STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING -- B. WING	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(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: 11/10/22 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this Emergency Preparedness survey, Chateau Rehabilitation & Healthcare was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 99 and had a census of 89 at the time of this survey. Quality Review on 11/17/22	E 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
E 0023 SS=C Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Goran Prentoski	Facility Administrator	11/28/2022

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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	155249	A. BUILDING -- B. WING	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(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
	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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.			
	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR	E 0023	**E023 Policy/Procedures for Medical Documentation** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.***	11/30/2022

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	483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 10:35 a.m., the provided Emergency Preparedness Plan (EPP) did not contain documentation to indicate the use of a system to preserve resident medical documentation during an emergency. Based on interview at the time of record review, the DON and the Administrator stated the policy on a system to preserve resident medical documentation was not found. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference.		***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has reviewed and updated its Emergency Preparedness Plan to include a facility assessment policy indicating continuity of operations related to Medical Documentation.** **Communication of updates have been completed with Staff and any other parties the IDT determines to be necessary.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will present the Emergency Preparedness**	

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			Plan monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/30/2022	
E 0041 SS=C 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			

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	155249	A. BUILDING -- B. WING	11/10/2022

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	Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 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			

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	go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities	E 0041	K041 Emergency and Power Standby Systems The facility requests paper	11/30/2022

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	Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 10:02 a.m., the generator lacked monthly, weekly, and yearly testing required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference.		compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: a. 30 Minute Generator Load Exercise has been completed and is currently up to date. b. Weekly Generator inspections are being completed and are currently up to date. c. Annual Load Bank Inspection has been completed and is currently up to date. d. 3-year 4 hour run under load has been completed and is currently up to date. e. Emergency Generator light	

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			testing has been completed and is currently up to date. 4)How the corrective actions will be monitored: The Maintenance Director/designee will continue to conduct and schedule Generator Inspections accordingly. Maintenance Director/designee will bring inspections to Quality Assurance Meeting for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/30/2022	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 11/10/22 Facility Number: 000153 Provider Number: 155249 AIM Number: 100266910 At this Life Safety Code survey, Chateau Rehabilitation & Healthcare 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	K 0000	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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	Health Care Occupancies and 410 IAC 16.2. This one story facility with a walk up mechanical room was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility is fully protected by a Type II EES 350 kW Diesel powered generator. The facility has a capacity of 99 and had a census of 89 at the time of this survey. All areas providing customary access to the residents were sprinklered. The facility had a detached garage and three sheds providing facility services including storage of old equipment, new beds, mattresses and maintenance supplies that were not sprinklered. Quality Review on 11/17/22			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 1 of 13 exit discharge doors were free of impediments to full instant use in the case of fire or other emergency in accordance with LSC 7.1.10.1. LSC 7.2.1.7.1 states where a door assembly is required to be equipped with panic or fire exit hardware, (3) It shall be constructed so	K 0211	**K211 Quality Review Means of Egress-General** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not***	11/30/2022

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	that a horizontal force not to exceed 15 lbf (66 N) actuates the cross bar or push pad and latches. This deficient practice could affect 20 residents in one hall. Findings include: Based on observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 11:35 a.m., the exit door by the DON office was equipped with panic hardware, but the door would not open on the first try. It took three tries to open the door taking excessive force to open the door. Based on interview at the time of observation, the Maintenance Assistant and the U.P. Maintenance Director agreed it took excessive force to open the exit door due to the paint making the door stick. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		***constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** The exit door located by the DON office was evaluated and repaired to ensure proper opening and closing. **4)How the corrective actions will be monitored:** **Maintenance Director/Designee will audit 5 random exit doors weekly to ensure] the doors properly open and close.** **Maintenance Director/Designee will provide the findings of the audit to the QAA committee monthly for 6 months or when**	

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			100%compliance is achieved. **5) Date of compliance: 11/30/2022**	
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 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			

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	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 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 2 exits with special locking arrangements for the clinical security needs of the residents were readily accessible by remote control of locks; keys carried by staff at all times; or other such reliable means available to the staff at all times. This deficient practice could affect 25 residents in the Memory Care hall.	K 0222	K222: Egress Doors The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement	11/30/2022

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CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

