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	154035	A. BUILDING **01 - 1015 MICHIGAN AVE** B. WING _____	**04/21/2021**

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K 000	INITIAL COMMENTS A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Dates: 04/20-21/21 Facility Number: 005199 Provider Number: 154035 AIM Number: 100273560A At this Life Safety Code survey, Four County Counseling Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Four County Counseling Center is comprised of the main hospital in Logansport, In (Building 01), and Market Street (Building 02), and Stepping Stones Clubhouse (Building 03). Four County Counseling Center main building, Building 01, a two story fully sprinklered building with a construction type that could be best determined by observation and without plans as Type II (000). The building with a fire alarm system with partial smoke detection surveyed with Chapter 19, Existing Health Care occupancies. Building 01 provides overnight care. Building 01 has a capacity of 15 and had a census of 8 at the time of this survey. Quality Review completed on 05/05/21	K 000		
K 211	Means of Egress - General CFR(s): NFPA 101	K 211		

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

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K 211	Continued From page 1 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 This STANDARD is not met as evidenced by: Based on observation, the facility failed to meet the clear width requirement for 1 of 4 corridors or met an exception per 19.2.3.4(5). LSC 19.2.3.4(5) states where the corridor width is at least 8 feet, projections into the required width shall be permitted for fixed furniture, provided that all of the following conditions are met: (a) the fixed furniture is securely attached to the floor or to the wall. (b) the fixed furniture does not reduce the clear unobstructed corridor width to less than six feet, except as permitted by 19.2.3.4(2). (c) the fixed furniture is located only on one side of the corridor. (d) the fixed furniture is grouped such that each grouping does not exceed an area of 50 square feet. (e) the fixed furniture groupings addressed in 19.2.3.4(5) (d) are separated from each other by a distance of at least 10 feet. (f) the fixed furniture is located so as to not obstruct access to building service and fire protection equipment. (g) corridors throughout the smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, or the fixed furniture spaces are arranged and located to allow direct supervision by the facility staff from a nurse's station or	K 211		

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K 211	Continued From page 2 similar space. (h) the smoke compartment is protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.8 This deficient practice could affect all staff on Trans hall. Findings include: Based on observation on 04/20/21 at 1:27 p.m. with the Director of Facilities and Safety (DFS), the Trans hall corridor on the first floor measured six feet wide and contained two large 30 gallon plastic garbage cans which limited the corridor width to less than three feet. Based on interview at the time of the observation and measurement with the DFS it was acknowledged the items stored in the corridor limited corridor access to less than four feet. This finding was reviewed with the DFS and the Director of Compliance during the exit conference.	K 211		
K 271	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 6 exit discharges was clear of all obstructions which could prevent travel to a public way. This deficient practice could affect staff only.	K 271		

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K 271	Continued From page 3 Findings include: Based on observation on 04/20/21 at 1:38 p.m. with the Director of Facilities and Safety (DFS), the back exit out of the Boiler room led to a loading dock was blocked on the outside by a heavy loading cart and could not be opened. Based on interview concurrent with the observation with the DFS it was stated staff had been told not to store the loading cart in front of the back door of the Boiler room. This was discussed with the DFS and the Director of Compliance during the exit conference.	K 271		
K 281	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure continuity of egress lighting for 1 of 6 exits. For the purposes of this requirement, exit access shall include only designated stairs, aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect clients, staff and visitors.	K 281		

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K 281	Continued From page 4 Finding include: Based on observation on 04/20/21 at 1:05 p.m. with the Director of Facilities and Safety (DFS), the exit discharge out of 100 hall did not have any outside lighting for illumination of the public way. Based on interview at the time of observation, the DFS confirmed there was no lighting devices illuminating the public way for 100 hall. This finding was reviewed with the DFS and the Director of Compliance during the exit conference. 2. Based on observation and interview, the facility failed to ensure the lighting for 1 of 6 exit means of egress was arranged so the failure of any single lighting fixture (bulb) would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect 9 residents who reside on the Old Hall. Findings include: Based on observation on 04/20/21 at 1:08 p.m. with the Director of Facilities and Safety (DFS), the exit discharge outside the IT exit there is only a one bulb fixture available to illuminate the outside path to a public way. Based on interview at the time of observation, the DFS confirmed there was only a single bulb fixture available for the IT exit discharge. This finding was reviewed with the DFS and the Director of Compliance during the exit conference.	K 281		
K 291	Emergency Lighting	K 291		

