STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	154020	A. BUILDING -- B. WING	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
REGIONAL MENTAL HEALTH CENTER	8555 TAFT ST MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.15. Survey Date: 01/28/2025 Facility Number: 005184 Provider Number: 154020 AIM Number: 100273350A At this Emergency Preparedness survey, Regional Mental Health Center 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 2. The requirement at 42 CFR, Subpart 482.15 is NOT MET as evidenced by: Quality Review conducted on 01/31/25	E 0000		
E 0037 Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.542(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §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).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Bakaitis		02/17/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	*[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. (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			

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	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 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			

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	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 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			

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	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, 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			

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	CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP) in accordance with 42 CFR 482.15(d)(1). The Hospital 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; (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 hospital must conduct training on the updated policies and procedures. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., no documentation of initial or annual EPP training was available and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Director of Facilities searched the facility's online training program, "Relias", which indicated no training had been completed in Emergency Preparedness. This finding was reviewed with the Vice President	E 0037	**How the deficiency will be or has been corrected.** **Emergency Preparedness (EP) training has been incorporated into our New Employee Orientation (NEO) to guarantee that all new employees receive foundational training. Additionally, EP training has been integrated into our online training platform, Relias, and is now mandatory for all employees. Human Resources will oversee the maintenance of training records for both NEO and Relias, which will facilitate real-time reporting of EP training completion. This training is scheduled to be reassigned on an annual basis.** **How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to ensure the deficiency will not recur.** **Emergency Preparedness (EP) has been incorporated into the mandatory training checklist for New Employee Orientation (NEO) by the Human Resources department. Additionally, Human Resources has included an EP training module in the annual training requirements for employees on the Relias**	02/21/2025

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	of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference.		**platform.** Who is responsible to ensure the deficiency will be/has been corrected and compliance maintained. **Director of Facilities**	
E 0041 Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new			

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	structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.			

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	If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	1. Based on record review and interview, the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1	E 0041	**How the deficiency will be or has been corrected.** The local utility gas company (Nipsco) was contacted on 2/12/25 and a Letter of Reliability of gas service was requested.	02/28/2025

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	states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., the facility's emergency generator had a natural gas fuel source. The facility failed to provide a letter of reliability from the utility providing the natural gas. Based on interview the Director of Facilities stated he was not aware of the requirements of the Letter of Reliability and stated he knew they did not have such a letter. This finding was reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference. 2. Based on record review and interview, the		Anticipate receipt of the letter by 2/28/25. Follow up with the utility company is scheduled for every two weeks until receipt of the letter. The weekly inspection and monthly load test for the generator was conducted on 2/14/25. The Director of Facilities conducted training with all maintenance personnel to review the step-by-step procedures for conducting the weekly inspection and monthly load testing of the generator. Additionally, the documentation and recording procedures were also reviewed with all responsible staff members. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to ensure the deficiency will not recur. Both the weekly inspection and the monthly generator load testing were entered into our Computerized Maintenance Management Software (CMMS) as a Monthly Preventive Maintenance task to guarantee that future monthly tests are executed accurately and punctually. Who is responsible to ensure the deficiency will be/has been corrected and compliance maintained. Director of Facilities	

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	facility failed to maintain a complete written record of monthly generator load testing for 6 of 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 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. 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 in the facility. Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., documentation for the monthly load tests were incomplete. Documentation for monthly load tests for July 2024 through December 2024 was not completed and lacked Transfer time, time ran under load, and load percentage. It was not clear from the documentation if the generator was run under load during those months. Based on an interview at the time of record review, the Director of Facilities agreed not all of the required information was documented and stated a new maintenance technician had started to perform the inspections around the time the information was not documented. This finding was reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the			

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	exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 01/28/2025 Facility Number: 005184 Provider Number: 154020 AIM Number: 100273510A At this Life Safety Code survey, Regional Mental Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This two-story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and patient sleeping rooms. The In-Patient Unit is located on the second floor and has a capacity of 16. The census was 2 at the time of this survey. Quality Review conducted on 01/31/25	K 0000		
K 0324 Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for			

