STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155208	A. BUILDING -- B. WING	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

(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 483.73. Survey Date: 03/08/23 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080 At this Emergency Preparedness survey, Hanover Nursing Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 125 certified beds. At the time of the survey, the census was 66. Quality Review completed on 03/14/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific finding or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 4/12/23	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §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), §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,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Mace	Consultant	04/05/2023

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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	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 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			

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	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. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice			

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	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 twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise			

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	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: (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,			

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	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: (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.			

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	(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. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID			

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	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 community-based or individual, facility based functional exercise following the			

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	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 engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and			

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	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.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility 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. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	**E039** The facility will conduct a community-based exercise annually No occupants of the facility were affected. All facility occupants have the potential to be affected by this finding. The maintenance department will receive re-education in servicing on conducting a community-based exercise annually. A community-based exercise has been scheduled for completion on 4-17-23 The Administrator or designee will monitor that the exercise is completed according to the regulation. This monitoring will occur weekly times four weeks	04/17/2023

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	a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is 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 LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants in the facility. Findings include: Based on review of the Emergency Preparedness plan on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator In Training (AIT) and Activity Director present, the facility was able to provide documentation of a table top exercise dated 06/22/22, however, the facility was unable to provide documentation of a community based exercise performed during the past 12 month period. This was confirmed by the AIT during record review. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit conference.		then monthly times 5 months. he findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the maintenance director or designee times six months. if 100% compliance has not been achieved this will continue until the threshold is met.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(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			

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	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) (e) Emergency and standby power systems. The [LTC facility and the CAH] 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), §485.625(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 structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(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) 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			

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	power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), 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. 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.			

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	155208	A. BUILDING -- B. WING	03/08/2023

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	(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.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 12 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient	E 0041	The facility ensures that there is a written record of weekly inspections for the generator. 1).This testing ensures that there is a plan in place for how it will keep emergency power systems operational during emergencies 2).The generator was tested and a written record of monthly generator load testing will be completed monthly. The maintenance department will receive re-education in servicing on testing the generator weekly and conduct the additional written load testing monthly . To ensure weekly testing and monthly load testing is completed as required , the Administrator or designee will monitor that the testing is completed according to the regulation. This monitoring will occur weekly times four weeks then monthly times 5 months. The findings of the monitoring will be reported to the QAPI	04/12/2023

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	practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection reports on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator-In-Training (AIT) and Activity Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 12 of the most recent 52 week period. Based on interview at the time of record review, the AIT said the generator does start automatically every week, however, there has not been a maintenance person on a consistent basis during the past several months to document the weekly generator exercises. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 4 of the past 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. 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. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be		committee monthly at the QAPI meeting by the maintenance director or designee times six months. if 100% compliance has not been achieved this will continue until the threshold is met.	

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	maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator-In-Training (AIT) and Activity Director present, there was no monthly generator load test documentation available for November and December of 2022, and January and February of 2023. Based on interview at the time of record review, the AIT confirmed there was no emergency generator load test documentation for the previously mentioned months in 2022 and 2023. Based on interview at the time of record review, the AIT said there has not been a maintenance person on a consistent basis during the past several months to ensure a monthly generator load test has been completed. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)			

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K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/08/23 Facility Number: 000115 Provider Number: 155208 AIM Number: 100291080 At this Life Safety Code survey, Hanover Nursing Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA)101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 125 and had a census of 66 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has a detached wooden storage garage and a detached wooden building housing the emergency generator which were not sprinkled. Quality Review completed on 03/14/23	K 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific finding or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 4/12/23	

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K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS			

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	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 1 of 11 locked exit doors was readily accessible for residents, staff, and visitors. This deficient practice could affect at least 20 residents, as well as staff and visitors. Findings include: Based on observations on 03/08/23 at 11:55 a.m. during a tour of the facility with the Activity Director, the smoking area exit door was magnetically locked and could only be opened by entering a code on a keypad located adjacent to the exit gate. The code to open the exit door was	K 0222	The facility ensures the means of egress of locked exit doors are readily accessible for residents, staff, and visitors. the code was posted on the keypad. All exit doors (11) audited. Codes were posted at each keypad. Any resident visitors or staff in the area of the 11 exit doors have the potential to be affected by this finding. There were no adverse effects reported by residents', visitors, or staff.	04/12/2023

