STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155272	A. BUILDING -- B. WING	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(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: 06/22/22 Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130 At this Emergency Preparedness survey, Allison Pointe Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 159 certified beds. At the time of the survey, the census was 129. Quality Review completed on 06/27/22	E 0000	Paper compliance requested.	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475,			

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

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

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	HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training.			

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	(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.			

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	(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies			

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	and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility	E 0037	Staff Training on Emergency	07/29/2022

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	failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Manual" documentation dated 06/08/22 with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Executive Director agreed staff training documentation on the emergency preparedness program conducted within the most recent twelve month period was not available for review at the time of the survey. This finding was reviewed with the Executive Director during the exit conference.		preparedness will be conducted. All residents have the potential to be affected. Emergency preparedness training will be provided to staff upon hire and annually. Documentation of emergency preparedness training will be reviewed monthly by administrator or designee and results reported through QAPI for 6 months with immediate corrections made as necessary.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements			

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	§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,			

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	clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a			

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	set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.			

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	*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must			

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	conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using			

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	the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise			

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	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise			

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	every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an			

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	emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation	E 0039	A table top exercise will be conducted to test the emergency plan. All resident have the potential to be affected. the maintenance director or designee will conduct a quarterly review of Fullscale drills, mock disaster drills, and/ or table top exercises or workshops to ensure compliance. Results of the quarterly review will be submitted through QAPI and	07/08/2022

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	of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness Manual" documentation dated 06/08/22 with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, the facility has not documented an additional full-scale drill, mock disaster drill, or table-top exercise or workshop to test the emergency plan as required. Based on interview at the time of record review, the Executive Director agreed the facility is currently experiencing the Covid pandemic but agreed documentation for an additional exercise to test emergency preparedness policies and procedures within the most recent twelve month period was not		any concerns addressed immediately.	

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	available for review. This finding was reviewed with the Executive Director during the exit conference.			
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system			

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	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 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.			

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	(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 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 review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Monthly Generator Exercise and Inspection (under load)" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record	E 0041	The current Maintenance director has been operating within compliance of this preventative measure since his hire date All residents have the potential to be affected. The Current maintenance director will continue to conduct the monthly load test and maintain documentation of that exercise within Direct Supply TELS Logbook documentation “Emergency Generators: Weekly Generator Exercise and Inspection (no load)” The documentation of the monthly	07/29/2022

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	review from 9:20 a.m. to 12:50 p.m. on 06/22/22, monthly load testing documentation for the facility's diesel fired emergency generator for the three month period of March 2022 through May 2022 was not available for review. In addition, based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Weekly Generator Exercise and Inspection (no load)" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, weekly inspection documentation for the facility's diesel fired emergency generator for the 13 week period of 03/17/22 through 06/21/22 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility 3 to 4 weeks ago and monthly load testing documentation and weekly generator inspection documentation lapsed because of staff turnover. This finding was reviewed with the Executive Director during the exit conference.		load test will be reviewed monthly for 6 months by the Administrator or designee to ensure compliance and reported through QAPI.	
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: 06/22/22 Facility Number: 000172 Provider Number: 155272 AIM Number: 100267130 At this Life Safety Code survey, Allison Pointe	K 0000	Paper compliance requested.	

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	Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility 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 and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 159 and had a census of 129 at the time of this survey. All areas where residents have customary access were sprinklered. The facility has two detached buildings providing facility storage services which were each not sprinklered. Quality Review completed on 06/27/22			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on observation and interview, the facility failed to maintain latching hardware on 2 of 10 sets of smoke barrier doors and 1 of 2 doors to the kitchen in accordance with 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to	K 0100	The latching hardware was corrected in the corridor door set by the payroll office The latching hardware was corrected in the corridor door set	07/29/2022

