STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155707	A. BUILDING -- B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLAGE	1350 W MAIN ST BERNE, IN 46711

(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: 02/20/24 Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540 At this Emergency Preparedness survey, Swiss Village was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 128 and had a census of 82 at the time of this survey. Quality Review completed on 02/21/24 The requirements of 42 CFR, Subpart 483.73 are Not Met as evidenced by:	E 0000		
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 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sierra Saylor	VP of Operations	03/07/2024

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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	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 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.			

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	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. (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			

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	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 records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Director of Facilities (DF) on 02/20/24 at 02:00 p.m., the generator annual fuel quality testing required by LSC and NFPA 110 failed. In the comment section of the annual fuel quality test it was recommended that the fuel be filtered due to the contamination level. Based on interview at the time of record review, the DF stated the fuel quality test failed and they are working to correct the problem. The finding was reviewed with the Administrator and DF at the exit conference.	E 0041	**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No individual resident was identified in this alleged deficiency. All residents have the potential to be affected. We are currently working with a company on cleaning out the generator tank and replacing the fuel. On February 27, 2024, Clean Fuels came to do a Pumpout and a Washout of the generator. Follow up testing will occur. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents were identified. All residents had potential to be affected. We are currently working with a company on cleaning out the generator tank and replacing the fuel. Clean Fuel is doing a Pumpout and Washout on February 27, 2024. Follow up testing will occur. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient**	05/10/2024

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K 0000			**practice does not recur.** Education was provided to the Director of Facilities regarding emergency generator inspection and testing. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By May 10, 2024, the systemic changes for this deficiency will be completed.	

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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: 02/20/24 Facility Number: 000280 Provider Number: 155707 AIM Number: 100274540 At this Life Safety Code survey, Swiss Village 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 VIII construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 128 and had a census of 82 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/21/24	K 0000		
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			

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	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 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			

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	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 over 10 exit doors in the facility were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect 10 residents. Findings include: Based on observation with the Administrator and the Director of Facilities (DF) on 02/20/24 at 02:25 p.m., the exit door at the Assisted Dining Room was marked as a facility exit, was magnetically locked, and could be opened by entering a	K 0222	K222 SS E **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** There were 10 residents that were identified to be affected. The signage posted for this door was taken down per the surveyor guidance. Once removed, it was stated there needed to be a code posted. The code was posted. This door will change as an exit on March 1, 2024, as it will be in a Memory Care Unit. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what**	03/01/2024

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	four-digit code on the access control pad. The code was not posted at the exit. Based on interview at the time of observation, the DF stated that they are preparing to move their Dementia unit to this area soon. The finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)		**corrective action(s) will be taken.** The residents with the potential to be affected will now have a sign posted for access until the area becomes a part of a specialized security unit on 3/1/24. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated on egress doors and signage posted at the door. The other doors checked by the surveyor had signage posted. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted**	

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			as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. By March 1, 2024, the systemic changes for this deficiency will be completed.	
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 Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler systems in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic	K 0353	K353 SS F **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No individual resident was identified in this alleged deficiency. All residents have the potential to be affected. The report	03/01/2024

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	material. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Facilities (DF) on 02/20/24 at 11:20 a.m., the internal inspection of piping documentation from Shambaugh and son did not have a date. Based on interview at the time of record review, the DF agreed the internal inspection documentation provided was incomplete as it did not have a date. This finding was reviewed with the Administrator and DF at the exit conference. 3.1-19(b)		with the missing date was resent by Shambaugh & Son with a completion date of February 8, 2023. This inspection was completed within the required timeframe. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** This inspection was updated in the new TELS system for maintenance to track and log inspections. This was assigned to the Director of Facilities for Completion in February of 2028. This assignment is attached under the heading Life Safety Sprinkler Inspection TELS assignment. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated on the Sprinkler System maintenance and testing and complete documentation. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the	

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			Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By March 1, 2024, the systemic changes for this deficiency will be completed.	
K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.			

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	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 corridor door was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 2 residents in resident room 386. Findings include: Based on observation with the Administrator and Director of Facilities (DF) on 02/20/24 at 02:45 p.m., the corridor door to resident sleeping room 386 would not close and latch into the frame when tested. Based on interview at the time of	K 0363	K363 SS D **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Two residents were identified in this alleged deficiency. On February 20, 2024, this door was fixed to properly latch. It was checked again on February 26, 2024. **2. How other residents having the potential to be affected by the same deficient practice will**	04/02/2024

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	observation, the DF agreed the corridor door to room 386 would not close and latch into the door frame. The finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b)		**be identified and what corrective action(s) will be taken.** All doors are checked monthly for proper latching. An audit of all doors on this hall will be checked once a week for 4 weeks, and then continue monthly with all other resident doors. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated regarding corridor doors and proper latching. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155707	A. BUILDING 01 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SWISS VILLAGE	1350 W MAIN ST BERNE, IN 46711