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	Findings include: Based on observation with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 9:35 a.m., the Memory Care exit door was locked, could be opened by entering a four-digit code, and the hall had special locking arrangements for residents with clinical security needs; but when a Nurse on the hall was asked to open the door, the staff person did not enter the correct code and could not open the door. Based on interview at the time of observation, the Nurse stated she did not know the code and the U.P. Maintenance Director agreed a staff person on the hall did not know the code to open the exit door. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: a. All exit doors have the key code posted at a visible level near the keypad. 4)How the corrective actions will be monitored: The Maintenance Director/designee has re-educated staff members of the location of the key codes. Maintenance Director/designee will audit all exit doorways to ensure codes are present and visible weekly for 6 months. The audit will be reviewed in Quality Assurance Meeting monthly to ensure no changes or until 100% of education has been achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the	

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			plan of correction as indicated. 5) Date of compliance: 11/30/2022	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 Based on observation and interview, the facility failed to ensure 3 of 3 attic smoke hatch doors were self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 35 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 3:00 p.m., in the upstairs mechanical room there were three attic hatch smoke doors that were open and not self-closing due to the springs to close the doors were disconnected. Based on interview at the time of observation, the Maintenance Assistant	K 0223	**K223 Doors with Self-Closing Devices** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions***	11/30/2022

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	agreed the attic hatch smoke doors had the self-closing device (the spring) disconnected. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		***of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Maintenance Director has corrected the springs to the three attic hatch smoke doors to allow for self-closing** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit the three attic hatch smoke doors for proper mechanism and closing weekly. Maintenance Director/designee will present the audit monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The audit will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance:** **11/30/2022**	

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K 0324 SS=E 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 record review, observation and interview; the facility failed to ensure 2 of 3 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect 25 residents in	K 0324	K324: Cooking Facilities The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is	11/30/2022

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	therapy and the activities room. Findings include: Based on observation with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 11:55 a.m. and at 2:30 p.m., the therapy gym and the activities room contained cooktops with a fire-extinguishing system. Based on records review at 11:55 a.m. and 2:30 p.m., the only documentation of semiannual kitchen exhaust system inspection available for review was dated March of 2021. Based on interview at the time of record review and observation, the U.P. Maintenance Director and Administrator agreed the two fire-extinguishing systems were last inspected in March 2021 and stated when the new contractor stared in 2021 they were unaware of the systems in the therapy gym and the activities room. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: a. Facility has ensured the cooktops with a fire extinguishing system in the Physical Therapy and Activities have a current inspection. 4)How the corrective actions will be monitored: The Maintenance Director/designee will monitor all inspections moving forward. Maintenance Director/designee will bring current and future inspections to Quality Assurance Meeting monthly for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/30/2022	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and			

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	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 e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: During records review with the Maintenance Assistant and the U.P. Maintenance Director on 11/10/22 at 9:35 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 01/07/22. Based on interview at the time of records review, the Maintenance Assistant and the U.P. Maintenance Director stated a visual inspection of the fire alarm	K 0345	**K345 Fire Alarm System-Testing and Maintenance** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:**	11/30/2022

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	system six months after the annual fire alarm inspection was not conducted. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		**Maintenance Director has completed a visual inspection of the fire alarm system. Education was completed to ensure Maintenance Director/Designee understand the facility procedure related to this inspection.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will complete a visual inspection of the fire alarm systema and document this inspection weekly to ensure proper functioning of system. Maintenance Director/designee will present the audit monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The audit will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of compliance: 11/30/2022**	
K 0353 SS=E 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			

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	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, 7.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to ensure 6 of 6 sprinkler heads in the laundry were not loaded and covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 25 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 12:29 p.m., all the sprinkler heads in the laundry were loaded with	K 0353	**K353 Sprinkler System Maintenance and Testing** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.**	11/30/2022

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	dirt and lint. Based on interview at the time of observation, the Maintenance Assistant confirmed the sprinkler heads in the laundry were loaded with dirt and lint. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		**2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Sprinkler heads noted in the 2567 in laundry room have been cleaned and inspected in-house.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will visually inspect 5 sprinkler heads per week to ensure proper cleanliness. Maintenance Director/Designee will present audit to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **5) Date of Compliance:** **11/30/2022**	

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K 0355 SS=E 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 ensure 1 of 1 portable fire extinguishers in the chapel were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (3) In a cabinet or wall recess. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 12:20 p.m., an ABC portable fire extinguisher in the chapel was sitting on the floor unsecured. Based on interview at the time of observation, the Maintenance Assistant agreed the extinguisher was sitting on the floor unsecured. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)	K 0355	**K355 Portable Fire Extinguishers** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice**	11/30/2022