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	the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 30 residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the latching hardware at the top of the north door in the corridor door set by the Payroll Office failed to latch into the door frame when tested to close multiple times. The latching hardware at the top of the east door in the corridor door set by Room 132 also failed to latch into the door frame when tested to close multiple times. In addition, the corridor door to the kitchen nearest the kitchen rolling fire door was equipped with a self closing device but the self closing device failed to close and latch the door into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned doors failed to latch into the door frame when tested to close multiple times. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain fire resistance rating label documentation for 1 of 10 sets of smoke barrier doors in accordance with 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient		by room 132. The corridor door to the kitchen nearest the kitchen rolling fire door was corrected so that it closed and latched properly. All residents have the potential to be affected. The maintenance director will conduct weekly rounds to ensure all appropriate doors close and latch properly within the facility and document the results. The administrator or designee will review the results monthly and the results will be reported through QAPI. The fire resistance rating labels affixed to the top of each door in the corridor door set by the Payroll Office were made unobscured with paint so that they are now legible All residents have the potential to be affected. The fire resistance rating labels on doors that require them will be monitored and documented monthly by the Maintenance Director or designee and kept with preventative maintenance documentation TELS log book to ensure the fire resistance rating labels are legible The results of the monthly monitoring will be reviewed by the administrator or designee monthly for 6 months and reported through QAPI	

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	practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the fire resistance rating labels affixed to the top of each door in the corridor door set by the Payroll Office were painted and were not legible. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned fire resistance rating labels were painted and were not legible. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			
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 ensure 5 of 9 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 30 residents, staff and visitors if needing to exit the facility.	K 0211	The two pallets of large boxes stacked on the pallets and wrapped with plastic were moved prior to the end of the survey. Staff education to be provided. The wooden chair in the corridor outside of room 203 was removed.	07/29/2022

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	Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 8:45 a.m. to 9:05 a.m. on 06/16/22, the following was noted: a. two pallets of large boxes which were stacked on the pallets and wrapped with plastic were stored in the corridor outside the service hall in the path of egress for the ambulance entrance/exit. b. a wooden chair was stored in the corridor outside the service hall in the path of egress for the ambulance entrance/exit next to the stacked boxes on the pallets. The chair was not affixed to the floor or to the wall. c. the west door in the corridor door set serving as the entrance to the service hall from the ambulance entrance corridor was propped in the fully open position with a cardboard box. d. a wedge was used to prop the corridor door to the breakroom in the service hall in the fully open position. e. a wooden chair was stored in the corridor outside resident sleeping Room 203. The chair was not affixed to the floor or to the wall. f. a Hoyer lift was stored in the corridor at the exit door to the facility outside resident sleeping Room 205. g. a wooden chair was stored in the corridor outside the Linen Closet by resident sleeping Room 231. The chair was not affixed to the floor or to the wall. h. a large wheelchair was stored in the corridor at the exit door to the facility outside resident sleeping Room 232. i. a fan was plugged into a wall mounted electrical receptacle in the corridor outside Room 112. j. a small wastebasket was stored in the corridor outside the Payroll Office.		The hoyer lift in the corridor at the exit door to the facility outside room 205. The box propping open the west door in the corridor in the corridor door set serving as the ambulance entrance corridor was immediately removed. The large wheelchair in the corridor at the exit door to the facility outside room 232 was immediately removed. The fan plugged into the wall mounted electrical receptacle in the corridor outside room 112 was removed. The small waste basket outside the payroll office was removed. All residents have the potential to be affected. The Maintenance Director or designee will inspect the corridors weekly to ensure all means of egress are maintained free of obstructions and document the results. The results of the weekly inspection will be reviewed monthly be the Adminstrator or designee for 12 months with the results reported through QAPI	

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	Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the pallets for the large boxes and the wooden chair were still stored in the ambulance entrance corridor. The fan was still plugged into a wall mounted electrical receptacle in the corridor outside Room 112 and the small wastebasket was still stored in the corridor outside the Payroll Office. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned means of egress were not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			
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			

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	other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by 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			

