

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	Based on observation during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 at 12:14 p.m., a wall in the center corridor to the 300 hall was constructed of combustible plywood with two by fours wood studs. Based on an interview at the time of observation, the building was determined to be of construction Type II (222), and the Maintenance Director stated the wall was constructed by the facility out of plywood to prevent residents from entering the 300 hall. 3.1-19(b)		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 for those residents identified:** The facility immediately following survey placed a self-closure device on room 303 to house combustible materials. Room 302 also had a self-closure device to house noncombustible materials. The interior separation wall was removed. A wall framed using a 5/8 drywall and a door made of 5/8 drywall to comply with regulations of a minimum of 2 hour fire resistance rating **2) How the facility identified other residents:** **All resident could be affected** **3) Measures put into place/ System changes:** Maintenance Director/designee will make weekly checks to ensure combustible and non-combustible materials are stored correctly to life safety regulations. Executive Director/designee will complete rounds with maintenance director/assistant director monthly	

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			to ensure compliance. Rounds will be added to weekly maintenance log. **4) How the corrective actions will be monitored:** Maintenance director will bring results to the monthly QAA meeting for 6 months and quarterly thereafter if 100% complaint. **5) Date of compliance: 2/17/2018**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 2 300 hall corridor means of egresses were continuously maintained free of obstructions. This deficient practice was not in a residents care area but affects staff in the 300 hall. Findings include: Based on an observation during a tour of the facility with the Maintenance Director and	K 0211	**K211 Means of Egress** **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	02/28/2018

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	the Executive Director on 1/29/18 at 12:36 p.m., all of the 300 hall corridors were being used for storage. Items being stored included furniture, beds, mattresses, and boxes. Based on an interview at the time of observations, the Maintenance Director agreed that all items were stored in the aforementioned location throughout the day and night. 3.1-19(b)		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 for those residents identified:** Hall 300 corridor has been cleared for means of egress. Furniture, mattress, beds and boxes removed **2) How the facility identified other residents:** Potential to affect staff, no residents are housed on this unit **3) Measures put into place/ System changes:** During rounds of facility, the hall will be checked for compliance of means of egress and no storage of items in hall **4) How the corrective actions will be monitored:** Finding will be taken to monthly QAA meeting Quarterly until 100% compliance or deemed unnecessary **5) Date of compliance:** **2/28/2018**	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors			

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	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 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			

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	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 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 the means of egress through 2 of 10 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.3 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect as 50 residents in the 100 hall.	K 0222	**K222 Egress Doors** **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	02/28/2018

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	Findings include: Based on an observation during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 between 11:00 a.m. and 2:50 p.m., the exit door by room 100 had delayed egress key pad, but no code was posted. This condition would delay evacuation of the building of a person that did not know the code. Also, the boiler room double exit doors had a two by four cross bar running across the doors in addition to a locking door handle. This condition would block the egress to the exit because the doors could not be pushed open. Based on interview at the time of observation, the Maintenance Director agreed there was a cross bar on the boiler room exit, no code was posted at the 100 hall exit, and there was no clinical need not to post the codes. 3.1-19(b)		executed solely because it is required by the provisions of federal and state law. **1) Immediate actions taken for those residents identified:** The facility posted the code next to the door on 100 hall. The boiler room double exit doors with a two by four running across the doors was removed. Safe Care was notified to obtain a quote on replacement door with locking door handle **2) How the facility identified other residents:** All resident could be affected **3) Measures put into place/ System changes:** Maintenance director/designee will make monthly checks to ensure all doors requiring a code to exit will have a code posted by doors. Executive director /designee will complete rounds with maintenance director/assistant maintenance director to ensure compliance. Rounds will be added to monthly maintenance log. **4) How the corrective actions will be monitored:** Maintenance Director will bring results to QAA meeting for 6 months and quarterly thereafter if 100% complaint. **5) Date of compliance:**	

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K 0226 SS=E Bldg. 01	NFPA 101 Horizontal Exits Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 3 fire door sets were arranged to automatically close and latch. LSC-101 2012 edition, 7.2.4.3.10 requires all fire door assemblies in horizontal exit shall be self-closing or automatic-closing. In addition NFPA-80 2010 edition, 6.1.4.3.1 states the fire door shall latch upon closing. This deficient could affect 50 residents in the four smoke compartments. Findings include: Based on observations during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 between 12:34 p.m. and 3:00 p.m. ,the fire door sets by room 121 and 104 failed to latch into the frame. Based on interview at the time of observation, Maintenance Director agreed the fire doors did not latch when tested and confirmed these were two hour fire doors in a two hour fire wall.	K 0226	**K226 Horizontal Exits** **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 for those residents identified:** The facility notified Safe Care to evaluate and repair fire doors by rooms 121 and 104 and repair as required **2) How the facility identified**	02/28/2018