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			3) Measures put into place/ System changes: **The portable fire extinguisher that was found in the chapel on the floor was mounted on the wall.** **4)How the corrective actions will be monitored:** **Maintenance Director/Designee will audit all existing fire extinguishers to ensure they are properly mounted.** **Thereafter, Maintenance Director/designee will audit 5 fire extinguishers weekly to ensure they are properly mounted and secured. Audits will be reviewed monthly with the QAA Committee for 6 months or until 100% compliance is met.** **5. Date of compliance:** **11/30/2022**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing			

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	in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 6 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 25 residents in C3-hall. Findings include: Based on observation with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 1:55 p.m., the set of smoke barrier doors in C3-hall corridor would not close due to a patient lift parked up against one of the smoke doors. This condition would leave the door fully open upon activation of the fire alarm. Based on interview during the time of observation, the U.P. Maintenance Director stated the door was part of a smoke barrier, was blocked form closing and removed the lift. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)	K 0374	**K374 Subdivision of Building Spaces-Smoke Barrier Doors** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/**	11/30/2022

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			System changes: **Patient lift was removed and relocated to an appropriate location. C3-hall corridor smoke doors were evaluated and noted to safely open and close as required. No other doors were noted to have this concern.** **4) How the corrective actions will be monitored:** The Maintenance Director/designee will monitor all corridor smoke doors weekly to ensure doors are not blocked from being able to open and close correctly. Maintenance Director/designee will bring audits to Quality Assurance Meeting monthly for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated 5) Date of compliance: 11/30/2022	
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 1 of 1 electrical panel on the C2-hall was guarded from energized parts. NFPA	K 0511	**K511 Utilities Gas and Electric** **The facility requests paper compliance for this citation.**	11/30/2022

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	155249	A. BUILDING 01 B. WING	11/10/2022

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	70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could 20 resident on C2-hall. Findings include: Based on observation with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 1:40 p.m., in the C2-hall electrical closet an electrical panel was not enclose exposing energized parts. The cover and door to the panel was laying on the floor. Based on interview at the time of observation, the U.P. Maintenance Director agreed the electrical panel was not enclosed and the Maintenance Assistant did put the cover back onto the panel. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Correction was made via proper placement of electrical panel cover.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will audit the electrical panel cover weekly to ensure proper placement and present compliance audits**	

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			monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance: 11/30/2022**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills on each shift for 4 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. This deficient practice affects all staff and residents.	K 0712	K712: Fire Drills The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement	11/30/2022

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	Findings include: Based on records review with the with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 9:35 a.m., the following shifts were missing documentation of a completed fire drill: a) The first quarter of 2022 was missing the first and third shift fire drills. b) The second quarter of 2022 was missing a third shift fire drill. c) The third quarter of 2022 was missing the second and third shift fire drills. d) The fourth quarter of 2021 was missing a third shift fire drill. Furthermore, there has not been a third shift fire drill within the past 12 months and no documentation was available to show the last time a third shift fire drill was conducted. Based on interview at the time of record review, the Maintenance Assistant stated the aforementioned drills were not conducted and did not know when the last third shift fire drill was conducted. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b) 3.1-51(c)		by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding. 2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: a. All fire drills have been brought up to date and into compliance 4)How the corrective actions will be monitored: The Maintenance Director/designee will continue to conduct Fire Drills per Life Safety Code. Maintenance Director/designee will bring fire drills to Quality Assurance Meeting for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/30/2022	

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K 0761 SS=F Bldg. 01	Based on records review, observation and interview, the facility failed to ensure 10 of 10 smoke barrier door assemblies are routinely inspected and repaired as part of the facility maintenance program. Also, the facility failed to ensure annual inspection and testing of 3 of 3 fire door assemblies and 2 of 2 oxygen room fire door assemblies met the requirements of NFPA 80. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or	K 0761	**K761-Maintencance, Inspection & Testing-Door** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/**	11/30/2022

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	prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review and observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 between 10:00 a.m. and 3:00 p.m., the following smoke/fire doors were not inspected or repaired: A.) Annual inspections: no documentation of an annual inspection for the three fire door assemblies and the two O2 room fire doors were available for review. B.) Routine inspections: no documentation was available for review of a routine inspection for the six corridor smoke door assemblies, the attic smoke door in upper mechanical room, and the three attic smoke door hatches in upper mechanical room. C.) Open holes or breaks exist in surfaces of either the door or frame: the fire door assembly to therapy had six small holes in the door frame where a door coordinator was removed. D) Modifications to the door assembly have been performed that void the label: the fire door rating labels on the six corridor smoke door assemblies, the three corridor fire door assemblies, and the two O2 room fire doors had paint completely covering the labels and the door ratings could not be determined.		**System changes:** **A- Annual inspections-completed and current up to date** **B-Routine inspections-Inspection on all doors have been complete and up to date** **C- Holes and break in door and frame have been corrected** **D-All door labels have been cleaned and door rating are now legible** **4) How the corrective actions will be monitored:** The Maintenance Director/designee will monitor all inspections moving forward. Maintenance Director/designee will bring current and future inspections to Quality Assurance Meeting monthly for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated 5) Date of compliance: 11/30/2022	