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	not posted anywhere near the keypad. Based on interview at the time of observation, the Activity Director confirmed the code was not posted anywhere near the keypad. This finding was reviewed with the Administrator-in-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)		To ensure Codes are posted, the Administrator or designee will monitor that the codes, according to the regulation are posted at each exit door that has a keypad. This monitoring will occur daily times four weeks, weekly times 4 weeks then monthly times 4 months. The findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the maintenance director or designee times six months. if 100% compliance has not been achieved this will continue until the threshold is met.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure 1 of 11 exit means of egress was properly lighted and would not leave the area in darkness. LSC 7.8.1.4 requires illumination shall be arranged so that that the failure of any single lighting unit does not result in an illumination level of less than 0.2 foot-candle in any designated area. This deficient practice could affect at least 10 residents as well as staff and visitors in the event of an emergency.	K 0281	The facility ensures the exit means of egress are properly lighted and will not leave the facility in darkness. The exit across the small dining room now provides exterior lighting outside of the exit door. An audit was conducted at each exit to assure adequate lighting is provided. The maintenance director will	04/12/2023

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	Findings include: Based on observations on 03/08/23 at 11:40 a.m. during a tour of the facility with the Activity Director, the exit across from the Small Dining Room was not provided with exterior lighting outside the exit door. Based on interview at the time of observation, the Activity Director agreed there needs to be exterior lighting provided outside this exit door. This finding was not reviewed during the exit conference. 3.1-19(b)		receive in service education that alerts him to this regulation. the administrator or designee will monitor ongoing compliance weekly times four weeks then monthly times five months. The monitoring will be conducted monthly times six months. the findings of the monitoring will be reported to the Qapi committee monthly at the QAPI meeting by the main as director or his designee pe if 100% compliance has not been achieved this will continue until the threshold has been met.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 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.			

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	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 Based on observation and interview, the facility failed to ensure the cook top in 1 of 1 Activity Room was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect at least 5 residents while in the Activity Room. Findings include: Based on observations on 03/08/23 at 11:27 a.m. during a tour of the facility with the Activity Director, there was a cooktop stove in the Activity Room. When checked, and not in use, this stove top appliance was not deactivated from the individual cooktop power source. Based on interview at the time of observation, the Activity Director confirmed the cooktop stove was not deactivated when not in use.	K 0324	**The facility ensures that the cooktop stove is shut off when not in use.** **The cook top stove was shut off immediately.** **Any residents in the Activity room could have potentially been affected by this finding.** **All activities staff received re-in servicing to ensure that the cook top stove is disengaged when not in use** **The administrator or designee will monitor to ensure that the cook top stove is turned off when not used. The monitoring will take place weekly Times four weeks then monthly times five months.** **The findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the administrator or designee times six months. if 100% compliance is not achieved this will occur until the threshold has been met**	04/12/2023

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	This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)			
K 0347 SS=F Bldg. 01	NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 Based on record review, interview, and observation; the facility failed to ensure documentation was complete for the preventative maintenance of 79 of 79 battery operated smoke alarms in resident rooms, plus an unknown number of battery operated smoke alarms in other rooms and areas of the facility. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator-In-Training (AIT) and Activity Director present, there was documentation available to show resident room battery operated smoke alarms were tested for functionality on a monthly basis during the past twelve months, except for December of 2022, and January and February of 2023. Based on interview at the time of record review, the AIT confirmed the lack of monthly testing of all battery smoke alarms during the previously mentioned months. Based on	K 0347	The facility ensures documentation is completed for the preventative maintenance of battery-operated smoke alarms in resident rooms. The battery-operated smoke alarms have been tested in all resident sleeping rooms, with documentation. All residents had the potential to be affected by this finding. The maintenance director has received in service training related to monthly testing and documentation of all battery-operated smoke alarms The administrator or designee will monitor that battery operated smoke alarms testing is being conducted and completed as required. The monitoring will be conducted monthly times six months. the findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by	04/12/2023

