STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154014	A. BUILDING **02, 03, 10** B. WING _____	**12/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OTIS R BOWEN CENTER FOR HUMAN SERVICES INC	**9 PEQUIGNOT DR** **PIERCETON, IN 46562**

(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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.15. Survey Dates: 12/05/24-12/06/24 Facility Number: 005179 Provider Number: 154014 AIM Number: 100273260A At this Emergency Preparedness survey, Otis Bowen Center for Human Services was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 482.15. The facility has 16 certified beds. At the time of the survey, the census was 7. Quality Review completed on 12/11/24	E 000		
E 015	Subsistence Needs for Staff and Patients CFR(s): 482.15(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:	E 015		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/17/2025

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E 015	Continued From page 1 (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies	E 015		

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E 015	Continued From page 2 and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the emergency preparedness plan failed to address the provision of subsistence needs for staff and patients whether they evacuate or shelter in place. Based on interview at the time of record review, the Director of the In-patient Unit was not able to provide the documentation. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	E 015		
E 018	Procedures for Tracking of Staff and Patients CFR(s): 482.15(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2),	E 018		1/31/25

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E 018	Continued From page 3 §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which	E 018		

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E 018	Continued From page 4 includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff during and after an	E 018		

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E 018	Continued From page 5 emergency. If on-duty staff and sheltered patients are relocated during the emergency, the hospital must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 482.15(b) (2). This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the emergency preparedness plan included a system to track the location of sheltered patients in the hospital's care during and after an emergency; however, the plan did not address tracking of on-duty staff. Based on interview at the time of record review, the Director of the In-Patient Unit was not able to provide documentation regarding tracking of on-duty staff. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	E 018		
E 022	Policies/Procedures for Sheltering in Place CFR(s): 482.15(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.542(b)(4), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3).	E 022		1/31/25

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E 022	Continued From page 6 (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures included means to shelter in place for patients, staff, and volunteers who remain in the facility, in accordance with §482.15(b)(4) This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24,	E 022		

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E 022	Continued From page 7 documentation of a system to shelter in place for patients, staff, and volunteers who remain in the facility during an emergency was not provided. Based on interview at the time of record review, the Director of the In-Patient Unit was not able to provide documentation addressing a system to shelter in place. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	E 022		
E 024	Policies/Procedures-Volunteers and Staffing CFR(s): 482.15(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of	E 024		1/31/25

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E 024	Continued From page 8 volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 482.15(b)(6). This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the facility's plan did not address the use of volunteers in an emergency. Based on interview	E 024		

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E 024	Continued From page 9 at the time of record review, the Director of the In-Patient Unit said she was not able to locate a policy for the use of volunteers in an emergency. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	E 024		
E 025	Arrangement with Other Facilities CFR(s): 482.15(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services	E 025		1/31/25

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E 025	Continued From page 10 to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services in accordance with 42 CFR 482.15(b)(7). This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the emergency preparedness plan provided did not include policies and procedures for the development of arrangements with other providers to receive patients in the event of	E 025		

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E 025	Continued From page 11 limitations or cessation of operations to maintain the continuity of services to patients. Based on interview at the time of record review, the Director of the In-Patient Unit stated she was not able to locate documentation of any arrangements with other provider to receive patients. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	E 025		
E 037	EP Training Program CFR(s): 482.15(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		1/31/25

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E 037	Continued From page 12 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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	154014	A. BUILDING **02, 03, 10** B. WING _____	**12/06/2024**

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E 037	Continued From page 13 arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 14 arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,	E 037		

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E 037	Continued From page 15 personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff could demonstrate knowledge of emergency procedures Emergency Preparedness Program (EPP). The facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 16 least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the facility failed to provide documentation of initial training or training of staff every 2-years in emergency preparedness. Based on interview with the Director of the In-Patient Unit, she stated she was not able to provide any documentation of training in the emergency preparedness policies or procedures. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	E 037		
E 039	EP Testing Requirements CFR(s): 482.15(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2),	E 039		2/7/25

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E 039	Continued From page 17 §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

