STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING -- B. WING	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RETREAT AT THE STRATFORD, THE	2460 GLEBE ST CARMEL, IN 46032

(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: 04/22/24 Facility Number: 011151 Provider Number: 155794 AIM Number: NA At this Emergency Preparedness survey, The Retreat at the Stratford was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 18 certified beds. At the time of the survey, the census was 15. Quality Review completed on 04/24/24	E 0000	This Plan of Correction represents The Retreat at the Stratford (community) Allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	
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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lorna Ray		05/08/2024

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

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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency 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			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (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.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Maintenance Technician on 04/22/24 between 10:35 a.m. and 1:35 p.m., prior to 01/24, no documentation was available for review to show the diesel generator set in service was exercised at least once monthly, for a minimum of 30 minutes. The monthly load test documentation provided reflected tests for January through April of 2024. The Maintenance Technician stated documentation for monthly generator tests prior to 1/24 was not available for review at the time of the survey. Based on review of "Emergency Generator - Weekly Inspection Checklist" documentation with the Maintenance Technician during record review from 10:35 a.m. to 1:35 p.m. on 04/22/24, documentation of weekly emergency generator inspections for 35 weeks of the 52 week period in May 2023 through April 2024 was not available for review. There were no weekly inspections documented for the emergency generator set prior to 01/03/2024. Based on interview at the time of record review, the Maintenance Technician	E 0041	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The maintenance team will be educated on requirements for generator monthly generator testing and weekly generator inspection. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: The Facilities Director will audit generator logs every week to ensure that weekly generator inspection and monthly generator testing are completed and logged. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged	06/05/2024

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	confirmed that documentation of weekly emergency generator inspections for the aforementioned period was not available for review. This finding was reviewed with the Executive Director, Care Services Administrator and Maintenance Technician at the exit conference.		deficient practice will not reoccur. The administrator or designee will review audits for compliance. Audits will then continue monthly until 100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease, or discontinue auditing.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/22/24 Facility Number: 011151 Provider Number: 155794 AIM Number: NA At this Life Safety Code survey, The Retreat at the Stratford was found not in compliance with Requirements for Participation in Medicare, 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 facility located on the second floor of a three-story building was determined to be of Type II (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the	K 0000	This Plan of Correction represents The Retreat at the Stratford (community) Allegation of compliance. Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

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	corridors, and hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 18 and had a census of 15 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 04/24/24			
K 0345 SS=C Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances	K 0345	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Facility Director will be educated on requirements for semi-annual visual inspection of fire alarm system. Semi-annual visual inspection to be conducted in the week of August 5th, 2024. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to	06/05/2024

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	e. Magnetic hold-open devices This deficient practice could affect all building occupants. Findings include: Based on records review and interview with the Maintenance Technician and Care Services Administrator on 04/22/24 between 10:35 a.m. and 1:35 p.m., no documentation could be provided regarding a visual semi-annual fire alarm system inspection 6 months prior to the Annual inspection dated 02/13/24. Based on interview with the Maintenance Technician, he stated there was no documentation of a semi annual visual inspection available for review at the time of the survey. This finding was reviewed with the Executive Director, Care Services Administrator and Maintenance Technician at the exit conference. 3.1-19(b)		be affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: The Facility Director will schedule date and time of inspection. Executive Director to audit log for completion. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur. The administrator or designee will review audits for compliance. Audits will then continue semi-annually until 100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease, or discontinue auditing.	
K 0353 SS=F Bldg. 02	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			

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	secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 1 of 1 automatic sprinkler piping system was inspected every five years in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff and visitors in the facility. Findings include: Based on record review on 04/22/24 between 10:35 a.m. and 1:35 p.m. with the Care Services Administrator and Maintenance Technician, documentation of an internal inspection of the	K 0353	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The Facility Director will be educated on the requirements of an internal inspection of the facility sprinkler system every 5 years. Inspection scheduled for May 16th and May 17th, 2024. The maintenance team will be educated on monthly wet pipe sprinkler system's gauges and valves inspection requirements and documentation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: The Facility Director has	06/05/2024

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	facility sprinkler system performed within the most recent five year period was not available for review. A quarterly sprinkler inspection dated 08/28/2023 indicated in the deficiencies section 'System needs a five year internal inspection done'. Based on interview at the time of record review, the Maintenance Technician confirmed documentation of an internal inspection of the sprinkler system within the most recent five year period was not available for review. This finding was reviewed with the Executive Director, Care Services Administrator and Maintenance Technician during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly, or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance		schedules the date and time of inspection. Executive Director to audit log for completion. Facility Director will audit log for monthly wet pipe sprinkler system's gauges and valves inspection. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur. The administrator or designee will review audits for compliance. Audits will then continue until 100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease, or discontinue auditing.	