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K 291	Continued From page 5 CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 5 of 5 battery backup lights were tested monthly for 30 seconds over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. 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. Findings include: Based on record review on 04/20/21 at 11:30 a.m. with the Director of Facilities and Safety (DFS), the Battery Operated Emergency Light Test Log for 2021 indicated the facility did not document the time for each month the lights were tested. Based on an interview at the time of record review, the DFS indicated the facility has battery operated emergency exit lights tested throughout the facility, but the facility neglected to document the number of seconds the lights were tested each month. This was discussed with the DFS and the Director of Compliance during the	K 291		

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K 291	Continued From page 6 exit conference.	K 291		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 4 hazardous areas observed such as Storage rooms over 50 square feet, would latch in their frame and be provided	K 321		

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K 321	Continued From page 7 with a self-closing device. This deficient practice could affect staff on first floor. Findings include: Based on observation on 04/20/21 at 1:10 p.m. with the Director of Facilities and Safety (DFS), there were twenty six cardboard boxes stored in the "Mancave" on first floor next to the front reception area and there was no self closing device on the corridor door. Based on interview at the time of observation with the DFS it was acknowledged the corridor door to the Mancave was not provided with a self closing device on the corridor door. It was further acknowledged the area was over 50 square feet. This was discussed with the DFS and the Director of Compliance during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 4 hazardous areas observed such as Elevator Machine rooms was provided with an entry/exit door which was 3/4 hour fire rated. This deficient practice could affect all occupants in the facility. Findings include: Based on observation on 04/20/21 at 1:32 p.m. with the Director of Facilities and Safety (DFS), the entry/exit door to the Elevator Machine room was missing a fire rated label and could not be identified as having the 3/4 hour fire rating. Based on interview at the time of observation with the DFS it was acknowledged the Elevator Machine room door did not have a label to indicate it's fire rating and had to be considered a non-rated door. This was discussed with the DFS and the Director of Compliance during the exit	K 321		

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K 321	Continued From page 8 conference.	K 321		
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is not met as evidenced by: 1. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Facilities and Safety (DFS) on 04/20/21, the fire alarm annual report dated 03/11/21 in the comments section regarding the elevator stated: "This device will shut down the elevator will reset when system is reset, does not recall the elevator, the elevator stops where it's at until its reset." Based on interview at the time of record review it was acknowledged by the DFS the statement on the fire alarm annual report must be valid. This was discussed with the DFS and the	K 345		

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K 345	Continued From page 9 Director of Compliance during the exit conference. 2. Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 2010 Edition, Section 14.4.5 requires testing shall be performed in accordance with Table 14.4.5 Testing Frequencies. Section 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. Section 14.4.5.3.2 states sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. 14.4.5.3.5 states smoke detectors or smoke alarms found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. Section 14.6.2.4 states a record of all inspections, testing and maintenance shall be provided that includes all applicable information requested in Figure 14.6.2.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Brenneco's Fire Alarm Systems "Initiating & Supervisory Device Tests & Inspections" documentation dated 03/11/21 with the with the Director of Facilities and safety (DFS) during record review on 04/20/21 it was stated in the device specs: Johnson controls duct detector model # 760 sensitivity test was not available. Based on interview at the time of record review, the DFS acknowledged the statement made in the device specs section must be correct. This	K 345		

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K 345	Continued From page 10 was discussed with the DFS and the Director of Compliance during the exit conference 3. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Section 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all clients and staff. Findings include: Based on record review on 04/20/21 at 12:00 p.m. with the Director of Facilities and Safety (DFS), no documentation could be provided regarding a visual semi-annual fire alarm system inspection during the past 12 months. Based on interview at the time of record review, the DFS acknowledged there was no documentation for a semi-annual visual fire alarm system test/inspection during the past 12 months available for review.	K 345		
K 351	Sprinkler System - Installation CFR(s): NFPA 101	K 351		

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K 351	Continued From page 11 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure a 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Director of Facilities and Safety (DFS) on 04/20/21 at 1:35 p.m., the Boiler room on the first floor had several low voltage communication lines attached to the metal sprinkler pipe. Based on interview at the time of observation, the DFS acknowledged there	K 351		

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K 351	Continued From page 12	K 351		

were wires attached to the sprinkler pipe and was unaware this condition existed.

