STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING -- B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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: 01/14/25 Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720 At this Emergency Preparedness survey, Cardinal Care Strategies 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 104 and had a census of 72 at the time of this survey. Quality Review completed on 01/15/25 The requirements of 42 CFR, Subpart 483.73 are Not Met as evidenced by:	E 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 01/27/2025 to the state findings of the recent Life Safety Survey. We are requesting paper compliance,	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power 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). Findings include: Based on record review with the Maintenance Director on 01/14/25 at 11:38 a.m., documentation	E 0041	It is the practice of this facility to implement the emergency power system inspection, testing, and maintenance requirements in the Health Care Facilities Code. 1 What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a There were no residents affected by the alleged deficient	01/16/2025

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

Denise Arbuckle | RN DON AIT | 01/30/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING -- B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
	for the last twelve months of generator under load testing did not include the percentage under load. The Load kW column was blank for every month. Based on interview at the time of record review, the Maintenance Director confirmed the generator ran under load on a monthly basis but the load percentage was not documented monthly. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		practice. 2 - How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a. All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice. 3 -What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a. Emergency Generator – Monthly Test Log implemented and added to monthly maintenance duties list. b. The Maintenance Director completed the monthly generator log with load kW on 1/16/2025 4 - How the corrective actions will be monitored to ensure the deficient practices will not occur: a. The Maintenance Director has added the Emergency Generator – Monthly Test Log b. The administrator and/or designee shall review weekly inspection checklist and monthly test log to ensure compliance. This is an ongoing program, should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during Quality Assurance Meeting and the plan of action adjusted accordingly as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING -- B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
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: 01/14/25 Facility Number: 000269 Provider Number: 155400 AIM Number: 100267720 At this Life Safety Code survey, Cardinal Care Strategies 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 104 and had a census of 72 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 01/15/25	K 0000	By submitting the following material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 01/27/2025 to the state findings of the recent Life Safety Survey. We are requesting paper compliance,	
K 0321 SS=E	NFPA 101 Hazardous Areas - Enclosure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 01 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
Bldg. 01	Based on observation and interview, the facility failed to ensure 1 of over 5 hazardous areas such as fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:15 p.m. to 2:45 p.m. on 01/14/25, the corridor door to the mechanical room on 100 Hall contained three natural gas fired water heaters would not positively latch into the door frame when tested four times. Based on interview at the time of the observation, the Maintenance Director confirmed the door to the aforementioned hazardous area failed to latch when the door self-closed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0321	K321 It is the practice of this facility to ensure hazardous area doors would close completely and latch automatically or provided with a self-closing device. 1 What corrective actions will be accomplished for those residents found to be affected by the deficient practice:a There were no residents affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:a All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice 3 What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur:a The Maintenance Director adjusted the mechanical room door closure to ensure proper latching into the door frames on 1/15/2025 b The Maintenance Director will check randomly once a week during facility rounds to ensure doors are properly closing with self-closure devices 4 How the corrective actions will be monitored to ensure the	01/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 01 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
			deficient practices will not occur: a The Maintenance Director will check randomly once a week during facility rounds to ensure doors are properly closing with self-closure devices. The monitoring will be an ongoing process and if non-compliance is observed, corrective action will be taken immediately. b Data will be presented at the quarterly Quality Assurance meeting to determine trends, patterns, and effectiveness of plan. The process will be updated as needed	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on record review, observation and interview, the facility failed to ensure 1 of 1 portable fire extinguisher in the laundry room was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher	K 0355	It is the practice of this facility to ensure fire extinguishers have maintenance at periods of not more than one year apart 1 What corrective actions will be accomplished for those residents found to be affected by the deficient practice a There were no residents affected by the alleged deficient practice 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:	01/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 01 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
