STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155442	A. BUILDING -- B. WING	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT FRANKLIN	580 LEMLEY STREET FRANKLIN, IN 46131

(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: 08/04/22 Facility Number: 000352 Provider Number: 155442 AIM Number: 100290720 At this Emergency Preparedness survey, Hickory Creek at Franklin was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 36 certified beds. At the time of the survey, the census was 30. Quality Review completed on 08/09/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

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

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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	The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			

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	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of "Hickory Creek at Franklin Disaster Plan" documentation dated 11/06/19 with the Administrator and the Field Maintenance Supervisor during record review from 9:00 a.m. to 12:00 p.m. on 08/04/22, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned plan was dated as being reviewed on 11/06/19 which was not within the most recent twelve month period. In addition, the second copy of emergency preparedness program documentation entitled "Disaster Plan" which is kept at the nurse's station also had its most recent review on 11/06/19 which was not within the most recent twelve month period. Based on interview at the time of record review, the Administrator agreed emergency preparedness policies and procedures have not been reviewed within the most recent twelve month period. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference.	E 0004	EOO4 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The administrator and Maintenance Director have reviewed and updated Preparedness program. Documentation has been updated. 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 copies of the Emergency Preparedness plan have been reviewed/updated and documented. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Executive Director/Maintenance Director have been educated to review Emergency Preparedness Program every 12 months in QAPI. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program at least annually.	09/03/2022

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			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: Annual review of the Emergency Preparedness Program was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review is completed annually.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]			

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	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment.			

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	*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach which was reviewed within the most recent twelve month period and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Hickory Creek at Franklin Disaster Plan" documentation dated 11/06/19 with the Administrator and the Field Maintenance	E 0006	E006 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A Facility Risk Assessment, including strategies for addressing these events, was completed. 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: The Facility Risk Assessment review included events that could affect all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Executive Director/Maintenance Director educated that Facility	09/03/2022

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	Supervisor during record review from 9:00 a.m. to 12:00 p.m. on 08/04/22, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned risk assessment was dated as being reviewed on 11/06/19 which was not within the most recent twelve month period. The risk assessment also listed "Infectious Disease Outbreak" as a relative threat but did not include EID threats. In addition, the second copy of emergency preparedness program documentation entitled "Disaster Plan" which is kept at the nurse's station also had its most recent review on 11/06/19 which was not within the most recent twelve month period. The "Disaster Plan" copy at the nurse's station did not have an emergency preparedness risk assessment included in the documentation. Based on interview at the time of record review, the Administrator agreed the emergency preparedness program documentation risk assessment documentation was not documented as being conducted within the most recent twelve month period. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference.		Risk Assessment will be completed every 12 months. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Facility Risk Assessment at least annually. 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: Annual review of the Facility Risk Assessment was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the Facility Risk Assessment is completed annually.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b),			

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	§485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water			

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	failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area.			
	Based on record review and interview, the facility failed to review and update its emergency preparedness policies and procedures to include policies and procedures for emerging infectious diseases (EID) in accordance with the CMS Survey & Certification memo QSO: 19-06-ALL. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 416.54(b). This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Hickory Creek at Franklin Disaster Plan" documentation dated 11/06/19 with the Administrator and the Field Maintenance Supervisor during record review from 9:00 a.m. to 12:00 p.m. on 08/04/22, emergency preparedness	E 0013	E013 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Executive Director updated building Emergency Preparedness Plan to include emerging infectious diseases (EID). 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: The updates to the plan to include	09/03/2022

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	policies and procedures based on a documented facility based and community based risk assessment reviewed within the most recent twelve month period was not available for review. Emergency preparedness policies and procedures also did not include EID. In addition, the second copy of emergency preparedness program documentation entitled "Disaster Plan" which is kept at the nurse's station also did not have its emergency preparedness policies and procedures reviewed within the most recent twelve month period and also did not include emergency preparedness policies and procedures for EID. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference.		EID apply to all residents. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur: Executive Director/Maintenance Director were educated to include EID in the Emergency Preparedness Plan. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Emergency Preparedness Program to ensure it includes EID at least annually. 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: Annual review of the Emergency Preparedness Program to include EID was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review to include EID is completed annually.	

