STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155618	A. BUILDING -- B. WING	02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(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: 02/28/18 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 At this Emergency Preparedness survey, Manor Care Health Services Summer Trace was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 104 certified beds. At the time of the survey, the census was 38. Quality Review completed on 03/06/18 - DA	E 0000	**The statements made in this plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take actions set forth in the following Plan of Correction. This Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.** **Summer Trace respectfully requests desk review for deficiencies noted.**	
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: 02/28/18 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500	K 0000	**The statements made in this plan of correction are not an admission to and does not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or is planning to take actions set forth in the following Plan of Correction.**	

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

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	At this Life Safety Code survey, Manor Care Health Services Summer Trace 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 two story facility was determined to be of Type I (332) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 104 and had a census of 38 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/06/18 - DA		**This Plan of Correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.** **Summer Trace respectfully requests desk review for deficiencies noted.**	
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 1. Based on record review, observation and interview; the facility failed to ensure annual inspection and testing of 3 of 3 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. In addition, the facility failed to	K 0211	**·what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	03/30/2018

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	ensure 1 of 3 fire door assemblies latching hardware operates and secures the door when closed. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 states openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80 except as otherwise specified in this Code. NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 Edition, Section 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, Section 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, Section 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated		Record of door inspections were completed and are attached. Identified door to be repaired by contractor. Hardware is ordered. Scale removed from hallway and placed in storage room when not in use. Chairs and table were removed from entrance to “Gerbil Tube” hallway Door was lubed and debris was cleared to ensure unobstructed opening **·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 potential to be affected by this alleged deficient practice** **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff educated on proper storage of equipment ·Maintenance and housekeeping staff educated on clearance in hallways/exits · Maintenance educated on inspection and maintenance of exits and doors ·How the corrective action(s) will	

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	from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with Maintenance Director from 9:15 a.m. to 12:00 p.m. on 02/28/18, annual inspection documentation of facility fire door assemblies within the most recent twelve month period was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, there were three fire door assemblies noted in the building that were in an occupancy separation two hour fire barrier separating the comprehensive care areas from assisted living. The three door assembly locations were on the second floor at the 'gerbil tube' leading to assisted living, the first floor across from the entrance to the service hall by the telephone room and the first floor exit door set east of the assisted living dining room. In addition, the latching hardware for the exit door set east of the first floor assisted living dining room failed to latch into the frame when tested five separate times. Based on interview at the time of record review and of the observations, the Maintenance Director stated an annual inspection		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Maintenance Director/Designee to perform door inspections weekly. Maintenance Director/Designee to inspect facility 5 times a wk., for 4 wks. Any deficiencies will be reported to the Administrator and corrected immediately. ·IDT to review any deficiencies during monthly QA&A	

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	was not conducted for the fire door assemblies in the last year and agreed the doors were in an occupancy separation two hour fire barrier with the latching hardware for the door set east of the first floor assisted living dining room not securing the door set when closed. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 3 of 6 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, the following was noted: a. a weigh scale which projected three feet into the eight foot wide corridor was stored outside the second floor corridor near the entrance to the 'gerbil tube' to assisted living. b. two chairs and a table each projecting two feet into the six foot wide corridor were stored in the 'gerbil tube' passageway to assisted living. c. the first floor stairwell exit to the outside of the facility by the elevator on the first floor could not be opened without excessive force. The surveyor could not open the door after repeated attempts and only the Maintenance Director could open the door after excessive force was used. It could not be determined why the door took excessive force to open. Based on interview at the time of the observations, the Maintenance Director agreed			

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	the aforementioned means of egress were not continuously maintained free of all obstructions or impediments to full instant use. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants 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			

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	space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 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 9 delayed egress locks was readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Sign placed at entrances stating "PUSH (PULL) UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS.	03/30/2018

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	fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include:		Letters of sign to be at least 1 inch in height. Door release mechanism ordered and to be repaired Door Codes to be posted at each key pad **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 **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 to be educated on proper exit signage and operation **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; and** Maintenance Director/Designee to inspect doors weekly. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A	