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	3.1-19(b)		**other residents:** Residents in the vicinity of the fire doors are affected **3) Measures put into place/ System changes:** Maintenance Director/designee will make Quarterly checks to ensure fore doors latch when tested. Executive Director/designee will complete rounds with maintenance personnel quarterly to ensure compliance. **4) How the corrective actions will be monitored:** Maintenance Director will bring results to the QAA meeting Quarterly/ **5) Date of compliance:** **2/28/2018**	
K 0293 SS=D Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 2 doors in the boiler room was not mistaken as a facility	K 0293	**K293 Exit Signage** **The facility requests paper compliance for this citation.**	02/28/2018

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	exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect could affect staff in the boiler room Findings include: Based on observations during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 at 1:32 p.m., there was a single door to the outside in the boiler room that looked like an exit. When opened, it led to a small enclosed area with no gates. An NO EXIT sign was not posted on the door. Based on interview at the time of the observations, the Maintenance Director stated the aforementioned door was not an exit and the door did not have a NO EXIT sign posted. 3.1-19(b)		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 for those residents identified:** A No Exit sign was applied to the door that is not an exit **2) How the facility identified other residents:** Occupants of boiler room would be affected **3) Measures put into place/ System changes:** Maintenance Director/designee will make quarterly checks to ensure doors that are not an exit have correct signage posted. Maintenance /designee will inform Executive director of noncompliance of signs required **4) How the corrective actions will be monitored:**	

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			Maintenance director will bring results to the monthly QAA meeting for 6 months and Quarterly thereafter if 100% compliant **5) Date of compliance: 2/28/2018**	
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)			

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	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 failed to ensure the corridor door to 1 of 1 hazardous areas such as a combustible storage room over 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could affect staff and up to 15 residents in the 300 hall. Findings include: Based on observations during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 at 1:04 p.m., there was a storage hall, which contained a large quantity of combustible items and measured over 50 square feet, off of the conference room and the door between them was not self-closing or self-latching. Furthermore, the corridor door to the conference room was not equipped with a self-closing device. Based on interview at the time of observations, the Maintenance Director agreed the storage hall was used to store combustible material, was greater than 50 square feet, and did not have a self-closing and self-latching door between the hall and corridor.	K 0321	**K321 Hazardous Area** **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 for those residents identified:** A Self closing device was applied to door referred as storage hall. Area has been cleared of all combustible materials. **2) How the facility identified other residents:** All occupants in the vicinity of this room and conference room could be affected **3) Measures put into place/**	02/28/2018

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	3.1-19(b)		**System changes:** Maintenance Director/designee will make weekly rounds to ensure combustible items are stored correctly. Findings will be brought to the executive director immediately following any noncompliance. **4) How the corrective actions will be monitored:** Maintenance Director will bring results to the monthly QAA meeting for 6 months and quarterly thereafter if 100% compliant. **5) Date of compliance:** **2/28/2018**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.			

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	9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on observation and interview, the facility failed to ensure 5 of 5 rooms and 1 of 1 lobbies in the 300 hall ceiling construction contained ceiling tiles that would trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 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 could affect 20 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 at 12:34 p.m., about half of the suspended ceiling tiles in rooms 300, 301, 302, 303, 304, and in the 300 hall lobby were missing. This condition caused the pendant sprinkler heads to be mounted about 36 inches below the ceiling, which could delay activation of the sprinkler system in event of a fire. Based on interview at the time of the observations, the Maintenance Director and the Executive Director agreed that the aforementioned areas were missing ceiling tiles.	K 0353	**K353 Sprinkler system-maintenance and testing** **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 for those residents identified:** All rooms on 300 hall that had missing ceiling tiles have been installed. Rooms 300,301,302,303,304 and 305. Safe Care has been notified to complete sprinkler system gauges and valve test. Facility will schedule monthly test per life safety regulations **2) How the facility identified other residents:** All resident could be affected	02/28/2018