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E 039	Continued From page 18 designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 19 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan	E 039		

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E 039	Continued From page 20 twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:	E 039		

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E 039	Continued From page 21 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:	E 039		

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E 039	Continued From page 22 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.	E 039		

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E 039	Continued From page 23 (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale	E 039		

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E 039	Continued From page 24 community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from	E 039		

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E 039	Continued From page 25 engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year. The facility must do all of the following: i. Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or b. an individual, facility-based. If the hospital experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following	E 039		

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E 039	Continued From page 26 the onset of the actual event. ii. Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. iii. Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the facility was unable to provide documentation of two exercises within the past twelve months. Based on interview at the time of record review, the Director of the In-Patient Unit stated she was not able to locate any documentation of any exercises conducted. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	E 039		

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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 Date: 12/05/24-12/06/24 Facility Number: 005179 Provider Number: 154014 AIM Number: 100273260A At this Life Safety Code survey, Otis Bowen Center for Human Services (Bld. 02) 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), Chapter 19, Existing Health Care Occupancies. This one-story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility is separated between health care occupancies and a mix occupancy of business, storage, and assembly. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and patient rooms. The facility is fully protected by a 150-kW diesel generator. The facility has a capacity of 16 and had a census of 7 at the time of this survey. Quality Review completed on 12/11/24	K 000		
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).	K 000		

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K 000	Continued From page 28 Survey Date: 12/05/24-12/06/24 Facility Number: 005179 Provider Number: 154014 AIM Number: 100273260A At this Life Safety Code survey, Otis Bowen Center for Human Services (Bld. 03) 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), Chapter 39, Existing Business Occupancies. This one-story partly sprinklered facility with a basement was determined to be construction type V (000). The facility has a fire alarm system with hard-wired smoke detection in the corridors. Quality Review completed on 12/11/24	K 000		
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 Date: 12/05/24-12/06/24 Facility Number: 005179 Provider Number: 154014 AIM Number: 100273260A At this Life Safety Code survey, Otis Bowen Center for Human Services (Bld. 10) was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 000		

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K 000	Continued From page 29 Subpart 482.41(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 38, New Business Occupancies. (Bld. 10) This one-story fully sprinklered facility was determined to be construction Type II (000). The facility has a fire alarm system with hard-wired smoke detection in the corridors. Quality Review completed on 12/11/24	K 000		
K 324	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		1/17/25

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K 324	Continued From page 30	K 324		

This STANDARD is not met as evidenced by:
1) Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at least every six months. This deficient practice could affect kitchen staff.

Findings include:

Based on record review and interview with the Facilities Director from 9:27 a.m. to 1:44 p.m. and on observation and interview with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, documentation was available of a service and inspection of the kitchen fire suppression system completed on 3/13/24; however, no documentation of any maintenance or inspection six months after was available for review. Based on observation with the Facilities Director, the kitchen contained a fire suppression system. Based on interview at the time of record review, the Facilities Director stated documentation was not available at the time of survey.

2) Based on record review and interview, the facility failed to ensure 1 of 1 kitchen exhaust systems was inspected semiannually. NFPA 96,

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K 324	Continued From page 31 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substances. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice could affect kitchen staff. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, documentation of the kitchen hood exhaust system cleaning or inspection was not available during the past twelve months. Based on interview at the time of record review, the	K 324		

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K 324	Continued From page 32 Facilities Director said no documentation of the kitchen hood exhaust system cleaning or inspection was available at the time of survey. These findings were reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 324		
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: 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 Sections 19.3.4.5.1 and 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	K 345		12/11/24

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K 345	Continued From page 33 appliances e. Magnetic hold-open devices. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director from 9:27 a.m. to 1:44 p.m. on 12/05/24, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, when the Facilities Director was asked if there was documentation of a visual semi-annual fire alarm system inspection he stated "Don't have that." This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 345		
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: Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in	K 345		12/11/24