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	observations between 9:15 a.m. and 4:00 p.m. during a tour of the facility with the Activity Director, battery operated smoke alarms were observed in all resident sleeping rooms. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)		the main as director or his designee if 100% compliance has not been achieved this will continue until the threshold has been met.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler system during the past 52 weeks. 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	K 0353	The facility does inspect and document dry sprinkler system gauges weekly per regulation and sprinkler control valves monthly. The facility does ensure ceilings in sprinklered smoke compartments are maintained to allow sprinkler heads to function to their full	04/12/2023

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	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. 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 residents, staff, and visitors in the facility. Findings include: Based on record review on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator-In-Training (AIT) and Activity Director present, there was no documentation available to show the facility's dry sprinkler system gauges were inspected weekly during the past 52 week period, and sprinkler control valves monthly during the past 12 month period. Based on interview at the time of record review, the AIT confirmed there was no documentation available to show that the facility's sprinkler gauges have been inspected at least weekly during the past 52 weeks, and the sprinkler control valves inspected at least monthly during the past 12 month period. Based on observations with the Activity Director during a tour of the facility between 9:15 a.m. and 4:00 p.m. the facility had four pressure gauges at the sprinkler riser. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference.		capacity. All residents had the potential to be affected by this finding. The dry sprinkler system gauges were inspected with documentation and continue to be done weekly; the sprinkler control valve was inspected with documentation and is done monthly. The Wing 2 DR ceiling drywall patch was repaired and the opening properly sealed as was the other noted opening. The holes in the ceiling in the Electrical Room across from the large DR were repaired and the holes around the water lines/tubes and wire bundles were properly fire stopped. The maintenance director has received in service training related to inspecting dry sprinkler system gauges and sprinkler control valves as well as ensuring ceilings in sprinklered smoke compartments are maintained. The administrator or designee will monitor the inspecting dry sprinkler system gauges and sprinkler control valves as well as ensuring ceilings in sprinklered smoke compartments are maintained. The monitoring will be conducted monthly times six months. the findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the main as director or his	

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the ceiling in 2 of 10 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 30 residents, staff, and visitors. Findings include: Based on observations on 03/08/23 between 9:15 a.m. and 4:00 p.m. during a tour of the facility with the Activity Director, the following was noted: a. The Wing 2 dining room had approximately a four foot by six foot ceiling drywall patch that was not properly finished. The edge of the drywall patch was not sealed leaving a three foot long by two inch opening to the attic space. Also, there was another three inch opening along another edge. b. The Electrical Room across from the large dining room had two, six inch holes in the ceiling with water lines/tubes and wire bundles running through the holes. The holes around the water lines/tubes and wire bundles were not properly fire stopped. Based on interview at the time of each observation, the Activity Director acknowledged the openings and holes into the attic space at the previously mentioned areas of the facility and agreed they were not properly fire stopped. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)		designee if 100% compliance has not been achieved this will continue until the threshold has been met.	

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K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 1 of 31 portable fire extinguishers had documented annual maintenance in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.3.1.1.1 states fire extinguishers shall be subject to maintenance at intervals of not more than one year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficient practice could affect mostly staff in the Supply Room and adjacent Service Hall. Findings include: Based on observations on 03/08/23 at 11:48 a.m. during a tour of the facility with the Activity Director, the ABC type portable fire extinguisher in the Supply Room across from the Maintenance Office had affixed maintenance tag documenting the date the most recent annual maintenance was performed as December of 2021. All other fire extinguishers in the facility had affixed maintenance tags documenting the date the most	K 0355	The facility ensures all portable fire extinguishers have documented annual maintenance in accordance with the rule. 1). the ABC type portable fire extinguisher in the supply room across from the maintenance office was tested by Any resident near the Supply Room near the Maintenance office had the potential to be affected by this finding. 2). All portable fire extinguishers were identified and inspected. This finding has the potential to affect all residents. 3). The K class fire extinguisher in the kitchen near the service or hall door was immediately unobstructed BY Removing the large floor fan. This finding has the potential to affect any resident near the kitchen. The maintenance director has received in service training related to the annual inspection required of all portable fire extinguishers; monthly inspection of portable fire extinguishers and ensuring fire extinguishers are not blocked. Dietary staff in serviced	04/12/2023

