STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155278	A. BUILDING -- B. WING	08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - BLOOMINGTON CARE CENTER	155 E BURKS DR BLOOMINGTON, IN 47401

(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: 08/08/23 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Emergency Preparedness survey, Brickyard HealthCare - Bloomington Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 153 certified beds. At the time of the survey, the census was 116. Quality Review completed on 08/10/23	E 0000	The submission of this Plan of Correction, for survey event ID 1C4421 does not indicate an admission by Bloomington Care Center that the findings and allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Bloomington Care Center. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is thus submitted as a matter of statute only. We are requesting paper compliance for this survey.	
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).	K 0000	The submission of this Plan of Correction, for survey event ID 1C4421 does not indicate an admission by Bloomington Care Center that the findings and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Swaby	Executive Director	08/25/2023

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

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	Survey Date: 08/08/23 Facility Number: 000177 Provider Number: 155278 AIM Number: 100289860 At this Life Safety Code survey, Brickyard HealthCare -Bloomington Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a partial basement was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 153 and had a census of 116 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 08/10/23		allegations contained herein are an accurate and true depiction of the quality of care and services provided to the residents of Bloomington Care Center. The Facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The Facility hereby maintains it is in substantial compliance with the requirements of participation for Comprehensive Health Care Facilities. To this end, this Plan of Correction shall serve as a credible allegation of compliance with all state and federal requirements governing the management of this Facility. It is thus submitted as a matter of statute only. We are requesting paper compliance for this survey.	
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 record review, observation, and	K 0291	**What corrective action(s) will**	08/25/2023

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	interview; the facility failed to ensure there was complete documentation for the testing of all battery backup lights that were tested monthly for 30 seconds during the past 12 months to ensure the light would provide lighting during periods of power outages. LSC 19.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review on 08/08/23 from 10:30 a.m. to 1:08 p.m. with the Maintenance Director present, the facility did have a preventative maintenance (PM) report that battery powered emergency lights were tested monthly for 30 seconds and annually for 90 minutes. There were no documented 30 second testing prior to January 2023 for the battery powered emergency lights. Based on an interview at the time of record review, the Maintenance Director stated he started in his position on January 2023 and there are no additional battery powered emergency light testing documentation available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director during the exit		**be accomplished for those residents found to have been affected by the deficient practice** The were no residents affected by the alleged deficient practice. All battery backup emergency lighting was tested after January 2023 and was documented. **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 have the potential to be affected by the alleged deficient practice. No residents were noted to be affected by the alleged deficient practice. Testing will be completed monthly. All battery backup emergency lighting were tested after January 2023 and were documented. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The community has initiated the "Tels" program to help monitor due dates and documentation of required task to be completed. This system prompts when task needs to be completed in accordance with the NFPA.	

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	conference. 3.1-19(b)		Reminders are sent to the Maintenance Director, Executive Director, and the Regional Maintenance Director. The TELS assignment sheet is attached (Exhibit A). The Life Safety Code CMS form 2786R was reviewed and is attached (Exhibit B). The policy “Emergency Lighting” was reviewed with no changes made (Exhibit C). Testing has been consistent since January 2023. **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 audit tool titled “Maintenance Life Safety Survey Audits” (Exhibit D) will be utilized to determine compliance. The audit tool will be completed by the Maintenance Director or designee Monthly for 6 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**. Systemic changes will be completed by 8/25/2023.	

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K 0300 SS=C Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on record review, interview and observation, the facility failed to ensure documentation for the preventative maintenance of battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the Monthly Battery Operated Smoke Detector Testing documentation on 08/08/23 at 11:23 a.m. with the Maintenance Director present, the itemized list of resident room battery operated smoke alarms tested for functionality on a monthly basis was not complete for the last 12 months. Monthly documentation of battery operated smoke alarm testing prior to January 2023 was not available for review. Based on interview at the time of record review, the	K 0300	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**. There were no residents identified as being affected by the alleged deficient practice. Testing has been completed consistently since January 2023. **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 have the potential to be affected by the alleged deficient practice. There were no residents identified as being affected by the alleged deficient practice. Battery Operated Smoke Detector Testing has been completed consistent since January 2023. **What measure will be put into place and what systemic changes will be made to**	08/25/2023

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	Maintenance Director confirmed that documentation for battery operated smoke detector testing prior to January 2023 was not available for review at the time of the survey. Based on observations during a tour of the facility on 08/08/23 with the Maintenance Director, battery operated smoke alarms were observed in all resident sleeping rooms. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**ensure that the deficient practice does not recur.** The community has initiated the "Tels" program to help monitor due dates and documentation of required task to be completed. This system prompts when task needs to be completed in accordance with the NFPA. Reminders are sent to the Maintenance Director, Executive Director, and the Regional Maintenance Director. TELS was reviewed and the monthly assignment was reviewed (Exhibit E). The Life Safety Code CMS form 2786R was reviewed (Exhibit F). **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 audit tool titled "Maintenance Life Safety Survey Audits" (Exhibit D) will be utilized to determine compliance. The audit tool will be completed by the Maintenance Director or designee Monthly for 6 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee.	