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K 345	Continued From page 34 accordance with NFPA 72, as required by LSC 101 Sections 39.3.4.1 and 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 patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director, Director of Kosciusko County, Facility Regional Coordinator, Executive Director of North-East Region, Facilities Coordinator and the Facilities Administrative Assistant from 11:33 a.m. to 12:39 p.m. on 12/06/24, no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, when the Facilities Director was asked if there was documentation of a visual semi-annual fire alarm system inspection he stated, "Don't have that." This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 345		

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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: 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 Sections 39.3.4.1 and 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 patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director, Executive Director of North-East Region, the Office Manager, Facilities Coordinator and the Facilities Administrative Assistant from 9:00 a.m. to 11:00 a.m. on 12/06/24, no documentation could be provided regarding a visual semi-annual fire alarm system	K 345		12/11/24

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K 345	Continued From page 36 inspection. Based on interview at the time of record review, when the Facilities Director was asked if there was documentation of a visual semi-annual fire alarm system inspection he stated, "Don't have that." This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 345		
K 346	Fire Alarm System - Out of Service CFR(s): NFPA 101 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 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to provide 1 of 1 correct written policy for the protection of patients 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 could affect all patients, staff and visitors. Findings include: Based on record review and interview with the	K 346		1/31/25

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K 346	Continued From page 37 Facilities Director and the Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the facility's fire watch plan titled "Fire Watch" stated "1. If the fire/sprinkler system becomes inoperable or placed in test mode, we must initiate a Fire Watch." The fire-watch plan failed to indicate when the system is out of service for 4 or more hours in a twenty-four-hour period, that the person(s) assigned to fire watch was to be trained, or that no other duties may be assigned to the person(s) conducting fire watch. Based on interview with the Director of the In-Patient Unit, when asked if the document provided was the fire watch plan or if there was anything additional to the fire watch plan, she stated the policy provided was the only plan. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 346		
K 351	Sprinkler System - Installation CFR(s): NFPA 101 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.	K 351		1/17/25

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K 351	Continued From page 38 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: Based on observation and interview, the facility failed to ensure that a complete automatic sprinkler system or documentation of fire retardant material was provided for 1 of 1 canvas canopies. NFPA 13-2010 Edition, Section 8.15.7.1 states sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft. (1.2 m) in width. Section 8.15.7.2 states sprinklers shall be permitted to be omitted where the canopies, roofs, porte-cocheres, balconies, decks, or similar projections are constructed with materials that are noncombustible or limited-combustible, or fire retardant. Textiles such as canvas used as an awning shall meet NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient practice could affect , staff and visitors using the service entrance. Findings include: Based on observation and interview with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, there was a canvas canopy in excess of 4 feet in width not sprinkled and attached to the building outside of the kitchen and service entrance. Based on interview at the time of observation the Facilities Director acknowledged there was no sprinkler coverage for the canopy.	K 351		

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	154014	A. BUILDING **02, 03, 10** B. WING _____	**12/06/2024**

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K 351	Continued From page 39 This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 351		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection	K 353		12/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 353	Continued From page 40 Systems, Section 14.2.1. Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director from 9:27 a.m. to 1:44 p.m. on 12/05/24, no documentation was available to show that an internal pipe inspection had been completed in the past five years. Based on interview with the Facilities Director at the time of record review, he stated there was no documentation for an internal pipe inspection available at the time of survey. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 353		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353		12/6/24

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K 353	Continued From page 41 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 ensure 1 of 1 sprinkler piping systems was examined for internal obstructions where conditions exist that could cause obstructed piping as required by NFPA 25, as required by NFPA 13 Section 26.1 and LSC 101 Sections 39.1.3.2.2 and 9.7.1.1(1). NFPA 25, 2011 Edition, the Standards for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, Section 14.2.1 states, "except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice affects all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director, Director of Kosciusko County,	K 353		

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K 353	Continued From page 42 Facility Regional Coordinator, Executive Director of North-East Region, Facilities Coordinator and Facilities Administrative Assistant from 11:33 a.m. to 12:39 p.m. on 12/06/24, no documentation was available to show that an internal pipe inspection had been completed in the past five years. Based on interview with the Facilities Director at the time of record review, he stated there was no documentation for an internal pipe inspection available at the time of survey. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 353		
K 354	Sprinkler System - Out of Service CFR(s): NFPA 101 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) This STANDARD is not met as evidenced by: Based on record review and interview, the facility	K 354		1/31/25