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	recent annual maintenance was performed as December of 2022. Based on interview at the time of observation, the Activity Director acknowledged the aforementioned portable fire extinguisher did not have documented annual maintenance within the most recent twelve month period. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3-1.19(b) 2. Based on observation and interview, the facility failed to inspect 31 of 31 portable fire extinguishers each month during the past 12 month period. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device/system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to require corrective action. Section 7.2.4.3 requires		obstructing fire extinguishers. The administrator or designee will monitor that the fire extinguishers monthly inspections, annual inspections and that all are free from blockage. this monitoring will take place monthly times six months the findings of the monitoring will be reported to the QAPI committee at the monthly QAPI meeting by the administrator or designee times six months if 100% compliance has not been achieved, this will continue until the threshold has been met. Completion date	

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	where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations on 03/08/23 between 9:15 a.m. and 4:00 p.m. during a tour of the facility with the Activity Director, all 31 fire extinguisher in the facility were not inspected monthly in January and February of 2023. The annual inspection of all fire extinguishers by the facility's vendor was performed in December of 2022. Based on interview at the time of observation, the Activity Director acknowledged the aforementioned portable fire extinguishers had not been inspected monthly during January and February of 2023. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 31 fire extinguishers was readily accessible at all times. NFPA 10, Standard for Portable Fire Extinguishers, 6.1.3.1 requires that fire extinguishers shall be			

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	conspicuously located where they will be readily accessible and immediately available in the event of fire. This deficient practice could affect kitchen staff plus residents in the adjacent dining room. Findings include: Based on observations on 03/08/23 at 11:36 a.m. during a tour of the facility with the Activity Director, the K Class fire extinguisher in the kitchen near the Service Hall door was obstructed with a large floor fan. Based on interview at the time of observation, the Activity Director agreed the large floor fan was obstructing the K Class fire extinguish. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of 31 portable fire extinguishers had pressure gauge readings in the acceptable range. LSC 33. 1.1.3 states the provisions of Chapter 4, General, shall apply. LSC 4.6.12.4 requires any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified in applicable NFPA standards. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.2 requires periodic inspection of fire extinguishers shall include pressure gauge reading or indicator in the operable range or position. When an inspection of any rechargeable dry chemical fire extinguisher reveals			

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	a deficiency in Section 7.2.2(3) or 7.2.2(4), the extinguisher shall be subjected to applicable maintenance procedures. This deficient practice could affect at least 10 residents, staff and visitors. Findings include: Based on observations on 03/08/23 at 11:10 a.m. during a tour of the facility with the Activity Director, the pressure gauge on the portable fire extinguisher in the corridor near room 110 showed the extinguisher was undercharged. Based on interview at the time of observation, the Activity Director agreed the fire extinguisher in the corridor near room 110 indicated the fire extinguisher was undercharged. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not			

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	apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 4 kitchen doors had no impediment to closing. This deficient practice could affect mostly staff in the Service Hall. Findings include: Based on observations on 03/08/23 at 11:45 a.m. during a tour of the facility with the Activity Director, the dishwashing room door to the Service Hall corridor was held wide open with a five gallon bucket. Based on interview at the time of the observation, the Activity Director agreed	K 0363	The facility ensures that smoke barrier doors are not propped open at any time. The kitchen door that was being held wide open with a 5-gallon bucket that was removed immediately. An audit was conducted of all smoke barrier doors to ensure none were propped open. Any resident near the service hall had the potential to be affected by this finding.	04/12/2023