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	Based on interview at the time of records review and observation, the Maintenance Assistant and the U.P. Maintenance Director stated the fire/smoke door inspection were not completed within the last year, all rated doors had the labels painted, and the therapy fire door assembly had holes in the frame. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications,			

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	containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on observation, record review, and interview; the facility failed to ensure electrical receptacles in 82 of 82 resident sleeping rooms were tested at least annually for non-hospital receptacles and initially for hospital grade receptacles. NFPA 99, Health Care Facilities Code 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade, at patient bed locations and in locations where deep sedation or general anesthesia is administered, shall be tested at intervals not exceeding 12 months. Additionally, Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). This deficient practice could affect all patients. Findings include: Based on observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 between 11:00 a.m. and 3:00 p.m., the facility's resident sleeping rooms contained five to eight electrical receptacles with a mix of hospital and non-hospital grade receptacles. Based on records review at 10:10 a.m., there was no documentation available to show receptacle testing for the sleeping rooms. Based on interview at the time of the observation and records review, the Maintenance Assistant	K 0914	**K914 Electrical Systems Maintenance and Testing** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Facility has completed the annual receptacle testing and has corrected all faults found.**	11/30/2022

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	stated the receptacles will need to be tested. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		**4)How the corrective actions will be monitored:** **The Maintenance Director/designee will present an audit of 10 rooms monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 12 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** 5) Date of Compliance: 11/30/2022	
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 once every 36 months for 4 continuous hours. Scheduled test under load conditions include			

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	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 observation, records review, and interview; the facility failed to maintain 1 of 1 diesel power generators in accordance with NFPA 99 2012 Chapter 6 which requires 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. This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Assistant and the U.P. Maintenance Director on 11/10/22 at 9:05 a.m., the following required testing documentation was not available for review: A.) Generator exercised under load monthly for a minimum of 30 minutes. The required monthly load tests were not conducted for the months of January and February 2022.	K 0918	K918: Electrical Systems The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)Immediate actions taken for those residents identified No resident was found to be affected by the finding.	11/30/2022

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	B.) Generator inspected weekly. A total of 17 weeks were missing the weekly inspections. C.) Annual load bank test for the diesel generator. Some of the monthly load test indicated the load was under 30%. The facility is required to have an annual load bank test due to the load being under 30%. No documentation of an annual load bank was provided for review. D.) Four hour run under load. The facility is required to have a four-hour run under load once every three years. No documentation of a four-hour run was provided for review. E.) Emergency generator light testing. The battery powered generator task lighting testing for 30 seconds monthly was not conducted. Based on an interview at the time of record review, the Maintenance Assistant and the U.P. Maintenance Director stated the testing and inspection documentation for the generator was lost or not completed by the previous Maintenance Director and no other generator paperwork could be found. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		2)How the facility identified other residents: Visitors, staff and residents that reside at the community have the potential to be affected by the alleged deficient practice 3) Measures put into place/ System changes: a. 30 Minute Generator Load Exercise has been completed and is currently up to date. b. Weekly Generator inspections are being completed and are currently up to date. c. Annual Load Bank Inspection has been completed and is currently up to date. d. 3-year 4 hour run under load has been completed and is currently up to date. e. Emergency Generator light testing has been completed and is currently up to date. 4)How the corrective actions will be monitored: The Maintenance Director/designee will continue to conduct and schedule Generator Inspections accordingly. Maintenance Director/designee will bring inspections to Quality Assurance Meeting for 6 months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/30/2022	

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K 0920 Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 11 of 11 flexible extension cords and power strips were installed properly, used in a safe manor, and met the required UL rating of 1363A or 60601-1 in patient care locations in accordance with NFPA 99. This deficient practice was found throughout the building therefore can affect all residents. Findings include: Based on observations with the Maintenance	K 0920	**K920 Electrical Equipment-Power Cords and Extension Cords** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or***	11/30/2022