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	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 13 delayed egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks allows approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: (a) The doors unlock upon actuation of an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, or upon the actuation of any heat detector or not more than two smoke detectors of an approved, supervised automatic fire detection system installed in accordance with Section 9.6. (b) The doors unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be	K 0222	The exit door to the outside of the facility by room 205 was equipped with delayed egress signage. Education provided to Maintenance Director All residents seeking to exit to the outside of the facility through the exit door by room 205 have the potential to be affected. The maintenance director or designee will make weekly rounds to ensure all delayed egress doors are equipped with the proper delayed egress signage and document the result The results will be monitored by the administrator or designee for 6 months and the results reported through QAPI	07/29/2022

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	by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This deficient practice could affect over 10 residents if needing to use the exit door by Room 205. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 8:45 a.m. to 9:05 a.m. on 06/16/22, the exit door to the outside of the facility by Room 205 was magnetically locked and could be released by entering a four digit code but the code was not posted to release the door to open. The exit door was not equipped with delayed egress signage. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the exit door to the outside of the facility by Room 205 was magnetically locked and could be released by entering a four digit code. The code was still not posted to release the doors to open. When the exit door was pushed to open, the door did not open but a beeping noise started at the keypad which indicated the door was a delayed egress door. The door released to open after pushing for 15 seconds. The door was not equipped with the necessary delayed egress signage. Based on interview at the time of the observations, the Executive Director stated the			

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	residents in the 200 Hall do not have a clinical diagnosis to be in a secure wing and agreed the exit door was not equipped with the necessary delayed egress signage. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observations and interview, the facility failed to ensure 1 of 13 exit discharge was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 30 residents, staff and visitors if needing to exit the facility from the west exit by the Therapy Room and if needing to exit the facility by the exit door by Room 232. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, overgrown bushes on each side of the means of egress in the exit discharge for the west exit by the Therapy Room and the exit discharge for the exit door by Room 232 was noted which	K 0271	The bushes on either side of the means of egress leading from the west exit by the therapy room were trimmed back. All residents seeking a means of egress leading from the west exit by the therapy room have the potential to be affected. The Maintenance Director or designee will make weekly rounds of the facility grounds to ensure all emergency means of egress to the outside from the facility are free of obstructions or impediments and document the results. The administrator or designee will review the documentation monthly for 6 months and the results will	07/29/2022

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	restricted the path of egress. The overgrown bushes were near the Ambulance entrance exit discharge. Based on interview at the time of the observations, the Executive Director agreed the overgrown bushes in the exit discharge would provide an impediment to full instant use in the case of fire or other emergency. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		be reviewed in QAPI.	
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review, observation and interview; the facility failed to document monthly testing for 3 of 4 battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3).	K 0291	The current Maintenance Director does conduct monthly testing of all battery backup lights in accordance with LSC 7.9 All residents have the potential to be affected. The Maintenance Director will conduct monthly testing of all batter back lights and record the results in Direct Supply TELS under “Emergency Lighting: Conduct a 30 second monthly functional test” The administrator or designee will review the results monthly for 12 months and the results will be reported thru QAPI.	07/29/2022

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	(5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Emergency Lighting: Conduct a 30 second monthly functional test" documentation with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, monthly functional testing documentation for three of four battery operated lights in the facility after 02/11/22 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility 3 to 4 weeks ago and battery operated light testing for the three month period of March 2022 through May 2022 lapsed because of staff turnover. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, two battery operated lights were noted at the generator location outside the facility and one battery operated light was noted in the main Mechanical Room in the service hall by the Maintenance Office. Each battery operated light operated when its respective test button was pushed. One additional battery operated lighting system was noted on the exit sign in the new dialysis room which illuminated when its respective test button was pushed. Interview with dialysis staff indicated the new dialysis wing became operational in early June 2022. This finding was reviewed with the Executive Director during the exit conference.			