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			By what date the systemic changes for each deficiency will be completed. Systemic changes will be completed by 8/25/2023.	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the Activity Center each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, cartridge-operated extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using push to-test pressure indicators. Section 7.2.4.1 states personnel making manual inspections shall keep records of all fire extinguishers inspected, including those found to	K 0355	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**. No residents were affected by the alleged deficient practice. A check was completed on the fire extinguisher. **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 have the potential to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. A check was completed on the fire extinguisher (See Exhibit G).	08/25/2023

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	require corrective action. Section 7.2.4.3 requires where at least monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Section 7.2.4.4 requires where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire extinguisher, on an inspection checklist maintained on file, or by an electronic method. Section 7.2.4.5 requires records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect 5 residents and staff in the area of Activity Center. Findings include: Based on observation during a tour of the facility with the Executive Director and Maintenance Director on 08/08/23 at 1:40 p.m., the monthly inspection tag on the fire extinguisher located in the Activity Center lacked documentation of a monthly inspections since January 2023. Based on interview at the time of observation, the Maintenance Director confirmed the fire extinguisher located in the Activity Center was missing the February 2023 - August 2023 monthly visual inspection. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The “TELS Masters” “NFPA 10 (2010)—Inspecting Fire Extinguishers was reviewed by the Maintenance Director and Executive Director. The “new” Maintenance Director was not aware there was a fire extinguisher in that area. He was educated on its location. Monthly checks were completed on all other Extinguishers. The identified extinguisher will have monthly checks completed. The policy and procedure for inspecting Fire extinguishers was reviewed (Exhibit H). The TELS assignments sheet was reviewed (Exhibit I). The CMS form 2876-R was reviewed (Exhibit J) **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 audit tool titled “Maintenance Life Safety Survey Audits” (Exhibit D) will be utilized to determine compliance. The audit tool will be completed by the Maintenance Director or designee Monthly for 6	

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			months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**. Systemic changes will be completed by 8/25/2023.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are			

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	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 2 of over 50 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 30 residents. Findings include: Based on observations and interview during a tour of the facility with the Executive Director and Maintenance Director on 08/08/23 between 1:08 p.m. and 2:25 p.m., the corridor doors of resident room 136 and 102 failed to latch positively into their respective door frames. This finding was confirmed by the Maintenance Director at the time of discovery and again at the exit conference with the Maintenance Director and Executive Director present. 3.1-19(b)	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**. Residents who reside in room 136 and 102 had their doors adjusted so that they would close with a positive latch. **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 have the potential to be affected by the alleged deficient practice. No other room/residents were identified as being affected.	08/25/2023

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			What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. The community has initiated the "Tels" program to help monitor due dates and documentation of required task to be completed. This system prompts when task needs to be completed in accordance with the NFPA. Reminders are sent to the Maintenance Director, Executive Director, and the Regional Maintenance Director. Door checks will be completed according to the TELS schedule and will be documented (Exhibit K). The Life Safety Code CMS for 2768-R was reviewed (Exhibit L). **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 audit tool titled "Maintenance Life Safety Survey Audits" (Exhibit D) will be utilized to determine compliance. The audit tool will be completed by the Maintenance Director or designee Monthly for 6 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been	

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			achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**. Systemic changes will be completed by 8/25/2023.	
K 0500 SS=C Bldg. 01	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observations and interview, the facility failed to ensure 2 of 2 fuel-fired boilers had current inspection certificates to ensure the boilers were in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations on 08/08/23 during a tour of the facility from 1:08 p.m. to 2:25 p.m. with the Executive Director and Maintenance Director, the two fuel-fired boilers in the facility had certificates with expiration dates of 02/01/22. Based on interview at the time of observations, the Maintenance Director confirmed the expiration	K 0500	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**. No Residents were affected by the alleged deficient practice. **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 have the potential to be affected by the alleged deficient practice. All boilers had been inspected and had an expiration date of 2/1/2024 or 2/2/2024.	08/25/2023