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E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws which was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of "Hickory Creek at Franklin Disaster Plan" documentation dated 11/06/19 with the Administrator and the Field Maintenance Supervisor during record review from 9:00 a.m. to 12:00 p.m. on 08/04/22, documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for review. In addition, the second copy of emergency preparedness program documentation entitled "Disaster Plan" which is kept at the	E 0029	E029 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Executive Director updated building Emergency Preparedness Plan Communication Plan. 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: The updates to the Communication Plan apply to all residents. What measures will be put into	09/03/2022

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	nurse's station also did not have its emergency preparedness communication plan reviewed within the most recent twelve month period. Based on interview at the time of record review, the Administrator agreed the emergency preparedness program communication plan documentation was not reviewed by the facility within the most recent twelve month period. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. .		place or what systemic changes will be made to ensure that the deficient practice does not reoccur: Executive Director/Maintenance Director were educated to review the Communication Plan in the Emergency Preparedness Plan annually. The QAPI and PM calendar was updated for the Executive Director/Maintenance Director to review the Communication Plan at least annually. 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: Annual review of the Emergency Preparedness Program Communication Plan was added to the TELS checklist and QAPI calendar. The Executive Director will review the TELS documentation and QAPI calendar monthly to ensure the annual review of the Communication Plan is completed annually.	

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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 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.			

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	155442	A. BUILDING -- B. WING	08/04/2022

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	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. 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,			

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	2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review, observation 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). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Field Maintenance Supervisor from 9:00 a.m. to 12:00 p.m. on 08/04/22, thirty-six month period emergency generator testing documentation for four continuous hours for the LP gas fired emergency generator for the facility was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor stated supplemental load testing for four hours within the most recent three year period was not available for review. Based	E 0041	E041 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The supplemental 4-hour load testing was performed and is available for review. 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 other generators on site to perform the supplemental load testing What measures will be put into	09/03/2022

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	on observations with the Administrator and the Field Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:10 p.m. on 08/04/22, the facility has one LP gas fired emergency generator located outside the building on the north side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 25 kW. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will be on 4-hour load testing requirements. The maintenance director will verify the thirty-sixth month period emergency generator load testing is completed based on the preventative maintenance schedule. 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: The Executive Director will review with the maintenance director prior to the compliance date to ensure the testing was completed. The thirty-sixth month period emergency generator load testing was added to the preventative maintenance schedule. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks completed.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State	K 0000	The creation and submission of	

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	Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/04/22 Facility Number: 000352 Provider Number: 155442 AIM Number: 100290720 At this Life Safety Code survey, Hickory Creek at Franklin 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 II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and has battery powered smoke detectors in all resident sleeping rooms. The facility has a capacity of 36 and had a census of 30 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility storage were sprinklered except for one detached garage which was not sprinklered. Quality Review completed on 08/09/22		this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.	
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 3 exits 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 Section 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 over 10 residents, staff and visitors if needing to exit the facility by using the exit door near the nurse's station by Room 4. Findings include: Based on observations with the Administrator and the Field Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:10 p.m. on	K 0222	K222 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: code to door was posted. 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 exit doors were inspected to ensure a door code was posted at each exit door. What measures will be put into place or what systemic changes	09/03/2022

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	08/04/22, the exit door near the nurse's station by Room 4 could be opened by entering a four digit code into a keypad at the exit door but the code was not posted at the exit door. Based on interview at the time of the observations, the Administrator and the Field Maintenance Supervisor stated not all residents in the facility have a clinical diagnosis to be in a secure wing or facility and agreed the code was not posted at the exit door by Room 4. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated to ensure door codes are posted at each exit door. Review of door codes posted will be added to the monthly preventative maintenance rounds. 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. The Executive Director will with the maintenance director prior to the compliance date to ensure all codes are posted at exit doors. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks completed.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 3 battery powered emergency	K 0291	K291 What corrective action(s) will be	09/03/2022

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	lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Field Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:10 p.m. on 08/04/22, three battery operated lighting systems were noted in the facility and each battery operated light functioned when its respective test button was pushed except for the battery operated light located on the north wall of the building at the emergency generator location outside the building. Based on interview at the time of the observations, the Field Maintenance Supervisor agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		accomplished for those residents found to have been affected by the deficient practice: Batteries in emergency lighting have been replaced. 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 emergency lights have been reviewed for proper functioning. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director educated battery powered lighting system maintenance. of battery powered emergency lighting systems will be added to the monthly preventative maintenance schedule 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: The Executive Director will round with the maintenance director prior to the compliance date to ensure all battery powered emergency lights are functioning properly.	