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	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			
	1) Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed with employees by management. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Director of Facilities on 01/28/2025 from 1:57 p.m.	K 0324	**How the deficiency will be or has been corrected.** The Director of Facilities conducted training with all Kitchen, Maintenance, Housekeeping and Security staff on 2/14/25 in the procedures for manually activating the fire suppression system in the kitchen. Training included an overview of the fire extinguishing devices in the kitchen (fire extinguisher, fire blanket, dry-chemical fire suppression system in range hood and fire sprinkler system) as well as actions to take in case of a fire in the kitchen which included manual activation of the range hood suppression system and	02/14/2025

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	to 4:30 p.m., the kitchen was provided with a UL 300 hood fire suppression system. Based on interview during tour of the kitchen, the Kitchen Supervisor was asked what she would do if there was a grease fire underneath the hood. She stated a list of things she would do but failed to mention activating the fire suppression system. When she was asked if she knew what the pipes with nozzles above the stove were, she was aware that it was the fire suppression system but was not familiar with the location of the pull station to activate the system. Based on interview the Director of Facilities acknowledged the kitchen staff needed required training. 2) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the		evacuation of the space. Moving forward a review of these procedures will be conducted with appropriate staff during the quarterly fire drills. The Facility Manager will be responsible for training of any new staff throughout the year as necessary. Yellow duct tape was placed on the floor in front of the range in the kitchen and training conducted with kitchen staff, so they know to replace the range in the proper location after cleaning or moving the range. The fire suppression contractor completed the relocation of the manual activation device for the range hood fire suppression system on 2/10/25 to lower the device to 46 inches above finish floor. Additionally, the contractor realigned the spray nozzles for the system above the gas range to ensure they are positioned correctly. H**ow the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to ensure the deficiency will not recur.** **A** review of these procedures will be carried out with the relevant personnel during the quarterly fire drills and subsequently reported to the Corporate Safety Committee. The Facility Manager will oversee the training of any new staff as required throughout the year, and	

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	appliance is returned to an approved design location. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Director of Facilities on 01/28/2025 from 1:57 p.m. to 4:30 p.m., cooking appliances including a gas burner stove were located under the hood in 1 of 1 kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, he was not aware of any method or procedure in place. 3) Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing system in accordance with NFPA 96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states A readily accessible means for manual activation shall be located between 42 in. and 48 in. above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. Additionally, NFPA 101, Life Safety Code, 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall be either maintained or removed. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Director of Facilities on 01/28/2025 from 1:57 p.m. to 4:30 p.m., the ANSUL "Remote Pull Station" was mounted 59 ½ inches above the floor as		this will be incorporated into the training checklist for new kitchen employees. Our painting contractor has been retained to paint a permanent line on the kitchen floor. Who is responsible to ensure the deficiency will be/has been corrected and compliance maintained. Director of Facilities	

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	measured with the surveyor's tape measure. Based on interview at time of observation, the Director of Facilities acknowledged the measurement and stated he believed it should be "grand-fathered". These findings were reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference.			
K 0345 Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 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 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 appliances e. Magnetic hold-open devices. This deficient practice could affect all patients, staff and visitors in the facility.	K 0345	**How the deficiency will be or has been corrected.** The Fire Alarm contractor has been retained to complete a semi-annual visual inspection of the Fire Alarm system. This has been scheduled for week of 2/24/25. The Annual inspection was last completed on 8/28/24. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to ensure the deficiency will not recur. A semi-annual PM has been created and added to our CMMS	02/28/2025

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	Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection. Based on interview at the time of record review, the Director of Facilities stated no documentation of a semi-annual inspection was available. This finding was reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference.		program to ensure compliance moving forward. **Who is responsible to ensure the deficiency will be/has been corrected and compliance maintained.** **Director of Facilities**	
K 0353 Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1.) Based on observation, interview, and record review; the facility failed to ensure 1 of 1 electric fire pump was inspected monthly for 12 of 12	K 0353	**How the deficiency will be or has been corrected.** **The** Director of Facilities	02/17/2025