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			as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. By April 2, 2024, the systemic changes for this deficiency will be completed.	
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 Based on observation and interview, the facility failed to ensure 1 of over 20 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 2 residents. Findings include: Based on observation with the Director of Facilities (DF) on 02/20/24 at 02:30 p.m. when the electric receptacle located within 6 feet feet from the sink in the Assisted Dining Room was tested with a GFCI tester the electric receptacle tripped but the reset button was broken. Based on interview at the time of observation, the DF agreed the GFCI electric receptacle within 6 feet of the sink in the Assisted Dining Room was broken	K 0511	K511 SS D **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Two residents were identified in this alleged deficiency. However, this hand washing area is used for staff in the Assisted Dining Room. During testing is when the reset button broke and popped out as the surveyor tested it. The GFCI had been tested on the same day prior to the surveyor entering and was working properly. The GFCI was replaced on February 20, 2024, and was checked again on February 26, 2024. It was working again properly on February 20, 2024.	02/26/2024

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	and needs replaced. This finding was reviewed with the Administrator and the DF during the exit conference. 3.1-19(b)		**2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** Two residents were identified in this alleged deficiency. However, this hand washing area is used for staff in the Assisted Dining Room. During testing is when the reset button broke and popped out as the surveyor tested it. The GFCI had been tested on the same day prior to the surveyor entering and was working properly. The GFCI was replaced on February 20, 2024, and was checked again on February 26, 2024. GFCIs will continue to be checked as scheduled on a monthly basis. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated regarding ground fault circuit interrupters being properly maintained. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the	

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			Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By February 26, 2024, the systemic changes for this deficiency will be completed.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 1 of 4 quarters. LSC 19.7.1.6 states drills shall be	K 0712	K712 SS F **1. What corrective action(s) will be accomplished for those**	04/02/2024

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	conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on records review with the Director of Facilities (DF) on 02/20/24 at 10:30 a.m., no documentation was available to show a second shift fire drill for the third quarter of 2023 was conducted. Based on interview at the time of record review, the DF stated the aforementioned drill was not conducted but there were 2 fire drills completed on first shift that quarter. This finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b) 3.1-51(c)		**residents found to have been affected by the deficient practice.** All residents and staff have the potential to be affected by this alleged deficiency. Education provided to Director of Facilities and audit created for the remaining calendar year of 2024 for fire drills. A new maintenance task and work order system implemented, and fire drills will also be tracked in this system. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents and staff have the potential to be affected by this alleged deficiency. Education provided to Director of Facilities and audit created for the remaining calendar year of 2024 for fire drills. Attached Audit under the title 2024 Fire Drill Audit. This will be turned into the Administrator/designee monthly through December 2024. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated regarding the required fire drill schedule. **4. How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance program will be put into place. This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By April 2, 2024, the systemic changes for this deficiency will be completed.	
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			

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	safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Director of Facilities (DF) on 02/20/24 at 02:00 p.m., the generator annual fuel quality testing	K 0918	K918 SS F **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No individual resident was identified in this alleged deficiency. All residents have the potential to be affected. We are currently working with a company on cleaning out the generator tank	05/10/2024

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	required by LSC and NFPA 110 failed. In the comment section of the annual fuel quality test it was recommended that the fuel be filtered due to the contamination level. Based on interview at the time of record review, the DF stated the fuel quality test failed and they are working to correct the problem. The finding was reviewed with the Administrator and DF at the exit conference. 3.1-19(b)		and replacing the fuel. On February 27, 2024, Clean Fuels came to do a Pumpout and a Washout of the generator. Follow up testing will occur. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No residents were identified. All residents had potential to be affected. We are currently working with a company on cleaning out the generator tank and replacing the fuel. Clean Fuel is doing a Pumpout and Washout on February 27, 2024. Follow up testing will occur. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Education was provided to the Director of Facilities regarding emergency generator inspection and testing. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the Administrator/designee or the VP	

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			of Operations. The Directors of Facilities will continue ongoing monitoring. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** By May 10, 2024, the systemic changes for this deficiency will be completed.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips			

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	for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure flexible cord was not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used as a substitute for fixed wiring. This deficient practice could affect up to 5 residents in the vicinity of room 510 and 10 residents in the 300 Hall. Findings include: 1. Based on observation during a tour of the facility with the Director of Facilities (DF) on 02/20/24 at 02:50 p.m., a TV amplifier was plugged into and supplied power by an extension cord in room 510. Based on interview at the time of observation, the DF acknowledged an extension cord was in use in room 510. The finding was reviewed with the Administrator and DF during the exit conference. 3.1-19(b) Findings include: 2. Based on observations with the Administrator and DF on 02/20/24 at 02:45 p.m. it was discovered	K 0920	K920 SS E **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** For the issue in 510, which is not a resident room, there were no residents on this hall as it was stated that 5 residents in the vicinity of this room would have been affected. An outlet was added in this room, and the extension cord was removed. The picture is attached. This correction was made on February 27, 2024. The lamps throughout the 300 hall have been counted and a new order of lamps has been made. If the lamps that were ordered work for the residents, another order will be made to replace the remaining lamps. The order is attached. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be**	04/02/2024

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	that personal electrical equipment was plugged into a lamp outlet in resident room 392, resident room 394, and resident room 396. Based on interview at the time of each observation, the DF acknowledged each aforementioned condition. This finding was reviewed with the Administrator and DF at the exit conference 3.1-19(b)		**taken.** Any lamps that have an outlet on them will be replaced. Maintenance has been educated on the use of extension cords. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Director of Facilities educated on power cords and extension cords. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This deficiency will be addressed during the next QAPI meeting. Any additional concerns will be addressed by the VP of Operations. The Directors of Facilities will continue ongoing monitoring and scheduling of testing. **5. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.**	

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			By April 2, 2023, the systemic changes for this deficiency will be completed.	