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K 354	Continued From page 43 failed to provide 1 of 1 correct written policy for the protection of residents indicating procedures to be followed in the event the fire sprinkler system has to be placed out of service for ten or more hours in a twenty-four-hour period in accordance with LSC, Section 9.6.1.6. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and the Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the facility's fire watch plan titled "Fire Watch" stated "1. If the fire/sprinkler system becomes inoperable or placed in test mode, we must initiate a Fire Watch." The fire-watch plan failed to indicate when the sprinkler system is out of service for 10 or more hours in a twenty-four-hour period, that the person(s) assigned to fire watch was to be trained, or that no other duties may be assigned to the person(s) conducting fire watch. Based on interview with the Director of the In-Patient Unit, when asked if the document provided was the fire watch plan or if there was anything additional to the fire watch plan, she stated the policy provided was the only plan. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 354		
K 363	Corridor - Doors	K 363		2/24/25

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K 363	Continued From page 44 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 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,	K 363		

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K 363	Continued From page 45 etc. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 8 of 8 patient sleeping room doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. LSC section 19.3.6.3.5 states: Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.7. This deficient practice could affect all patients, staff and visitors. Findings include: Based on observation and interview with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, none of the patient sleeping rooms were provided with a latching device. Based on interview at the time of exit, the CEO/President stated the requirement for latching patient sleeping room doors in the in-patient facility was an issue the facility had discussions about from previous surveys and he believed there was a conflict in requirements with different authorities. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of	K 363		

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K 363	Continued From page 46 Kosciusko County, and other executive staff at 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 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: Based on observation and interview, the facility failed to ensure receptacles within 6 feet from a sink were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 39.5.1 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, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where	K 511		1/17/25

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K 511	Continued From page 47 receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect male patients, staff, and visitors using the public restroom in the basement. Findings include: Based on record review and interview with the Facilities Director, Director of Kosciusko County, Facility Regional Coordinator, Executive Director of North-East Region, Facilities Coordinator and Facilities Administrative Assistant from 12:40 p.m. to 2:00 p.m. on 12/06/24, there was an electric receptacle within 6 feet from a sink in the male public restroom located in the basement. The electric receptacle was not GFCI protected and did not trip when tested. Based on interview at the time of observation, the Facilities Manager and Facilities Coordinator agreed the electric receptacle was not GFCI protected. The Director of Kosciusko County stated the basement is used by the public for routine use. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at	K 511		

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K 511	Continued From page 48 the exit conference.	K 511		
K 711	Evacuation and Relocation Plan CFR(s): NFPA 101 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 plans. 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 This deficient practice could affect all patients, staff and visitors. Findings include:	K 711		1/31/25

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K 711	Continued From page 49 Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the fire safety plan titled "Fire" failed to provide all of the required information. The plan failed to address: Transmission of alarm to fire department, Isolation of fire, or Extinguishment of fire. Based on interview with the Director of the In-Patient Unit, when asked if the document provided was the fire safety plan or if there was anything additional to the fire safety plan, she stated the policy provided was the only plan. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	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:	K 712		1/24/25

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K 712	Continued From page 50 Based on record review and interview, the facility failed to conduct fire drills on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, the following shifts were missing documentation of a completed fire drill: a) A first shift fire drill in the second quarter of 2024. b) A second shift fire drill in the third quarter of 2024. Based on interview at the time of record review, the Facilities Director stated no additional documentation of fire drills was available. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 712		
K 761	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to	K 761		12/12/24

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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 761	Continued From page 51 patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is not met as evidenced by: Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 2 of 2 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1. 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 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, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 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, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being subject to testing. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both	K 761		

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	154014	A. BUILDING **02, 03, 10** B. WING _____	**12/06/2024**

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K 761	Continued From page 52 sides to assess the overall condition of door assembly. NFPA 80, 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 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 patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, no	K 761		