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	Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, the following was noted: a. the exit door by the first floor nurse's station was equipped with signage stating the door would release after pushing for fifteen seconds but the door would not release after three attempts of pushing the door for fifteen seconds. The exit door could also be opened by entering a four digit code in a keypad at the exit but the code was not posted. b. the exit door by the stairwell by the elevator on the first floor was not equipped with the necessary signage stating the door would release after pushing for fifteen seconds. The exit door could also be opened by entering a four digit code in a keypad at the exit but the code was not posted. The exit door released when pushed for fifteen seconds when tested two separate times. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned exit doors should have been provided with the necessary delayed egress signage or opened when pushed for fifteen seconds. 3.1-19(b)			
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 horizontal exit doors were arranged to automatically close and latch. Section	K 0226	**What corrective action(s) will be accomplished for those residents found to have been**	03/30/2018

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	7.2.4.3.10 requires all fire door assemblies in horizontal exits shall be self-closing or automatic-closing. In addition NFPA 80, Standard for Fire Doors and Other Opening Protectives, 2010 edition, 6.1.4.3.1 states the fire door shall latch upon closure. This deficient could affect over 10 residents, staff and visitors on the first floor near the south exit of the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, the horizontal exit fire door set east of the Assisted Living Dining Room on the first floor failed to latch into the frame. The latching hardware for the exit door set would not latch into the door frame when tested five separate times. Based on interview at the time of observation, the Maintenance Director agreed the exit door set would not latch into the frame. 3.1-19(b)		**affected by the deficient practice;** Contractor inspected door latch and release. Will be repaired as soon as possible. **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 **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 to be educated by Administrator/designee on proper door operation **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; and** Maintenance Director/Designee to inspect doors weekly.. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A	
K 0293 SS=E	NFPA 101 Exit Signage			

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Bldg. 01	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 2 of 2 doors to the outside of the facility were not mistaken as a facility 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 over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, the set of doors to the second floor patio from the second floor dining room were not posted with an EXIT sign or a NO EXIT sign. Based on interview at the time of the observations, the Maintenance Director stated the door set to the patio is not an exit to the public way and agreed the aforementioned door set did not have a NO EXIT sign posted. 3.1-19(b)	K 0293	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Signs posted "NO EXIT" **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 **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 to be educated by Administrator/designee on proper exit signage **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**	03/30/2018

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			into place; and Maintenance Director/Designee to inspect doors weekly. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Fire Watch Emergency Procedure" with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 02/28/18, the fire watch plan for fire alarm system impairment was incomplete. The plan failed to include contacting the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method	K 0346	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Fire Watch Procedures updated with ISDH Gateway Website and email addresses for ISDH **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	03/30/2018

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MANOR CARE HEALTH SERVICES SUMMER TRACE	12999 N PENNSYLVANIA ST CARMEL, IN 46032

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	or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Maintenance Director agreed the fire watch documentation for fire alarm system impairment did not state to contact the Indiana State Department of Health via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		**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 to be educated by Administrator/designee on proper Fire Watch Procedures **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; and** Policy manuals reviewed by Maintenance Director to ensure all information is current. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in			

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	clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) 1. The facility failed to ensure 2 of over 50 resident sleeping rooms were provided with an automatic sprinkler to ensure sprinkler coverage in all portions of the building. This deficient practice could affect over 10 residents, staff and visitors on the second floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, the closet for Room 227 and the closet for Room 231 were each not provided with automatic sprinklers. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned locations do not have sprinkler coverage. 3.1-19(b) 3.1-19(ff) 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 first floor telephone rooms. The ceiling tiles 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 practice could affect over 10 residents, staff and visitors on the first floor.	K 0351	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Sprinkler heads in room 227 and 231 closets scheduled to be installed. Estimate attached. Work completed on 3/22/18. Pictures attached. Ceiling tiles replaced in 1st floor telephone 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 **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 to be educated by Administrator/designee on proper Sprinkler head placement and replacement of ceiling tiles.	03/30/2018