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(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
	Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 between 11:00 a.m. and 3:15 p.m., the following rooms had extension cords or improper use of power-strips: A.) A coffee pot (high power draw equipment) was plugged into and supplied power by a power strip in the Unit Manager office. B.) In the Unit Manager office a power strip used to power equipment, was not secured, and was dangling from a filing cabinet. C.) In the B-wing pantry a power strip used to power equipment, was not secured, and was dangling from the counter. D.) Extension cords were in use in resident rooms 134 and 211. E.) Power-strips in rooms 134, 127, 123, 121, 216 and 211 were in use within 6 feet of a resident care area that did not meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Assistant, U.P. Maintenance Director, DON, and the Administrator acknowledged power-strips and extension cords were missed used throughout the facility. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		***agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Maintenance Director/Designee has removed or corrected the power cords/extension cords listed as follows:** **1.Coffee Pot in the unit managers office was removed.** **2.Power strip in unit managers office was secured appropriately.** **3.B-wing pantry power strip was secured appropriately.** **4.Extension cords in Resident Rooms 134 and 211 were removed.** **5.Power strips noted in resident rooms 134, 127, 123, 121, 216 and 211 were removed.** **4)How the corrective actions will be monitored:**	

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	155249	A. BUILDING 01 B. WING	11/10/2022

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			The Maintenance Director/designee will complete a documented visual inspection of 5 random offices or resident rooms weekly to ensure no unapproved power strips are present and that approved power strips are properly secured. Maintenance Director/designee will present the audit monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The audit will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/30/2022	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible			

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	construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 4 of 4 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states	K 0923	**K923 Gas Equipment Cylinder and Container Storage** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not***	11/30/2022

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	cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 40 on the C-wing. Findings include: Based on observations with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 2:04 p.m., in the C-wing oxygen storage/trans-filling room four 'E' type oxygen cylinders were standing upright on the floor and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Administrator acknowledged four 'E' type oxygen cylinders in the C-wing oxygen storage/trans-filling room were not properly chained or supported in a proper cylinder stand or cart. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		***constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **All cylinders noted in the 2567 have been properly secured in oxygen rooms.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will re-educate staff on proper storage and securing of oxygen cylinders. Maintenance Director/Designee will complete as weekly audit of oxygen room storage and contents to ensure safe storage and present the audit monthly**	

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			to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The report will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: 11/30/2022	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure transfilling of oxygen took place in 1 of 2 oxygen transfilling rooms that are separated from any portion of a facility in accordance with NFPA 99 2012 edition 11.5.2.3.1., and failed to provide proper signage in accordance with NFPA 99 11.5.2.3.1(3). This deficient practice could affect up to 40 residents in	K 0927	**K927 Gas Equipment-Transfilling Cylinders** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of***	11/30/2022

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	B-wing. Findings include: Based on observation with the Maintenance Assistant, U.P. Maintenance Director, DON, and Administrator on 11/10/22 at 1:15 p.m., the following was observed at the B-wing oxygen storage/transfer room: A.) The oxygen transfilling room contained liquid oxygen tanks, oxygen cylinders, oxygen concentrators and other oxygen supplies completely filling the room to the door. This condition dose not leave enough room for a person transfilling oxygen inside the room with the door closed. B.) The door to the room oxygen transfilling room was not provided with caution signs nor a sing that indicates when transfilling of oxygen is occurring. Based on interview at the time of observation, the Administrator and DON stated the signs for the O2 room were not reinstalled after painting of the door, and the extra items will need to be removed to make room for a person transfilling oxygen. The finding was reviewed with the Maintenance Assistant, U.P. Maintenance Director, DON, Administrator, and the Regional Director via phone call during the exit conference. 3.1-19(b)		***compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified** **No resident was found to be affected by the finding.** **2)How the facility identified other residents:** **All residents that reside at the community have the potential to be affected by the alleged deficient practice** **3) Measures put into place/ System changes:** **Maintenance Director/Designee has corrected the two oxygen transfilling rooms as follows:** **1.Oxygen Transfilling room (A) was cleaned out to allow enough room for a person transfilling oxygen to close the door.** **2.Oxygen Transfilling room (B) was properly labeled with the correct signage.** **4)How the corrective actions will be monitored:** **The Maintenance Director/designee will**	

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			complete a documented visual inspection of both oxygen transfilling rooms weekly to ensure proper signage is posted and that the rooms are free of supplies to allow closing during filling. Maintenance Director/designee will present the audit monthly to the QAPI Committee during QAPI Meetings to ensure completion of any new necessary updates and compliance. The audit will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 11/30/2022	