2. Based on observation and interview, the facility failed to ensure an automatic sprinkler system provided complete coverage in 1 of 1 Housekeeping rooms on the second floor. This deficient practice could affect only staff.

Findings include:

Based on observation on 04/20/21 at 2:01 p.m. with the Director of Facilities and Safety (DFS), the Housekeeping room on the second floor was not provided with sprinkler protection. This was confirmed by the DFS at the time of observation. This was discussed with the DFS and the Director of compliance during the exit conference.

3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Transportation office's in accordance with NFPA 13. NFPA 13, 2010 edition, Section 6.2.7 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff in the Transportation office.

Findings include:

Based on observation on 04/20/21 at 1:25 p.m. with the Director of Facilities and Safety (DFS), an escutcheon was missing around 1 of 2 sprinkler heads in the Transportation office. Based on interview at the time of observation, the DFS acknowledged and confirmed the missing escutcheon. This was discussed with the DFS and the Director of Compliance during the exit

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FOUR COUNTY COUNSELING CENTER	**1015 MICHIGAN AVE LOGANSPORT, IN 46947**

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K 351	Continued From page 13 conference. 4. Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 Housekeeping closets first floor in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect 12 residents, visitors and staff. Findings include: Based on observation on 04/20/21 at 1:18 p.m. with the Director of Facilities and Safety (DFS), the Housekeeping closet on the first floor contained several cardboard boxes which were stored on shelves within two to three inches from the deflector on the sprinkler head. Based on interview at the time of observation, the DFS acknowledged the obstructions were less than eighteen inches from the sprinkler head and would convey this to Housekeeping. This was discussed with the DFS and the Director of Compliance during the exit conference.	K 351		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		

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K 353	Continued From page 14 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to document monthly sprinkler system inspections for 1 of 1 sprinkler risers 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 dry pipe sprinkler systems shall be inspected weekly 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 13.3.2.1.1 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 in the facility. Findings include:	K 353		

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K 353	Continued From page 15 Based on record review on 04/20/21 at 11:42 a.m. with the Director of Facilities and Safety (DFS) there was no documentation provided to verify the facility did monthly sprinkler gauge and control valve inspections for the past year. Based on interview during record review and at the exit conference it was confirmed no documentation could be produced to verify monthly sprinkler gauge and control valves had been inspected for the past year.	K 353		
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers observed was installed in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 6.1.3.8.1 states fire extinguishers having a gross weight not exceeding 40 lb. shall be installed so that the top of the fire extinguisher is not more than five feet above the floor. This deficient practice could affect staff only. Findings include: Based on observation on 04/20/21 at 1:30 p.m. with the Director of Facilities and Safety (DFS), the abc portable fire extinguisher mounted on the wall in the Elevator Machine room adjacent to the	K 355		

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K 355	Continued From page 16 Boiler room was measured to be sixty nine inches from the floor to the top of the extinguisher. Based on interview at the time of observation, the DFS stated she was unaware of this requirement and would remount the fire extinguisher to within five feet from the floor. This finding was reviewed with the DFS and the Director of Compliance during the exit conference	K 355		
K 363	Corridor - Doors CFR(s): NFPA 101 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 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	K 363		

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K 363	Continued From page 17 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. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 2 Central office corridor doors on the second floor would close completely and latch into their door frames. This deficient practice could affect 8 residents, visitors and staff on the second floor. Findings include: Based on observation on 04/20/21 at 1:43 p.m. with the Director of Facilities and Safety (DFS), the two Central office corridor doors on the second floor do not have latching equipment to latch into their respective door frames. Based on interview concurrent with the observation with the DFS it was stated no one has ever pointed this out before and she did not know the corridor doors must latch into their frame. This was discussed with the DFS and Director of Compliance during the exit conference.	K 363		
K 511	Utilities - Gas and Electric CFR(s): NFPA 101 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	K 511		