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, two suspended ceiling tiles were missing in the first floor telephone room which caused pendant sprinklers in the room to not be properly installed. Based on interview at the time of observation, the Maintenance Director agreed pendant sprinklers were not properly installed due to missing ceiling tiles. 3.1-19(b) 3.1-19(ff)		**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; and** Maintenance Director/Designee to inspect facility twice a day, 5 times a wk., for 4 wks. Maintenance Director/designee to continue daily tour of facility to ensure compliance Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A	
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 record review, observation and interview; the facility failed to document weekly and monthly fire pump inspection and testing in accordance with NFPA 25. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code to 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, 2011 Edition. NFPA 25, Section 8.1.1.1 provides the minimum requirements for the routine inspection, testing, and maintenance of fire pump assemblies. Table 8.1.1.2 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Section 8.3.1.2 requires a monthly test of electric motor-driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. A valve installed to open as a safety feature shall be permitted to discharge water in accordance with 8.3.2.5. The automatic timer shall be permitted to be substituted for the starting procedure. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Superior Systems & Supply Inc. "Fire Pump Test Data Sheet" documentation dated 08/02/17 during record review with the Maintenance Director from 9:15 a.m. to 12:00 p.m.	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Weekly and monthly fire pump inspections were completed, per TELS "Work History Report. See attached "K353 Sprinkler Inspect 1" and "K353 Sprinkler Inspect 2" Sprinkler System Inspection Form, dated 1/30/18 is attached. **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 **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 to be educated by Administrator/designee on proper Sprinkler/fire pump inspection. Maintenance Director/designee to educate maintenance staff and administrator on location of inspection schedule and results to ensure inspections can be easily accessed and provided when requested.	03/30/2018

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	on 02/28/18, only an annual test, inspection and maintenance of electric motor-driven pump assemblies was conducted and documented during the most recent 52 week period. Documentation of weekly fire pump inspections for 51 of 52 weeks of the most recent twelve month period was not available for review. Monthly fire pump testing for eleven months of the most recent twelve month period was also not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, an electric fire pump for the facility's sprinkler system was located in the sprinkler riser room. Based on interview at the time of record review and of the observations, the Maintenance Director stated he was unaware of weekly fire pump inspection and monthly testing for the fire pump was required and agreed documentation of weekly fire pump inspection and monthly testing within the most recent twelve month period was not available for review. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and		**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; and** TELS maintenance system has tasks entered and scheduled to be completed. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A	

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	trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of Superior Systems & Supply Inc. "Sprinkler System Inspection Report" documentation dated 04/28/17, 07/31/17, 10/23/17 and 01/30/18 during record review with the Maintenance Director from 9:15 a.m. to 12:00 p.m. on 02/28/18, monthly wet sprinkler system gauge inspection documentation for eight months of the most recent twelve month period was not available for review. In addition, monthly inspection documentation for all sprinkler system control valves for eight months of the most recent twelve month period was also not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, the facility has supervised wet sprinkler systems. Superior Systems had affixed hanging tags to the systems riser documenting quarterly sprinkler gauge and valve inspections in 2017 but monthly inspection documentation for the aforementioned eight month period was not available for review. Based on interview at the time of record review and of the observations, the Maintenance Director stated sprinkler gauges and valves monthly are checked regularly but the checks for the aforementioned eight month period have not been documented. 3.1-19(b)			
K 0354 SS=C	NFPA 101 Sprinkler System - Out of Service			

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Bldg. 01	Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25)			
	Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of 38 of 38 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Watch Emergency Procedure" with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 02/28/18, the fire watch plan for sprinkler system impairment was incomplete. The plan failed to include contacting the Indiana State Department	K 0354	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Fire Watch Procedures updated with ISDH Gateway Website and email addresses for ISDH **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 **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;**	03/30/2018

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	of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, agreed the fire watch documentation for sprinkler system impairment did not state to contact the Indiana State Department of Health via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)		Maintenance staff to be educated by Administrator/designee on proper Fire Watch Procedures for notification. **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; and** Policy manuals reviewed by Maintenance Director to ensure all information is current. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A	
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 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			

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	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 1 of over 50 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect over three, staff and visitors in the vicinity of the kitchen entrance from the service hall. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, the kitchen entrance door in the service hall across from the Laundry was equipped with one thumb twist deadbolt lock and was not equipped with a positive latching	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Identified door latch replaced in laundry room. Photo attached **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. Door latched	03/30/2018

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	device. Based on interview at the time of the observations, the Maintenance Director agreed the door had an impediment to closing, latching and would not resist the passage of smoke if the deadbolt was not employed. 3.1-19(b)		have been audited to ensure compliance. **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 to be educated by Administrator/designee on proper door latch requirements Routine maintenance entered into TELS system to ensure scheduled and completed timely. **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; and** Maintenance Director/Designee to inspect doors weekly. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A	
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI			