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	the kitchen door was being held wide open with the five gallon bucket. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)		Dietary staff received in servicing training related to not propping open smoke barrier doors. The maintenance director or designee will monitor all smoke barrier doors to ensure that none are propped open weekly x 4 weeks then monthly times five months. The findings of the monitoring will be reported to the QAPI committee monthly at the Qapi meeting by the maintenance director or designee times six months if 100% compliance has not been achieved this will continue until the threshold has been met	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 10 sets of smoke barrier doors would close to form a smoke resistant barrier.	K 0374	The facility ensures smoke barrier doors closed to form a smoke resistant barrier.	04/12/2023

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	LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect up to 20 residents, as well as staff and visitors. Findings include: Based on observations on 03/08/23 at 12:15 p.m. during a tour of the facility with the Activity Director, the set of smoke barrier doors near the Director of Nursing (DON) office did not close completely when tested. There was a one inch gap between the set of doors when closed fully. The south door was rubbing at the top of the door frame which caused it not to close fully. Based on interview at the time of observation, the Activity Director agreed the set of smoke barrier doors near the DON office did not close completely when tested. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)		the set of smoke barrier doors near the director of nursing office that did not close was adjusted and the gap between the set of doors closed fully Any resident near the DON office could be affected by this finding the maintenance director or designee received in service training related to ensuring that smoke barrier doors close properly and allow no gap that prohibits the door from closing fully The maintenance director or designee will monitor that doors close without gaps weekly times four weeks and then monthly times five months the findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the maintenance director or designee times six months if 100% compliance has not been achieved, this will continue until the threshold has been met completion date	
K 0500 SS=E Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.			

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	Based on observation and interview, the facility failed to ensure 1 of 1 fuel-fired water heater had a current inspection certificate to ensure the water heater was in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect at least 20 residents, staff and visitors in the facility. Findings include: Based on observations on 03/08/23 at 12:30 p.m. during a tour of the facility with the Activity Director, the fuel-fired water heater in the Mechanical Room had a sticker on the tank with an inspection date of 01/13/20, which would have expired by 01/13/22. Based on interview at the time of observation, the Activity Director confirmed the inspection date on the sticker attached to the tank as 01/13/20 for the fuel-fired water heater. This finding was reviewed with the Administraator-in-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)	K 0500	K500 The facility ensures that the fuel fired water heater has a current inspection certificate to ensure that the water heater is in safe and operating condition The facility now has a current Boiler Pressure Vessel H-Stamp (permit) and is displayed near the Hot Water Vessel. This finding has the potential to affect at least 20 residents Monitoring of this finding will be conducted by the administrator monthly times six months The findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the maintenance director or designee times six months if 100% compliance has not been achieved, this will continue until threshold has been met	04/12/2023
K 0511 SS=D 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 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			

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	Based on observation and interview, the facility failed to ensure 1 electrical receptacle in a staff room was provided with a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect one staff while in the Wing 2 Supply Storage Room. Findings include: Based on observations on 03/08/23 at 11:16 a.m. during a tour of the facility with the Activity Director, the Wing 2 Supply Storage Room had an electrical receptacle on the wall not provided with a cover plate. Wires were exposed from this electrical receptacle. Based on interview at the time of observation, the Activity Director acknowledged the lack of a cover plate on the electrical receptacle in the Wing 2 Supply Storage Room. This finding was reviewed with the Administrator-In-Training, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)	K 0511	**The facility ensures electrical receptacles are provided with a cover plate and protected from damage.** **The electrical receptacle in the staff room was provided with the cover plate to protect it from damage.** **An audit was conducted to ensure covers are positioned accordingly.** **The maintenance director or designee received in service education related to providing cover plates two all electrical receptacles.** **the maintenance director or designee will monitor their electrical receptacles in all areas are covered weekly times 4 weeks then monthly times 5 months** **the findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the maintenance director or designee times six months if compliance has not been achieved this will continue until the threshold has been met.**	04/12/2023
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying			