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	3.1-19(b) 2. Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system gauges and valves had been inspected for 12 of 12 past months. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal supply pressure is being maintained. Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure		**3) Measures put into place/ System changes:** Maintenance director/designee will make weekly checks to ensure that any missing ceiling tiles are replace immediately. Findings will be brought to the Executive Director immediately. Maintenance Director will notify Executive director of scheduled monthly checks for sprinkle system gauges and valve test. Checks will be added to weekly and monthly maintenance logs **4) How the corrective actions will be monitored:** Maintenance Director will bring results to the QAA meeting for 6 months and quarterly thereafter if 100% compliant **5) Date of compliance: 2/28/2018**	

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	that normal air and water pressures are being maintained. NFPA 25, 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review with Maintenance Director and the Executive Director on 1/29/18 at 9:33 a.m., there was no monthly inspection of the wet sprinkler system's gauges and valves available for review. During an interview at the time of record review, the Maintenance Director stated no monthly checks of the sprinkler system's gauges or valves were recorded. 3.1-19(b)			
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors			

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	to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of 30 resident room doors in the 100 hall were provided with a means suitable for keeping the door closed. This deficient practice could affect 3 residents in room two rooms.	K 0363	**K363 Corridor doors** **The facility requests paper compliance for this citation.** This Plan of Correction is the center's credible allegation of compliance.	02/28/2018

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	Findings include: Based on observations during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 between 1:34 p.m. and 2:30 p.m., the double set of corridor doors to room 125 did not latch in to the frame when tested due to the alignment of the door catch. Also, room 116 door did not latch into the frame due to the latching mechanism being remove from the door. Based on interview at the time of observation, the Maintenance Director tested the doors and stated they did not latch. 3.1-19(b)		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 for those residents identified:** Room 125 was repaired and does latch. Room 116 was repaired with a new latching mechanism **2) How the facility identified other residents:** Resident in rooms 125 and 116 were affected **3) Measures put into place/ System changes:** Maintenance Director/designee will make monthly checks to ensure that any doors not properly latching will be repaired/replaced immediately. Findings will be brought to the executive director. Checks will be added to the monthly maintenance logs **4) How the corrective actions will be monitored:** Maintenance Director will bring results to monthly QAA meeting for 6 months and quarterly	

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			thereafter if 100% compliant **5) Date of compliance: 2/28/2018**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 1 sets of smoke barrier door had a readable fire rating label. This deficient practice affects all residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 at 1:54 p.m., the rating of both sets of smoke doors at the end of the 100 hall could not be determined due to paint on the rating label. Based on interview at the time of	K 0374	**K374 subdivision of building spaces-smoke barrier** **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	02/28/2018

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	observation, the Maintenance Director agreed the rating labels on the doors were painted. 3.1-19(b)		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 for those residents identified:** Safe Care was notified to inspect the smoke barrier door at the end of 100 hall and replace label **2) How the facility identified other residents:** All resident could be affected **3) Measures put into place/ System changes:** Maintenance Director/designee will make quarterly checks to ensure smoke barrier doors have labels free of paint or any other obstruction. Findings of noncompliance will be brought to the executive Director. Checks will be added to Quarterly maintenance logs **4) How the corrective actions will be monitored:** Maintenance Director will bring result to monthly QAA meeting for 6 months and quarterly thereafter if 100% compliant **5) Date of compliance:** **2/28/2018**	
K 0511 SS=E	NFPA 101 Utilities - Gas and Electric			

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Bldg. 01	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 and interview, the facility failed to ensure electrical wiring in 2 of 2 areas was protected in accordance with LSC 9.1.2 which requires electrical wiring and equipment to comply with NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice was not in a resident care area but could affect staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 between 1:00 p.m. and 2:00 p.m., in the boiler room there was a conduit with exposed wires at the open end of the conduit. Also, in the back room in the green storage hall there was exposed wire hang out of a hole in the wall. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned condition and confirmed that exposed wiring was visible.	K 0511	**K511 Utilities and electric** **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 for those residents identified:** The exposed wires in the broiler room and green storage hall have been repaired **2) How the facility identified other residents:** All occupants in these areas could be affected	02/28/2018

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	3.1-19(b)		**3) Measures put into place/ System changes:** Maintenance Director/designee will make checks to ensure that there are no exposed wiring. Findings of non-compliance will be brought to the Executive Director. Checks will be added to quarterly maintenance logs **4) How the corrective actions will be monitored:** Maintenance Director will bring results to QAA monthly for 6 months and quarterly thereafter if 100% compliant. **5) Date of compliance: 2/28/2018**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to conduct fire drills quarterly per shift for 3 of 4 quarters. This	K 0712	**K712 Fire Drills** **The facility requests paper compliance for this citation.**	02/28/2018