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	months over the past year in accordance with NFPA 25. NFPA 25, 2011 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 8-3.1.2 requires electric motor-driven fire pumps shall be operated monthly. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on observation with the Director of Facilities on 01/28/2025 from 1:57 p.m. to 4:30 p.m., the sprinkler riser room, had an electric motor driven fire pump in operation for the sprinkler system. Based on an interview with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., the facility failed to provide documentation of monthly inspections of the electric motor driven fire pump. Documentation of quarterly sprinkler system inspections indicated the vendor performing the quarterly inspections, included inspection of the electric motor driven fire pump; however, no documentation of inspections was provided for 8 of 12 months including January 2024 or 2025, February 2024, April 2024, May 2024, July 2024, August 2024, October 2024 or November 2024. 2.) Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13.		conducted training with responsible maintenance staff in the procedures for conducting and recording the monthly fire pump test on 2/17/25. A monthly PM was created and added to our CMMS program to ensure compliance moving forward. The Director of Facilities conducted training with responsible maintenance staff in the procedures for conducted and recording weekly sprinkler gauge and valve inspections on 2/17/25. A weekly PM was created and added to our CMMS program to ensure compliance moving forward. The Fire Sprinkler service company conducted a visual inspection of all sprinkler heads throughout the facility on 2/14/25. They identified that the only area in the building with quick-response sprinkler heads was in Pod – B where the FQHC is located. The FQHC was built out in 2016/2017 and the date stamp on the sprinkler heads show the heads to be from 2017. Consequently the 20-year sprinkler head inspection is due in 2037. A PM was created in our CMMS program to ensure that required testing of these heads are completed in 2036. Additionally, the contractor took standard response sprinkler heads to be sent to the lab to conduct the 50-year sprinkler head inspection. Documentation for the	

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	Section 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., documentation was provided indicating inspection of sprinklers but did not include what was inspected. Weekly sprinkler gauge inspection documentation for 52 of 52 weeks was not available for review. In addition, inspection documentation for all sprinkler system control valves was also not available for review. Based on observation on 01/28/2025 from 1:57 p.m. to 4:30 p.m., the facility had a wet and a dry-sprinkler system. Based on interview with the Director of Facilities he acknowledged the documents that were provided did not show that valve or gauge inspections had been completed. 3.) Based on record review, observation and interview; the facility failed to provide written documentation or other evidence that quick response sprinkler heads were tested or replaced after 20 years. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be		50-yr sprinkler head inspection will be retained, and a PM was created for 2035 to ensure that follow on 10-year sprinkler heads are tested as required. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to ensure the deficiency will not recur. Weekly and monthly PMs were created and added to our CMMS program to ensure compliance moving forward. In addition, PM was created for 2035 to ensure that follow on 10-year sprinkler heads are tested as required. Who is responsible to ensure the deficiency will be/has been corrected and compliance maintained. Director of Facilities	

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	made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.3.1.1.1.3 Sprinklers manufactured using fast-response elements that have been in service for 20 years shall be replaced, or representative samples shall be tested and then retested at 10-year intervals. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., documentation of the sprinkler system failed to indicate a date the sprinkler heads were last inspected or replaced. Based on observation on 01/28/2025 from 1:57 p.m. to 4:30 p.m., the facility had standard-response and fast-response sprinkler heads. Based on interview the Director of Facilities stated the building was built in 1977 but could not advise when the sprinklers were last tested or replaced. These findings were reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference.			
K 0511 Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric			

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	Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review and interview, the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. This deficient practice could affect all patients, staff and visitors in the facility. Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., the facility's emergency generator had a natural gas fuel source. The facility failed to provide a letter of reliability from the utility providing the natural gas. Based on interview the Director of	K 0511	**How the deficiency will be or has been corrected.** The local utility gas company (Nipsco) was contacted on 2/12/25 and a Letter of Reliability of gas service was requested. Anticipate receipt of the letter by 2/28/25. Follow up with the utility company is scheduled for every two weeks until receipt of the letter. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to ensure the deficiency will not recur. The Letter of Reliability of Gas Service will be added to Facility Management's compliance binder. Who is responsible to ensure the deficiency will be/has been corrected and compliance maintained. Director of Facilities	02/28/2025