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	dates of the two fuel-fired boilers. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)		**What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The community has initiated the "Tels" program to help monitor due dates and documentation of required task to be completed. This system prompts when task needs to be completed in accordance with the NFPA. Reminders are sent to the Maintenance Director, Executive Director, and the Regional Maintenance Director. All "Boiler – Fired Pressure Vessel Report of Inspections" (Exhibit M) are on file for review. The Life Safety Code CMS form 2786-R was reviewed (Exhibit N) **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 audit tool titled "Maintenance Life Safety Survey Audits" (Exhibit D) will be utilized to determine compliance. The audit tool will be completed by the Maintenance Director or designee Monthly for 6 months. Audited records will be reviewed by the Quality Assurance Committee until such time that	

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	155278	A. BUILDING 01 B. WING	08/08/2023

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			consistent compliance has been achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**. . Systemic changes will be completed by 8/25/2023.	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying 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 provide documentation of a fire drill conducted on the third shift for 2 of 4 quarters. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Executive Director and the Maintenance Director from 10:30 a.m. to 1:08 p.m. on 08/08/23, there was no documentation for a third shift fire drill in the second quarter (April, May, June) 2023. Additionally, there was no documentation for a	K 0712	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**. No residents were identified as being affected by the deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	08/25/2023

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	third shift fire drill in the third quarter (July, August, September) 2022/2023. Based on interview at the time of record review, the Maintenance Director confirmed that no additional fire drill documentation was available for review at the time of the survey. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		**action(s) will be taken.** All residents have the potential to be affected by the alleged deficient practice. No other residents were identified as being affected by the alleged deficient practice. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The community has initiated the "Tels" program to help monitor due dates and documentation of required task to be completed. This system prompts when task needs to be completed in accordance with the NFPA. Reminders are sent to the Maintenance Director, Executive Director, and the Regional Maintenance Director. The Maintenance Director and Executive Director reviewed the K-712 "Operating Features Fire Drills" cms for 2786-R (Exhibit O). The Policy and procedure "Fire Drills" was reviewed with no changes made (Exhibit P). Fire drills are held quarterly on each shift per the Tels Assignment sheet (Exhibit Q). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place; The audit tool titled “Maintenance Life Safety Survey Audits” (Exhibit D) will be utilized to determine compliance. The audit tool will be completed by the Maintenance Director or designee Monthly for 6 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**. Systemic changes will be completed by 8/25/2023.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised			

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	once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review and interview; the facility failed to 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 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	K 0918	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**. No residents were affected by the alleged deficient practice. **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 have the potential to be affected by the alleged deficient practice. No residents were identified as being affected by the	08/25/2023

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	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 in the facility. Findings include: Based on record review with the Executive Director and the Maintenance Director from 10:30 a.m. to 1:08 p.m. on 08/08/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the diesel fired emergency generator for the facility was conducted on 03/06/2020. Based on interview at the time of record review, the Maintenance Director stated the facility has one 420kW diesel generator and agreed documentation of supplemental load testing for four hours within the most recent three-year period was not available for review. This finding was reviewed with the Executive Director and the Maintenance Director during the exit conference. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 12 months and weekly inspection for 4 of 52 weeks. 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 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Section 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected		alleged deficient practice. **What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The community has initiated the "Tels" program to help monitor due dates and documentation of required task to be completed. This system prompts when task needs to be completed in accordance with the NFPA. Reminders are sent to the Maintenance Director, Executive Director, and the Regional Maintenance Director. The Maintenance Director and Executive Director reviewed the K-918 "Health Care Facilities Code Requirements Electrical Systems – Essential Electrical System Maintenance and Testing" (Exhibit R). Also the Tels Masters "NFPA 110 (2010) – Operational Testing of Emergency Power Generator" (Exhibit S) was reviewed. The TELS assignment sheet of "Test Generator under load, perform routine checks, create entry in logbook—Diesel" (Exhibit T) and "Conduct a 4 hours Load test" (Exhibit U) were reviewed. A four hour test was conducted and weekly and monthly documentation will continue as it has since January 2023.	

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	weekly and exercised monthly. 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 records review with the Maintenance Director on 08/08/23 from 10:30 a.m. to 1:08 p.m., documentation for the 12/03/22 monthly generator load testing was incomplete. The documentation had 'na' marked on all items except the start, stop time and fuel level. Also, the generator weekly inspection log showed the weekly inspections were not conducted between November 14 and December 19, 2022. Based on an interview at the time of record review, the Maintenance Director stated he started the position in January 2023 and has no additional generator inspection documentation available for review. These findings were reviewed with the Executive Director and Maintenance Director 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 audit tool titled “Maintenance Life Safety Survey Audits” (Exhibit D) will be utilized to determine compliance. The audit tool will be completed by the Maintenance Director or designee Monthly for 6 months. Audited records will be reviewed by the Quality Assurance Committee until such time that consistent compliance has been achieved as determined by the Quality Assurance Committee. **By what date the systemic changes for each deficiency will be completed**. Systemic changes will be completed by 8/25/2023.	