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	conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 3 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator-In-Training (AIT) and Activity Director present, the facility lacked fire drill documentation for the following shift and quarters during the past 12 month period: Third shift (night) of the third quarter (July, August, and September), and fourth quarter (October, November, and December) of 2022, and first quarter (January, February, and March) of 2022 and so far for 2023. Based on interview at the time of record review, the AIT confirmed the lack of fire drill reports during the previously mentioned shift and quarters. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to provide complete fire drill	K 0712	The facility conducts fire drills on every shift at least quarterly. A fire drill was conducted and complete documentation was added. a re-education in service was conducted with the maintenance department to ensure fire drills are completed as required with proper documentation. All residents had the potential to be affected by this finding. the maintenance man received in service education on the necessities of conducting the fire drills quarterly at unexpected times with complete documentation. in addition, a calendar has been completed to aid in monitoring random dates. The administrator or designee will monitor that the fire drills are being conducted and completed as required. The monitoring will be conducted monthly times six months. the findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the main as director or his designee	04/12/2023

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	documentation for 5 of 13 fire drills performed during the past 12 month period. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator-In-Training (AIT) and Activity Director present, 5 of 13 documented fire drills performed during the past 12 month period did not include the names and signatures of staff that participated in the fire drills. Based on interview at the time of record review, the AIT confirmed the lack of staff signatures on 5 of 13 fire drill reports during the past 12 month period. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)		if 100% compliance has not been achieved this will continue until the threshold has been met.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to follow their own verbal policy and procedure regarding portable space heaters to ensure 1 of 1 portable space heater observed was not used in a staff area. This deficient practice could affect staff in the Medical Records room, plus any resident within the same smoke	K 0781	**The facility ensures that they follow their policy and procedures regarding portable space heaters.** **the portable space heater that was in the medical records office was removed**	04/12/2023

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	compartment. Findings include: Based on interview at the time of record review on 03/08/23 between 9:15 a.m. and 4:00 p.m., when asked, the Administrator-In-Training (AIT) said she could not locate a portable space heater policy and procedure, but, indicated she didn't think the facility allowed portable space heaters. Based on observations at 12:35 p.m. during a tour of the facility with the Activity Director, there was a portable space heater turned on in the Medical Records room while no staff was present. This was acknowledged by the Activity Director at the time of observation. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit conference. 3.1-19(b)		**immediately.** **An audit of the building was conducted, and no other space heater was found** **This finding has the potential to affect any resident in this smoke compartment area.** **all staff received inservice training related to the policy that prohibits all space heaters in the facility.** **the maintenance director or designee will monitor that no space heaters are in the facility weekly x four weeks then monthly times five months.** **the findings of the monitoring will be reported to the QAPI committee monthly at the QAPI meeting by the maintenance director or designee times six months.** **if 100% compliance has not achieved this will continue until the threshold has been met**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with			

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	NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 12 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a	K 0918	**The facility ensures a written record of weekly inspections for the generator is maintained.** **1) A written record inspection of the generator was completed and is now completed and documented weekly.** **2) A complete written record of monthly generator load testing was completed and is now done every month.** **This finding has the potential to affect residents.**	04/12/2023

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	written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of the generator inspection reports on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator-In-Training (AIT) and Activity Director present, there was no documentation available to show the emergency generator was inspected/tested weekly during 12 of the most recent 52 week period. Based on interview at the time of record review, the AIT said the generator does start automatically every week, however, there has not been a maintenance person on a consistent basis during the past several months to document the weekly generator exercises. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 4 of the past 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. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the		**the maintenance director or designee received re inservice education related to the requirements of maintaining the generator.** **the administrator or designee will monitor monthly times six months that these inspections/ test with written documentation is being completed.** **findings of the monitoring will be reported to the QAPI committee at the monthly QAPI meeting by the administrator or designee .** **If 100% compliance has not been achieved this will continue until the threshold has been met**	

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	generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review on 03/08/23 between 9:15 a.m. and 4:00 p.m. with the Administrator-In-Training (AIT) and Activity Director present, there was no monthly generator load test documentation available for November and December of 2022, and January and February of 2023. Based on interview at the time of record review, the AIT confirmed there was no emergency generator load test documentation for the previously mentioned months in 2022 and 2023. Based on interview at the time of record review, the AIT said there has not been a maintenance person on a consistent basis during the past several months to ensure a monthly generator load test has been completed. This finding was reviewed with the AIT, Activity Director, and Company Consultant during the exit			

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	conference. 3.1-19(b)			