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	3.1-19(b)			
K 0321 SS=D Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 9 hazardous areas such	K 0321	The active leaf door in the corridor door set to the washing machine	07/29/2022

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	as Laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 2 staff and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the active leaf door in the corridor door set to the washing machine room in the Laundry was propped in the fully open position by propping the handle side of the door up against a shelf in the room. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed propping the door open did not separate this hazardous areas from other spaces with smoke resistant partitions and doors. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		room in the Laundry was closed. Staff training provided. All residents have the potential to be affected The maintenance director will make rounds weekly to ensure hazardous areas are separated from other spaces by smoke resistant partitions and doors and document the results. The Administrator will review the results monthly for 12 months and report through QAPI.	
K 0351 SS=D Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be			

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	substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 storage rooms in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff only. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, box storage on shelving in the storage room by the Mechanical Room in the service hall was stored within six inches of the ceiling which provided sprinkler spray pattern obstruction for the ceiling mounted sprinkler in the room. Based on interview at the time of the observations, the	K 0351	The box on the shelving in the storage room by the mechanical room in the service hall was moved to a distance greater than 18” from the ceiling. Staff education to be provided. All residents have the potential to be affected. The maintenance director or designee will make weekly rounds to ensure sprinkler head spray patterns remain unobstructed and document the results.	07/29/2022

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	Executive Director agreed the sprinkler in the room had an obstructed spray pattern and had staffing remove the box storage in the room to greater than 18 inches below the ceiling. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves	K 0353	The current maintenance director currently conducts the monthly sprinkler system valve inspection and documents in Direct Supply TELS “Fire Sprinkler System: Monthly Fire Sprinkler Control Valve Visual Inspection” The current maintenance director currently will conduct the monthly	07/29/2022

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	shall be inspected weekly. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 13.3.2.2 states the valve inspection shall verify that the valves are in the following condition: (1) In the normal open or closed position (2) *Sealed , locked or supervised (3) Accessible (4) Provided with correct wrenches (5) Free from external leaks (6) Provided with applicable identification 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 could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS "Fire Sprinkler System: Monthly Fire Sprinkler Control Valve Visual Inspection" documentation with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, monthly sprinkler system valve inspection documentation after 03/07/22 was not available for review. Monthly sprinkler system valve inspection documentation for the two month period of April 2022 through May 2002 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility 3 to 4 weeks ago and monthly sprinkler system valve inspection documentation for the two month period of April 2022 through May 2022 lapsed because of staff turnover. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m.		sprinkler system valve inspection and document results in Direct Supply TELS “Fire Sprinkler System: Monthly Fire Sprinkler Control Valve Visual Inspection” All residents have the potential to be affected. The administrator or designee will review the documentation monthly for 12 months and report the results through QAPI. The current maintenance director conducts the In house fire sprinkler visual inspection weekly and records the results in Direct Supply TELS “Fire Sprinkler Visual Inspection – Weekly” All residents have the potential to be affected. The maintenance director will conduct in house fire sprinkler visual inspection weekly and record the results in Direct Supply TELS “ Fire Sprinkler Visual Inspection – Weekly” The results will be reviewed monthly by the Administrator or designee Monthly for 12 months and the results reported through QAPI. The two conduits penetrating the suspended ceiling tile next to the range hood in the kitchen will be corrected to be within compliance. The ceiling tile in the corridor outside room 207 was replaced. All residents have the potential to be affected. The maintenance director/designee will perform	

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	to 5:00 p.m. on 06/22/22, the facility has supervised dry sprinkler systems. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. 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 could affect all residents, staff, and visitors. Findings include: Based on review of Direct Supply TELS "Fire Sprinkler System: In-House Fire Sprinkler Visual Inspection - Weekly" documentation with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, weekly sprinkler gauge inspection documentation for the facility's dry sprinkler systems for the 13 week period of 03/14/22 through 06/21/22 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility 3 to 4 weeks ago and weekly sprinkler system gauge inspection documentation for the 13 week period of 03/14/22		weekly audits to ensure facility is in compliance. The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately. The ceiling mounted sprinkler in the 200 hall housekeeping closet will be replaced. All residents have the potential to be affected. The maintenance director/designee will perform weekly audits to ensure facility is in compliance. The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.	