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	Facilities stated he was not aware of the requirements of the Letter of Reliability and stated he knew they did not have such a letter. This finding was reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference.			
K 0712 Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on 1 shift for 1 of 4 quarters and 2 shifts 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 could affect all patients, staff and visitors in the facility. Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., the facility failed to document fire drills conducted	K 0712	**How the deficiency will be or has been corrected.** The deficiency was previously identified during our internal audit process and subsequently reported to the Corporate Safety Committee. In response, the Director of Facilities has developed a Corrective Action Plan to address this issue and is actively implementing the plan to ensure ongoing compliance. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to	02/06/2025

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	on second shift of the first quarter of 2024, the second and third shifts of the second quarter of 2024 and the second and third shifts of the third quarter of 2024. Based on interview at the time of record review, the Director of Facilities stated the facility was aware that fire drills had not been conducted on each shift for each quarter. The facility had documented a plan to ensure fire drills were completed when required. This finding was reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference.		ensure the deficiency will not recur. A comprehensive schedule for the completion of all fire drills has been formulated by the Director of Facilities. Furthermore, automatic reminders have been set up in Smartsheet to guarantee compliance. The Director of Facilities examines these reports to confirm that the drills have been conducted. Additionally, oversight is provided by the Corporate Safety Committee. Who is responsible to ensure the deficiency will be/has been corrected and compliance maintained. Director of Facilities	
K 0914 Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing 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			

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	than or 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) Based on observation, record review, and interview; the facility failed to ensure non-hospital grade electrical receptacles in 16 of 16 sleeping rooms 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 and staff in resident rooms. Findings include: Based on observation with the Director of Facilities on 01/28/2025 from 1:57 p.m. to 4:30 p.m., the facility's 16 sleeping rooms contained non-hospital-grade electrical receptacles. Based on records review on 01/28/2025 from 9:45 a.m. to 1:53 p.m., no annual electrical receptacle testing for non-hospital grade electrical receptacles had	K 0914	**How the deficiency will be or has been corrected.** The electrical contractor was on-site on 2/10/25 to inspect the outlets inside the sleep rooms and patient care areas in the Inpatient unit and inside the FQHC. A purchase order was issued on 2/12/25 to upgrade outlets in these areas to Hospital Grade outlets. Work is scheduled to be completed week of 2/24/25. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to ensure the deficiency will not recur. Upon completion of replacement of the outlets the completed invoice and specification sheet for the outlets will be retained for record/documentation purposes. Who is responsible to ensure the deficiency will be/has been corrected and compliance maintained. Director of Facilities	02/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154020	A. BUILDING 01 B. WING	01/28/2025

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	been conducted. The Director of Facilities was not aware of the requirement to test non-hospital grade electrical receptacles and stated they did not have documentation of any inspection. This finding was reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference.			
K 0918 Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained			

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	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)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 6 of 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 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. 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 in the facility. Findings include: Based on record review with the Director of Facilities on 01/28/2025 from 9:45 a.m. to 1:53 p.m., documentation for the monthly load tests were incomplete. Documentation for monthly load tests for July 2024 through December 2024 was not completed and lacked Transfer time, time ran under load, and load percentage. It was not clear from the documentation if the generator was run under load during those months. Based on an interview at the time of record review, the Director	K 0918	**How the deficiency will be or has been corrected.** The weekly inspection and monthly load test for the generator was conducted on 2/14/25. The Director of Facilities conducted training with all maintenance personnel to review the step-by-step procedures for conducting the weekly inspection and monthly load testing of the generator. Additionally, the documentation and recording procedures were also reviewed with all responsible staff members. How the deficiency will be prevented from recurring i.e., measures put into place or systematic changes made to ensure the deficiency will not recur. Both the weekly inspection and the monthly generator load testing were entered into our Computerized Maintenance Management Software (CMMS) as a Monthly Preventive Maintenance task to guarantee that future monthly tests are executed accurately and punctually. Who is responsible to ensure the	02/14/2025

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	of Facilities agreed not all of the required information was documented and stated a new maintenance technician had started to perform the inspections around the time the information was not documented. This finding was reviewed with the Vice President of Accreditation and Quality, the Director of Facilities and other administrative staff during the exit conference.		deficiency will be/has been corrected and compliance maintained. Director of Facilities	