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K 761	Continued From page 53 annual inspection of the fire door assemblies for Room 503 identified as "Linen Supply" and Room 502 identified as "Laundry Room" were available for review. Based on observation from 1:47 p.m. to 3:00 p.m. on 12/05/24, the fire door assemblies were in a two hour fire barrier. Based on interview at the time of records review, the Facilities Director acknowledged an annual inspection was not conducted for the fire door assemblies in the last year and confirmed the doors were in a two hour fire barrier as identified in the floor plan provided by the facility. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 761		
K 914	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or	K 914		1/17/25

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K 914	Continued From page 54 equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all nonhospital-grade electrical receptacles at resident room locations were tested at least annually. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all patients, staff and visitors. Findings include: Based on observation with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, 3 of 8 resident sleeping rooms contained non-hospital grade electrical receptacles. Based on record review and interview no documentation of annual testing per NFPA 99, Receptacle Testing	K 914		

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K 914	Continued From page 55 requirements was available for review at the time of survey. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 914		
K 918	Electrical Systems - Essential Electric Syste 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	K 918		1/6/25

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K 918	Continued From page 56 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: 1) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 5 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all patients, staff and visitors. Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, no documentation of monthly generator load testing was available for March 2024 or April 2024; documentation of monthly generator load tests for June 2024, July 2024, and August 2024 only stated "Pass" with no other information available. Based on an interview at the time of record	K 918		

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K 918	Continued From page 57 review, the Facilities Director stated the facility contracts the service and acknowledged the missing and incomplete documentation. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference. 3.1-19(b) 2) Based on record review, observation, and interview; the facility failed to document a 36-month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all patients, staff, and visitors.	K 918		

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K 918	Continued From page 58 Findings include: Based on record review and interview with the Facilities Director and Director of the In-Patient Unit from 9:27 a.m. to 1:44 p.m. on 12/05/24, no documentation of a thirty-six-month period emergency generator load test for four continuous hours for the diesel emergency generator was available for review. Based on interview at the time of record review, the Facilities Director stated the facility contracts the generator service and acknowledged no documentation was available at the time of survey. Based on observation with the Facilities Director the facaility has a 150kw diesel emergency generator located outside the building. 3) Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, 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 loads (Load Bank Test) at not less	K 918		

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K 918	Continued From page 59 than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all occupants. Findings include: Based on record review and interview with the Facilities Director from 9:27 a.m. to 1:44 p.m. on 12/05/24, the load percentage recorded on May 22, 2024, was 10 percent, the load percentage recorded on February 22, 2024, was 15 percent, the load percent recorded on October 18, 2024, was 5 percent. Based on interview at the time of record review, the Facilities Director acknowledged the documentation and stated, "I would dispute the load percentage." These findings were reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at 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	K 920		1/17/25

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K 920	Continued From page 60 may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect staff only. Findings include: Based on observation with the Facilities Director from 1:47 p.m. to 3:00 p.m. on 12/05/24, there was a power strip located under the nurses station desk, used to power computer equipment, but it was dangling from the connected power cords. This condition could put stress on the	K 920		

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K 920	Continued From page 61 power cord causing damage to the power cord. Based on interview at the time of observation, the Facilities Director confirmed that the power strip was dangling. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 920		
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 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	K 920		1/17/25

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K 920	Continued From page 62 (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 power strips were not used as a substitute for fixed wiring in staff only areas. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff in the lab. Findings include: Based on observation with the Facilities Director, Executive Director of North-East Region, the Office Manager, Facilities Coordinator and the Facilities Administrative Assistant from 10:00 a.m. to 11:00 a.m. on 12/06/24, a refrigerator was plugged into a power strip in the Lab. Based on interview at the time of observation, the Facilities Director acknowledged the use of the power strip to supply power to the refrigerator and disconnected the refrigerator and relocated it to another wall and plugged the refrigerator directly into a wall receptacle. This finding was reviewed with the President/CEO, Facilities Director, Facilities Regional Coordinator, Facilities Coordinator, Facilities Administrative Assistant, Executive Director of North-East Region, Director of Kosciusko County, and other executive staff at the exit conference.	K 920		