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	deficient practice affects all staff and residents. Findings include: Based on record review with the Maintenance Director and the Executive Director on 1/29/18 at 11:15 a.m., there was no documentation for any fire drills in the second quarter of 2017 and no third shift fire drills for the third and fourth quarters of 2017. Based on interview at the time of record review, the Maintenance Director confirmed the aforementioned drills for 2017 were missing. 3.1-19(b) 3.1-51(c) 2. Based on record review and interview, the facility failed to conduct fire drills at unexpected times under varying conditions on the second shift for 4 of 4 quarters. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the Maintenance Director and the Executive Director on 1/29/18 at 11:16 a.m., all second shift drills took place between 3:00		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 for those residents identified:** New maintenance Director conducted fire drills on all three shifts **2) How the facility identified other residents:** All residents, visitors and staff could be affected **3) Measures put into place/ System changes:** Maintenance Director/designee will perform fire drills according to life safety regulations and at unexpected times. Executive Director/maintenance director will schedule fire drills for the year and set reminders for drills to occur. Checks will be added to monthly maintenance log.	

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	p.m. and 3:30 p.m. for the last four quarters. Based on interview at the time of record review, the Maintenance Director agreed the aforementioned second shift fire drills were not conducted at unexpected times. 3.1-19(b) 3.1-51(c)		**4) How the corrective actions will be monitored:** Maintenance director will bring results to monthly QAA meeting for 6 months and quarterly thereafter if 100% compliant **5) Date of compliance: 2/28/2018**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover			

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	devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to enforce 1 of 1 smoking policies in 3 of 3 non-smoking areas. This deficient practice could affect 30 residents in event of an emergency. Findings include: Based on observation during a tour of the with the Maintenance Director and the Executive Director on 1/29/18 at 11:54 a.m. and 2:40 p.m., smoking was apparent due to over 50 cigarette butts on the ground outside the employee exit, over 20 cigarette butts on the ground outside the BHU/dock exit, and over 20 cigarette butts on the ground outside the kitchen exit. Based on records review with the Maintenance Director and the Executive Director at 10:08 a.m., the smoking regulations stated all of the facility's property was smoke free. Based on interview at the time of observation and records review, the Maintenance Director agreed there were cigarette butts on the ground in the aforementioned areas and stated the facility is a smoke free campus. 3.1-19(b)	K 0741	**K741 Smoking Regulations** **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 for those residents identified:** Housekeeping staff cleaned up cigarette butts on the ground outside the employee exit, grounds by behavioral unit, dock and by the kitchen exits **2) How the facility identified other residents:** All residents, visitors and staff could be affected **3) Measures put into place/**	02/28/2018

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			System changes: Maintenance director/designee will walk grounds daily to ensure cigarette butts are not on the grounds. Maintenance personnel will inform executive director of noncompliance. At the entrances to facility cigarette containers will be placed. Maintenance personnel will empty daily. A new sign will be posted at front entrance to remind visitors /staff and vendors that facility is smoke free. Staff will be re in serviced on facility smoke free policy. **4) How the corrective actions will be monitored:** Maintenance Director will bring results to monthly QAA for 6 months' and Quarterly thereafter if 100% compliant **5) Date of compliance:** **2/28/2018**	
K 0912 SS=E Bldg. 01	NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed.			

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	6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) Based on observation and interview, the facility failed provide ground-fault circuit interrupters (GFCI) for 3 of 3 receptacles within three feet of a water source in a patient care area. NFPA 70 2011 edition, 517.20 (A) defines wet locations as patient care areas subjected to wet conditions while patients are present. These include standing fluids on the floor shall be provide with special protection against electric shock by one of the following means: (1) Power distribution systems that inherently limits the possible ground fault current due to first fault to a low value, without interrupting the power supply. (2) Power distribution systems in which the power supply is interrupted if the ground fault current does. This deficient practice could affect 2 residents in the beauty shop. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Executive Director on 1/29/18 at 12:48 p.m., in the beauty shop the receptacle located on the wall was within two feet of a sink faucet did not contain GFCI protection. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned receptacle	K 0912	**K912 Electrical system receptacles** **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 for those residents identified:** GFCI receptacle was installed in Beauty shop by shampoo bowl **2) How the facility identified other residents:** All residents could be affected **3) Measures put into place/ System changes:** Maintenance will change out any receptacle that is within three feet of water source **4) How the corrective**	02/28/2018

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	was not GFCI protected. 3.1-19(b)		**actions will be monitored**: Results will be reported to monthly QAA meeting **5) Date of compliance: 2/28/2018**	
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 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.			