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	A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation and interview, the facility failed to ensure 1 of 1 elevators had current inspection documentation. This deficient practice could affect five residents, staff and visitors. Findings include: Based on review of Indiana Homeland Security elevator inspection documentation dated 04/18/17 with the Maintenance Director from 9:15 a.m. to 12:00 p.m. on 02/28/18, current elevator "Operating Certificate" documentation was not available for review. The aforementioned documentation stated "Operating Certificate" #43324 expires 12/14/17. Based on interview at the time of record review, the Maintenance Director agreed current elevator inspection and Operating Certificate documentation was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, one elevator was noted in the comprehensive care area of the building near the nurse's station and current "Operating Certificate" documentation was not posted in the elevator.	K 0531	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Current inspection is in place and posted in elevators, as required. Copy attached. **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 **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 to be educated by Administrator/designee on	03/30/2018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)		proper Elevator license display requirements. Inspections were sent to wrong address. Address confirmed and inspections are up to date **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; and** Scheduled maintenance items entered into TELS system to ensure items are scheduled and completed. Ongoing environmental tours will continue by maintenance director and Administrator/designee. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A.	
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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	155618	A. BUILDING 01 B. WING	02/28/2018

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	19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to document activation of the fire alarm system for fire drills conducted between 6:00 a.m. and 9:00 p.m.: a. in the second quarter 2017 for 1 of 3 shifts. b. in the third quarter 2017 for 1 of 3 shifts. c. in the fourth quarter 2017 for 1 of 3 shifts. d. in the first quarter 2018 for 1 of 3 shifts. LSC 19.7.1.4 states fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency fire conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of "Fire Alarm Report" documentation with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 02/28/18, the following was noted: a. documentation for the second quarter fire drill conducted on 04/23/17 at 8:30 p.m. indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal. The aforementioned fire drill documentation was left blank in response to "Alarm reported from switchbox to fire department or monitoring company." Documentation for the second quarter fire drill conducted on 05/30/17 did not include the time of day for the drill and was also left blank for alarm notification to the monitoring company. b. documentation for third quarter fire drills conducted on 07/27/17 at 6:40 a.m. and conducted	K 0712	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Fire drills will be conducted per policy and state regulations. Will ensure monitoring station is informed when drills are conducted during late evening/early morning drills. **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. **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 to be educated by Administrator/designee on proper Fire Drill procedures and Fire Drill documentation requirements **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; and** Maintenance Director/Designee to	03/30/2018

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	on 07/30/17 at 7:30 p.m. indicated the drills were conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the drill. The aforementioned fire drill documentation stated "No" in response to "Alarm reported from switchbox to fire department or monitoring company." c. documentation for the fourth quarter fire drill conducted on 12/13/17 at 6:00 p.m. indicated the drill was conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the drill. The aforementioned fire drill documentation stated "No" in response to "Alarm reported from switchbox to fire department or monitoring company." d. documentation for first quarter fire drills conducted on 01/28/18 at 9:30 a.m. and conducted on 02/22/18 at 10:00 a.m. indicated the drills were conducted after 6:00 a.m. but before 9:00 p.m. and did not include activation of the fire alarm system and transmission of the fire alarm signal at the time of the drill. The aforementioned fire drill documentation stated "No" in response to "Alarm reported from switchbox to fire department or monitoring company." Based on interview at the time of record review, the Maintenance Director stated additional fire drill documentation was not available for review and agreed the aforementioned fire drill documentation did not include activation of the fire alarm system and the transmission of the fire alarm signal at the time of the drill. 3.1-19(b)		ensure fire drills are conducted to regulation and are documented properly. Fire drills scheduled through TELS system, to ensure all scheduled events are known and completed. Maintenance will report fire drill results to administrator. Any deficiencies will be reported to the Administrator and corrected immediately. IDT to review any deficiencies during monthly QA&A.	
K 0754 SS=E Bldg. 01	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers			