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	Technician on 04/22/24 between 10:35 a.m. and 1:35 p.m., there were no monthly inspection records of the wet pipe sprinkler system's gauges and valves for eight of the last twelve months. Based on interview at the time of record review, the Maintenance Technician confirmed there was no documentation of the inspection of gauges and valves other than the four quarterly inspection performed by the sprinkler system inspectors. This finding was reviewed with the Executive Director, Care Service Administrator and Maintenance Technician at the exit conference. 3.1-19(b)			
K 0363 SS=D Bldg. 02	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			

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	applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 30 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 2 residents. Findings include: Based on observation and interview during a facility tour with the Maintenance Technician, Care Services Administrator and Executive Director on 04/22/24 at 2:05 p.m., the corridor door to Resident Room 263 failed to close and latch positively into the door frame. Based on interview at the time of the observation, the Maintenance Technician agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This finding was reviewed with the Executive	K 0363	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: The maintenance team will be educated on requirements to ensure corridor doors latch. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur:	06/05/2024

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	Director, Care Services Administrator and Maintenance Technician at the exit conference. 3.1-19(b)		The maintenance technician repaired the door on April 23, 2024. The maintenance team will audit all corridor doors monthly to ensure they latch. Facility Director will review audits. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur. The administrator or designee will review audits for compliance. Audits will then continue until 100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease, or discontinue auditing.	
K 0712 SS=F Bldg. 02	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	K 0712	What corrective actions will be	06/05/2024

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	155794	A. BUILDING 02 B. WING	04/22/2024

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RETREAT AT THE STRATFORD, THE	2460 GLEBE ST CARMEL, IN 46032

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	failed to ensure 9 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of monthly Fire Drill Reports with the Maintenance Technician and the Care Services Administrator on 04/22/24 from 10:35 a.m. to 1:35 p.m., eight monthly fire drill forms had 'Silent' and 'N/A' wrote at 'Did the monitoring company receive alarm' line. There was no verification of the transmission of the fire alarm signal for the following drills: 03/30/24 at 5:30 a.m., 02/11/24 at 4:00 p.m., 01/06/24 at 10:00 a.m., 12/06/23 at 5:45 p.m., 11/15/23 at 2:00 a.m., 09/30/23 at 11:15 p.m., 08/08/23 at 4:55 p.m., 07/22/23 at 10:00 a.m. and 05/23/23 at 3:25 p.m. Based on interview at the time of record review, the Maintenance Technician confirmed that documentation for the verification of the transmission of the fire alarm signal was not available for the aforementioned fire drills. This finding was reviewed with the Executive Director, Care Services Administrator and Maintenance Technician at the exit conference. 3.1-19(b) 3.1-51(c)		accomplished for those residents found to have been affected by the deficient practice: The maintenance team will be educated on requirements for fire alarm and verification of transmission of the fire alarm signal to the monitoring station during fire drills. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: One resident was affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: The Facilities Director will audit fire drill reports monthly. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur. The administrator or designee will review audits for compliance. Audits will then continue until 100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations for the need to increase, decrease, or discontinue auditing.	

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K 0918 SS=F Bldg. 02	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 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 maintain a complete written record	K 0918	What corrective actions will be accomplished for those residents	06/05/2024

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	of monthly generator load testing for 8 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. 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 and interview with the Maintenance Technician on 04/22/24 between 10:35 a.m. and 1:35 p.m., prior to 01/24, no documentation was available for review to show the diesel generator set in service was exercised at least once monthly, for a minimum of 30 minutes. The monthly load test documentation provided reflected tests for January through April of 2024. The Maintenance Technician stated documentation for monthly generator tests prior to 1/24 were not available for review at the time of the survey. This finding was acknowledged by the Maintenance Technician at the time of discovery and again at the exit conference with the Maintenance Technician and Care Services Administrator present. 3.1-19(b) 2. Based on record review and interview, the		found to have been affected by the deficient practice: The maintenance team will be educated on requirements for generator monthly generator testing and weekly generator inspection. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by the deficient practice. What measures will be put in place or what systemic changes the facility will makes to ensure that the deficient practice does not occur: The Facilities Director will audit generator logs every week to ensure that weekly generator inspection and monthly generator testing are completed and logged. How the corrective actions will be monitored to ensure the deficient practice will not recur, I,e., what quality assurance program will be put into place Corrective actions will be monitored to ensure the alleged deficient practice will not reoccur. The administrator or designee will review audits for compliance. Audits will then continue monthly until 100% compliance is achieved. Any negative patterns will be presented at QAPI monthly for further review/recommendations	

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	facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for 35 weeks of 52 week period in May 2023 through April 2024. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Emergency Generator - Weekly Inspection Checklist" documentation with the Maintenance Technician during record review from 10:35 a.m. to 1:35 p.m. on 04/22/24, documentation of weekly emergency generator inspections for 35 weeks of the 52 week period in May 2023 through April 2024 was not available for review. There were no weekly inspections documented for the emergency generator set prior to 01/03/2024. Based on interview at the time of record review, the Maintenance Technician confirmed that documentation of weekly emergency generator inspections for the aforementioned period was not available for review. This finding was reviewed with the Executive Director, Care Services Administrator and Maintenance Technician at the exit conference. 3.1-19(b)		for the need to increase, decrease, or discontinue auditing.	