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K 511	Continued From page 18 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 This STANDARD is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 1 of 1 corridors with electrical panels were secured from non-authorized personnel per LSC 19.5.1.1. LSC 19.5.1.1 states utilities shall comply with the provisions of Section 9.1. LSC 9.1.2 states electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70 Section 110.27(A) states live parts of electrical equipment over 50 volts or more shall be guarded against accidental contact by approved closures or by any of the following means: (1) by location in a room, vault, or similar enclosure that is accessible only to qualified persons. This deficient practice could affect all at least 9 residents, visitors and staff. Findings include: Based on observation on 04/20/21 at 1:16 p.m. with the Director of Facilities and Safety (DFS) there were two electrical panels installed in the corridor wall on Transportation hall which were not secured against non-authorized personnel. Based on interview during the observation, the DFS confirmed the electrical panels could be opened by anyone and was unaware they needed to be secured against unauthorized access. This was discussed with the DFS and the Director of Compliance during the exit conference.	K 511		

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K 511	Continued From page 19 2. Based on observation, the facility failed to ensure 1 of 1 electrical junction boxes observed were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 9 residents, staff and visitors. Findings include: Based on observation on 04/20/21 at 12:36 p.m. with the Director of Facilities and Safety (DFS), one electrical junction box with exposed electrical wiring and no cover plate was noted in the Electrical Mechanical room in Activities attached to an air handling unit. Based on interview at the time of the observation, the DFS acknowledged the electrical junction box location was not provided with a cover. This finding was reviewed with the DFS and the Director of Compliance during the exit conference.	K 511		
K 531	Elevators CFR(s): NFPA 101 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.	K 531		

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K 531	Continued From page 20 Existing elevators conform to ASME/ANSI 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 This STANDARD is not met as evidenced by: 1. Based on observation, record review and interview, the facility failed to maintain testing of 1 of 1 elevators firefighter recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect all residents, visitors and staff. Findings include: Based on observation on 04/20/21 at 1:10 p.m. with the Director of Facilities and Safety (DFS), the elevator had a key access fire department recall feature. Based on record review with the DFS there was no documentation of a monthly firefighter recall test for the past year. Based on interview with the DFS, when asked during record review it was indicated there was no documentation for the monthly firefighter recall testing for the elevator in the facility. This was	K 531		

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K 531	Continued From page 21 discussed with the DFS and the Director of Compliance during the exit conference. 2. Based on observation, interview, and record review; the facility failed to ensure the elevator equipment in 1 of 1 elevator equipment rooms was provided with a shunt trip. NFPA 13, 5-13.6.2 states automatic sprinklers in elevator machine rooms shall be ordinary or intermediate temperature rating. ASME/ANSI A17.1 permits sprinklers in elevator machine rooms when there is a means for disconnecting the main power supply to the affected elevator automatically upon, or prior to, the application of water from the sprinkler located in the elevator machine room. The elevator equipment room was located in the basement and could affect any resident using the elevator as well as visitors and staff. Findings include: Based on observation and interview on 04/20/21 at 1:32 p.m. with the Director of Facilities and Safety (DFS), the elevator equipment room located on the first floor was provided with a quick response sprinkler head and smoke detector protection, however a shunt trip could not be located. The DFS acknowledged she did not know what a shunt trip is and did not know where one may be located. Based on the Sprinkler Inspection and Test Report record review at 12:15 p.m. with the DFS, there was no mention of a shunt trip installation in the elevator machine room. This was discussed with the DFS and the Director of Compliance during the exit conference.	K 531		
K 711	Evacuation and Relocation Plan CFR(s): NFPA 101	K 711		

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K 711	Continued From page 22	K 711		