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			The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks completed.	
K 0324 SS=D 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. 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 install the kitchen range hood system in accordance with the requirements of LSC Section 9.2.3. Section 9.2.3 states commercial cooking equipment shall be installed in accordance with NFPA 96, Standard for Ventilation Control and	K 0324	K324 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	09/03/2022

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	Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 edition, Section 6.1.1 states listed grease filters, listed baffles, or other listed grease removal devices for use with commercial cooking equipment shall be provided. Section 6.2.3 states grease filters shall be arranged so that all exhaust air passes through the grease filters. Section 6.2.3.5 states grease filters shall be installed at an angle not less than 45 degrees from the horizontal. Section 6.2.5. states grease filters that require a specific orientation to drain grease shall be clearly so designated, or the hood shall be constructed so that filters cannot be installed in the wrong orientation. This deficient practice could affect over two staff in the kitchen. Findings include: Based on observations with the Administrator and the Field Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:10 p.m. on 08/04/22, four of four grease filters in the kitchen range hood system above the range were oriented parallel to the floor and were not oriented perpendicular to the floor to allow grease to drain into the drip tray at the bottom of the grease filters. Based on interview at the time of the observations, the Administrator and the Field Maintenance Supervisor agreed four of four grease filters in the kitchen range hood system above the range were not oriented perpendicular to the floor to allow grease to drain into the drip tray at the bottom of the grease filters. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		The facility has properly installed the grease filters. 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 other kitchen hoods in facility. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The maintenance director was educated on of grease filters in the kitchen. Hood inspection to be placed on routine maintenance schedule in TELS. 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: The Executive Director with the maintenance director prior to the compliance date to ensure hood inspection reports are available and recommendations followed up on. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks completed.	

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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 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the	K 0353	K353 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Sprinkler inspection repairs for room 17, 7, and outside room 4 were completed 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 other repairs were	09/03/2022

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	authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Form for Inspection, Testing and Maintenance of Wet Pipe Fire Sprinkler Systems" documentation dated 01/18/22 with the Administrator and the Field Maintenance Supervisor during record review from 9:00 a.m. to 12:00 p.m. on 08/04/22, deficiencies were noted for the facility's sprinkler system during the most recent annual inspection for the facility. The "Deficiency Summary" section of the 01/18/22 annual sprinkler system inspection report stated "Room 17, Room 7 and outside Room 4 have painted heads". Based on interview at the time of record review, the Field Maintenance Supervisor stated the contractor sent a quote to replace the sprinkler heads but the quote has not yet been approved by the facility. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		recommended during the last sprinkler inspection. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated regarding follow up of sprinkler inspection reports. The Maintenance Director will review all Deficiencies noted during annual sprinkler inspections and ensure follow up is completed as part of the preventative maintenance program. 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: The Executive Director with the maintenance director prior to the compliance date to ensure all sprinkler inspection report recommendations are followed up on. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks completed.	

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	155442	A. BUILDING 01 B. WING	08/04/2022

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K 0511 SS=E 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 electrical wiring in 1 of 2 smoke compartments was maintained in safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 300.15 states a box or conduit body shall be installed at each junction point unless otherwise permitted by 300.15(A) through (I). Article 314.28 states boxes and conduit bodies used as pull or junction boxes shall comply with 314.28 (A) through (E). This deficient practice could affect over 15 residents, staff and visitors in the vicinity of Room 5. Findings include: Based on observations with the Administrator and the Field Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:10 p.m. on 08/04/22, exposed electrical wiring was noted in an open ended conduit which was above the suspended ceiling near the smoked barrier door set by Room 5 and was not contained within a junction box or conduit body. Based on interview at the time of the observations, the Field Maintenance Supervisor agreed the exposed electrical wiring was not contained within a junction box or conduit body.	K 0511	K511- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: was made and are now in a junction box near room 5. 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 other areas were inspected for exposed wiring and repaired. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Maintenance Director educated on containing exposed wiring. Inspection for exposed electrical wiring in building ceiling will be added to our Preventative Maintenance Plan.	09/03/2022