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	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 11 of the last 12 months. NFPA 99, 2012 edition 6.4.4.1.1.4(a) 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. 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 and the Executive Director on 1/29/18 at 10:34 a.m., no monthly generator load test documentation for the months of February 2017 to December 2017 was available for review.	K 0918	**K918 Electrical Systems-Essential electrical systems** **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. **K918 Electrical Systems-Essential electrical systems** **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	02/28/2018

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	Based on an interview at the time of record review, the Executive Director stated no load tests were completed due to the previous Maintenance Director and Executive Director not ensuring the checks were completed. Monthly load test resumed in January 2018 once the current Executive Director and Maintenance Director started employment. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 48 of 52 weeks. NFPA 99, 2012 edition, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include:		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 for those residents identified:** Executive Director and maintenance Director conducted a Generator weekly load test for 30 minutes and recorded along with a 4-hour teat was completed. Maintenance Director contacted Safe Care to review and determine the generator met life safety guidelines 30 percent requirement. Maintenance Director completed a battery backup test for 90 minutes. Executive Director and maintenance Director conducted a Generator weekly load test for 30 minutes and recorded along with a 4 hour teat was completed. **2) How the facility identified other residents:** All residents could be affected **3) Measures put into place/ System changes:** Maintenance will complete weekly generator tests- 30 minutes, 4-hour continuous test as mandated by life safety	

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	Maintenance Director and the Executive Director on 1/29/18 at 10:35 a.m., the weekly generator inspection documentation showed no inspections for the months of February 2017 to December 2017. Based on an interview at the time of record review, the Executive Director stated no weekly inspections were not completed due to the previous Maintenance Director and Executive Director not ensuring the checks were completed. Weekly inspections resumed in January 2018 once the current Executive Director and Maintenance Director started employment. 3.1-19(b) 3. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Section 8.4.2.3. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS		regulations. Executive Director will schedule the test for the calendar year and set up reminders. Any discrepancies note during testing will be brought to the executive director immediately following the test. Maintenance will check generator during monthly test to assure generators meets life safety requirements. Maintenance will check generator during monthly test to assure generators meets life safety requirements. Maintenance will conduct 30 seconds monthly test for back up battery and a 90-minute test annually. All 3 corrections to electrical systems will be added to the maintenance logs. **4) How the corrective actions will be monitored:** Results will be taken to monthly QAA meeting for 6 months **5) Date of compliance: 2/28/2018** **1) Immediate actions taken for those residents identified:** Maintenance Director contacted Safe Care to review and determine the generator met life safety guidelines 30 percent requirement. **2) How the facility identified other residents:** All residents could be affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 01 B. WING	01/29/2018

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	(Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on review of generator load testing documentation with the Maintenance Director and the Executive Director on 1/29/18 at 10:34 a.m., The two monthly load tests available for review showed nameplate kW rating of the diesel powered generator as 250, and 75 kW are needed to reach 30 percent. The load test showed the load kW was between 39.40 and 44.41 which is less than 30 percent of the EPS nameplate kW rating, and no four hour annual load bank test was available for review. Based on interview at the time of record review, the Maintenance Director		**3) Measures put into place/ System changes:** Maintenance will check generator during monthly test to assure generators meets life safety requirements **4) How the corrective actions will be monitored:** Results will be taken to monthly QAA meeting for 6 months **5) Date of compliance:** **2/28/2018**	

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	agreed the generator did not achieve 30 % of the name plate rating for the two load tests, and load tests were missing. Additionally, the Maintenance Director stated a load bank test for the generator had not occurred within the past year. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of 1 emergency task generator battery backup lights was maintained. NFPA 110, 2010 Edition at section 7.3.1 requires the Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. 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, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered 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 in the facility.			

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	Findings include: Based on observation with the Maintenance Director on 1/29/18 at 11:53 a.m. there was an emergency battery powered light at the generator and in the transfer switch room. Based on record review with the Maintenance Director and the Executive Director on 1/29/18 at 10:39 a.m., there was no documentation available for review to show a 90 minute annul or a 30 second monthly test was conducted for the battery powered light at the generator. Based on an interview at the time of record review, the Maintenance Director stated the 90 minute annual test and the 30 second monthly test was not conducted. 3.1-19(b)			