Evacuation and Relocation Plan
There is a written plan for the protection of all patients and for their evacuation in the event of an emergency.
Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2.
18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3
This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plan. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following:
(1) Use of alarms
(2) Transmission of alarm to fire department
(3) Emergency phone call to fire department
(4) Response to alarms
(5) Isolation of fire
(6) Evacuation of immediate area
(7) Evacuation of smoke compartment
(8) Preparation of floors and building for evacuation
(9) Extinguishment of fire
Section 18.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and

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K 711	Continued From page 23 training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on record review on 04/20/20 at 12:05 p.m. with the Director of Facilities and Safety (DFS), the Fire Safety plan did not address a. types of fire extinguishers throughout the facility, b. how to evacuate a smoke compartment to another smoke compartment behind a set of smoke/fire doors, c. extinguishment of fire or d. isolation of fire. Based on interview at the time of record review with the DFS and the Director of Compliance during the exit conference it was agreed the Fire Safety policy did not identify items a through d.	K 711		
K 712	Fire Drills CFR(s): NFPA 101 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 This STANDARD is not met as evidenced by: Based on record review and interview, the facility	K 712		

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K 712	Continued From page 24 failed to verify transmission of the fire alarm signal for 3 of the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Monthly Fire Drill Reports on 04/20/21 at 12:13 p.m., with the Director of Facilities and Safety (DFS) there was no documentation for the transmission of the fire alarm signal the following quarter: a. First quarter 2021, Night shift 1/28/21 b. Fourth quarter 2020, Night shift 12/17/20 c. Third quarter 2020, Night shift 09/28/20 Based on an interview with the DFS at the time of record review, it was stated the transmission signal of the fire alarm to the monitoring station had not been documented for the last 3 of 4 quarters. This was discussed with the DFS and the Director of Compliance during the exit conference.	K 712		
K 741	Smoking Regulations CFR(s): NFPA 101 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.	K 741		

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K 741	Continued From page 25 (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 devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to include in 1 of 1 smoking policies the designated location where smoking by clients and staff was permitted. This deficient practice could affect any client and staff. Findings include: Based on record review on 04/20/21 at 12:11 p.m. with the Director of Facilities and Safety (DFS), the smoking policy presented for review did not indicate where smoking by clients and staff was permitted. Based on interview concurrent with the record review the DFS stated this current smoking policy only stated that smoking was allowed at designated areas, but did not specify where. This was discussed with the DFS and the Director of Compliance during the exit conference.	K 741		
K 918	Electrical Systems - Essential Electric Syste	K 918		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 918	Continued From page 26 CFR(s): NFPA 101 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. 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) This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to implement the emergency power system	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING **01 - 1015 MICHIGAN AVE** B. WING _____	**04/21/2021**

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K 918	Continued From page 27 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 residents, staff and visitors. Findings include: Based on review of generator Weekly and Monthly Load Test Log on 04/20/21 at 11:50 a.m., with the Director of Facilities and Safety (DFS) there was no documentation of monthly load testing done for the past twelve months. In addition, the last generator annual load bank test for diesel emergency power systems available for review was dated 05/06/19. Based on interview at the time of record review, the DFS acknowledged the load bank was past due and stated maintenance present before her did not keep records of weekly inspections or monthly load for the past year. This was discussed with the DFS and the Director of Compliance during the exit conference.	K 918		
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154035	A. BUILDING **01 - 1015 MICHIGAN AVE** B. WING _____	**04/21/2021**

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K 920	Continued From page 28	K 920		

PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.
10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5
This STANDARD is not met as evidenced by:
Based on observation and interview, the facility failed to ensure proper use of power strips in 3 of 3 rooms observed. This deficient practice could affect clients, visitors and staff.

Findings include:

Based on observations on 04/20/21 during the tour between 12:43 p.m. to 3:14 p.m. with the Director of Facilities and Safety (DFS), a power strip was used to power a lamp in the Front entrance lobby when the power cord from the lamp could easily reach the outlet. Next, a power strip was connected to another power strip in the IT room on the first floor. Lastly, a power strip was connected to another power strip in the Psychologist office on the second floor. Based on interview concurrent with the observations with the DFS, the misuse of the power strips described was confirmed. This finding was discussed with the DFS and the Director of Compliance during the exit conference