	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 staff in the laundry room. Findings include: Based on record review and interview with the Maintenance Director from 10:10 a.m. to 1:45 p.m. on 01/14/25, documentation an annual fire extinguisher inspection had been completed on 01/24/24. Based on observation during a tour of the facility with the Maintenance Director at 2:30 p.m., a portable fire extinguisher located in the laundry room had an inspection tag that was more than 1 year old. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher in the laundry room had an affixed maintenance tag dated Jan 2023 and was not inspected when the annual inspection had been completed on the other fire extinguishers in the facility. This finding was reviewed with the Interim Administrator and Maintenance Director at the exit conference. 3.1-19(b)		!--[if=""]>a All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice 3 What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a The Maintenance Director scheduled the annual fire extinguisher maintenance for laundry room fire extinguisher with Koorsen Fire and Security. Annual inspection of fire extinguisher was completed 01/27/2025. b The Maintenance Director will complete review of the annual maintenance date with his monthly fire extinguisher inspection. 4 How the corrective actions will be monitored to ensure the deficient practices will not occur: a The Maintenance Director has added the annual maintenance date to the monthly checklist for the portable fire extinguishers b This is an ongoing program, should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 01 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
			Assurance Meeting and the plan of action adjusted accordingly as needed	
K 0761 SS=E Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of 1 of 1 oxygen storage room fire door assemblies were completed in accordance with LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken.	K 0761	It is the practice of this facility to ensure annual inspection and testing of the oxygen storage room fire door assemblies are completed 1 What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a There were no residents affected by the alleged deficient practice 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice 3 What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a The Maintenance Director completed the Annual Inspection and Testing of Fire and Smoke	01/16/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 01 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
	(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect 10 residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director at 10:20 a.m. on 01/14/25, the facility provided swinging door assembly inspections dated 05/06/24; however, the documentation failed to include inspection of one oxygen transfill/storage room. Based on interview at the time of record review, the Maintenance Director confirmed the fire rated door of the oxygen room was not inspected annually within the last year and he would add it to the annual fire door inspection list. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		Door Assemblies on 1/16/2025. b The Annual Inspection and Testing of Fire and Smoke Door Assemblies form will be added to the monthly maintenance duties list 4 How the corrective actions will be monitored to ensure the deficient practices will not occur: a The Maintenance Director has added the Annual Inspection and Testing of Fire and Smoke Door Assemblies form to the monthly maintenance duties list. span="">b This is an ongoing program, should non-compliance be observed, corrective action shall be taken, the observations and any corrective actions taken will be reviewed during Quality Assurance Meeting and the plan of action adjusted accordingly as needed span="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 01 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 12 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2.4 states spark-ignited (Natural Gas) generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 01/14/25 at 11:38 a.m., documentation for the last twelve months of generator under load testing did not include the percentage under load. The Load kW column was blank for every month. Based on interview at the time of record review, the Maintenance Director confirmed the generator ran under load on a monthly basis but the load percentage was not documented monthly. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	K 0918	It is the practice of this facility to ensure that the weekly inspection of emergency generator is completed and that there is a written record of monthly generator load testing. 1 What corrective actions will be accomplished for those residents found to be affected by the deficient practice: a There were no residents affected by the alleged deficient practice. 2 How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken: a All residents, staff members, and visitors have the potential to be affected by the alleged deficient practice 3 What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not recur: a Emergency Generator – Monthly Test Log implemented and added to monthly maintenance duties list b The Maintenance Director completed the monthly generator	01/20/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155400	A. BUILDING 01 B. WING	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARDINAL CARE STRATEGIES	4600 E JACKSON ST MUNCIE, IN 47303

(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
	2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator was maintained for 52 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Emergency Generator testing documentation with the Maintenance Director, during record review from 10:10 a.m. to 1:15 p.m. on 01/14/25, weekly generator inspection documentation for the last 52 weeks was not available for review. Based on interview at the time of record review, the Maintenance Director stated that he searched records for weekly generator inspection documentation and could not locate them and there was not any available for the last 12 months. These findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		log with load kW on 1/16/2025 c Emergency Generator – Weekly Inspection Checklist implemented and added to monthly maintenance duties list d The Maintenance Director completed the weekly inspection checklist on 1/20/2025 4 How the corrective actions will be monitored to ensure the deficient practices will not occur: a The Maintenance Director has added the Emergency Generator – Monthly Test Log which includes the kW% and Weekly Inspection Checklist to the monthly maintenance duties list b The Administrator and/or designee shall review weekly inspection checklist and monthly test log to ensure compliance. This is an ongoing program, should non-compliance be observed, corrective action shall be taken. the observations and any corrective actions taken will be reviewed during Quality Assurance Meeting and the plan of action adjusted accordingly as needed.	