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	This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		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: The Executive Director will with the maintenance director prior to the compliance date to ensure all exposed wiring is contained. The Executive Director will review the preventative maintenance checks performed by the maintenance director monthly and sign off that the checks 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 1. Based on record review and interview, the facility failed to document quarterly fire drills or staff training documentation on fire drill procedures on the first and third shifts for 1 of 4 quarters and on the second shift for 2 of 4	K 0712	K712 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	09/03/2022

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	quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Logbook Documentation: Fire Drills" documentation with the Administrator and the Field Maintenance Supervisor during record review from 9:00 a.m. to 12:00 p.m. on 08/04/22, documentation of a first shift fire drill or staff training documentation on fire drill procedures in the second quarter (April, May, June) 2022 and on the third shift in the third quarter (July, August, September) 2021 was not available for review. In addition, documentation of a second shift fire drill or staff training documentation on fire drill procedures in the fourth quarter (October, November, December) 2021 and in the second quarter 2022 was also not available for review. Based on interview at the time of record review, the Administrator stated the facility operates three shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures for the aforementioned shifts and quarters in 2021 and 2022 was not available for review. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to document the staff who participated in quarterly fire drills or staff training documentation on fire drill procedures on the first, second and third shifts for 1 of 4 quarters. LSC		A fire drill was completed on each shift. 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: A fire drill was completed on each shift. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director was educated on monthly fire drill schedule. The fire drill schedule was added to the monthly preventative maintenance schedule. 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: The Executive Director will verify the current fire drills were held on each shift with the maintenance director prior to the compliance date to ensure all shifts have practiced a fire drill. The Executive Director will review the	

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	Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. LSC Section 19.7.1.8 states employees of health care occupancies shall be instructed in life safety procedures and devices. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Logbook Documentation: Fire Drills" documentation with the Administrator and the Field Maintenance Supervisor during record review from 9:00 a.m. to 12:00 p.m. on 08/04/22, documentation of the staff who participated in the first shift fire drill conducted on 02/02/22 at 1:00 p.m., the second shift fire drill conducted on 02/25/22 at 2:15 p.m. and the third shift fire drill conducted on 03/28/22 at 1:00 a.m. was not available for review. Based on interview at the time of record review, the Administrator stated the facility operates three shifts per day and agreed documentation of the staff who participated in the fire drills for the aforementioned shifts and quarters in 2022 was not available for review. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		preventative maintenance checks performed by the maintenance director monthly and sign off that the fire drills were 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			

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	monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 1 of 1 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and	K 0918	K918 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: The supplemental 4-hour load testing was performed and is available for review.	09/03/2022

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	Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and the Field Maintenance Supervisor from 9:00 a.m. to 12:00 p.m. on 08/04/22, thirty-six month period emergency generator testing documentation for four continuous hours for the LP gas fired emergency generator for the facility was not available for review. Based on interview at the time of record review, the Field Maintenance Supervisor stated supplemental load testing documentation for four hours within the most recent three year period was not available for review. Based on observations with the Administrator and the Field Maintenance Supervisor during a tour of the facility from 12:00 p.m. to 1:10 p.m. on 08/04/22, the facility has one LP gas fired emergency generator located outside the building on the north side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 25 kW. This finding was reviewed with the Administrator and the Field Maintenance Supervisor during the		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 other generators on site to perform the supplemental load testing What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: The Maintenance Director will be on 4-hour load testing requirements. The maintenance director will verify the thirty-sixth month period emergency generator load testing is completed based on the preventative maintenance schedule. 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: The Executive Director will review with the maintenance director prior to the compliance date to ensure the testing was completed. The thirty-sixth month period emergency generator load testing was added to the preventative maintenance schedule. The Executive Director will review the	

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	exit conference. 3.1-19(b)		preventative maintenance checks performed by the maintenance director monthly and sign off that the checks completed.	