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	Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7			
	Based on observation and interview, the facility failed to ensure soiled linen and trash receptacles stored in 1 of over 60 rooms were maintained in accordance with LSC 19.7.5.7. This deficient practice could affect over 10 residents, staff and visitors on the second floor. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, one 32 gallon soiled linen cart partially filled with soiled linen and one 32 gallon trash cart partially filled with trash were stored next to each other in resident resident Room 237 and were unattended. The corridor door to the room was not equipped with a self closing device. Based on interview at the time of the observations, the Maintenance Director agreed a total container capacity of greater than 32 gallons of soiled linen and trash was stored in	K 0754	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Trash bins returned to soiled utility room, with proper secured door lock. **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 **What measures will be put into place or what systemic**	03/30/2018

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	the room and the room was not located in a room protected as a hazardous area. 3.1-19(b)		**changes will be made to ensure that the deficient practice does not recur;** Maintenance, housekeeping, and nursing staff to be educated by Administrator/designee on proper storage of trash bins. **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; and** Administrator/designee will tour building to ensure all trash receptacles are stored properly. Any deficiencies will be corrected immediately. IDT to review any deficiencies during monthly QA&A.	
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.			

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	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, it could not be assured the facility exercised the generator for 2 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Contractor contacted to inspect/repair generator areas noted. Repairs will be completed as soon as possible. Generator Tests for 12 months completed are supplied in attachment. 4 hour test at 30% Load completed on 3/6/18 **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;**	03/30/2018

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	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 residents, staff and visitors. Findings include: Based on review of "Generator Operation Log" documentation with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 02/28/18, monthly load testing documentation for load testing conducted on 01/04/18 and 02/01/18 did not indicate if it was under loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer or under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating. The aforementioned documentation stated the amperage achieved for each generator phase for the test but did not indicate the load percent achieved for the test. Based on interview at the time of record review, the Maintenance Director stated additional monthly load testing documentation was not available for review, it could not be determined what amperage during a load test was equivalent to or greater than 30% load and the facility has a contractor perform an annual load bank test for the diesel fired generator but agreed monthly load testing documentation for January and February 2018 was incomplete. 3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition,		All residents have the potential to be affected by this alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Routine maintenance scheduled through TELS system to ensure completed.** External generator inspections continue. Repairs to generator housing estimate received and repairs scheduled to be complete by 4/20/18 **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; and** Any deficiencies will be communicated to Administrator and corrected. IDT to review any deficiencies during monthly QA&A.	

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	the Standard for Emergency and Standby Powers Systems, Section 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) 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 residents, staff and visitors. Findings include: Based on review of Buckeye Power Sales "Load Test Data" documentation dated 10/24/17 with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on 02/28/18, annual supplemental load testing documentation indicated the total test duration was less than 1.5 continuous hours. The annual supplemental load test documentation indicated the generator was run under 25.9% load for 15 minutes and at 51.9% load for 30 minutes for a total run time of 45 minutes. Based on interview at the time of record review, the Maintenance Director stated the generator is tested under load on a monthly basis, is not sure load testing achieves 30% of the name			

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	plate rating, Buckeye's 10/24/17 load bank test was not for a minimum of 1.5 hours and agreed additional annual load bank testing for the generator was not available for review at the time of the survey. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to ensure the outdoor enclosure for the emergency generator was capable of resisting the entrance of snow or rain in accordance with Section 7.2.1 of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review, observation and interview; the facility failed to ensure the weatherproof housing for the emergency generator was maintained to prevent deterioration in accordance with Section 8.3.1 of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems. Section 8.3.1 states the EPSS (Emergency Power Supply System) shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Buckeye Power Sales "Service" documentation dated 06/03/16 and 10/10/17 with the Maintenance Director during record review from 9:15 a.m. to 12:00 p.m. on			

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	02/28/18, the housing for the facility's emergency generator "is badly rusted and falling apart, recommend that some sort of building be built around the generator to help protect it from the elements." Based on interview at the time of record review, the Maintenance Director stated the facility is currently in the process of replacing the emergency generator and its housing but agreed replacement documentation was not available for review at the time of the survey. Based on observations with the Maintenance Director during a tour of the facility from 12:00 p.m. to 2:00 p.m. on 02/28/18, the housing for the facility's emergency generator which is located outside the north side of the building had several large holes on the top of the housing due to rust. 3.1-19(b)			