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	through 06/21/22 lapsed because of staff turnover. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the facility has supervised dry sprinkler systems. This finding was reviewed with the Executive Director during the exit conference. 3-1.19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 kitchens and in the corridor in 1 of 15 smoke compartments. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 15 residents, staff, and visitors. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, two conduits penetrated the suspended ceiling tile next to the range hood in the kitchen. In addition, two holes were noted in a ceiling tile in the corridor outside resident sleeping Room 207. The holes would not trap hot air and gases which would delay sprinkler activation. Based on interview at the time of the observations, the Executive Director agreed the holes in the ceiling			

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	tiles would delay sprinkler activation. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of over 100 sprinkler heads in the facility were free of corrosion were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over 15 residents, staff and visitors in the vicinity of the 200 Hall Housekeeping closet. Findings include: Based on observations with the Executive Director and the Maintenance Director during a			

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	tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the ceiling mounted sprinkler in the 200 Hall Housekeeping closet was green with corrosion. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned automatic sprinkler location was not free of corrosion. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are			

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	permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 5 of over 50 corridor doors to resident sleeping rooms had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 50 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 8:45 a.m. to 9:05 a.m. on 06/16/22, a wedge was used to prop the corridor door to the breakroom in the service hall in the fully open position. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, a one inch gap was noted in between the door and the door stop near the latching mechanism for the corridor door to Room 101 when the door was in the fully closed and latched position. The Brookshire nurse's station	K 0363	The wedge used to prop the corridor to the breakroom in the service hall was removed. The door to room 101 will be adjusted to reduce the gap when closed. The Brookshire nurses station supply closet corridor door latching mechanism will be adjusted, allowing it to latch and close properly The wooden chair against the corridor door to room 201 was removed. The cardboard box against the corridor door to the respiratory office was removed. Residents residing in the corridor where room 201 is located have the potential to be affected. Residents residing in the corridor where room 101 is located have the potential to be affected.	07/29/2022

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	supply closet corridor door latching mechanism failed to latch into the latching plate on the door frame when tested to close multiple times. A wooden chair was stored up against the corridor door to Room 201. A cardboard box was placed on the floor up against the corridor door to the Respiratory Office. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed the aforementioned corridor doors had an impediment to closing and latching into the door frame or would not resist the passage of smoke. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		**The maintenance director/designee will perform weekly audits to ensure facility is in compliance.** **The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.**	
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on record review, observation and interview; the facility failed to ensure 1 of 10 smoke barrier walls were protected to maintain the fire resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed	K 0372	**The smoke barrier wall near the payroll door will have the smoke barrier restored by removing the fusible link to the fire damper. Training will be**	07/29/2022

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	in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the corridor door set by the Payroll Office. Findings include: Based on review of floor plan documentation with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, an existing smoke barrier wall is near the Payroll Office. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, one fire damper was noted in the smoke barrier wall above the suspended ceiling above the corridor door set by the Payroll Office. The fire damper shutter was held in the fully open position with a fusible link. The opening in the smoke barrier wall caused by the open fire damper would not resist the passage of smoke. Based on interview at the time of the observations, the Executive Director contacted the Corporate owner's office by telephone to verify if the fire damper was in a smoke barrier wall or a fire barrier or a non-rated assembly. The Executive Director stated the Corporate owner's office stated the wall was a fire barrier wall but the Executive Director agreed the open fire damper would not resist the passage of smoke. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		**provide to maintenance on inspection of fire/smoke barriers for smoke resistance All residents have the potential to be affected** **The maintenance director or designee will perform monthly audits to ensure the facility is in compliance.** **The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.**	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie			

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	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 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 1 Therapy Room smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the Therapy Room. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the Therapy Office door inside the Therapy Room is in a smoke barrier wall which goes from outside wall to outside wall and was not equipped with a self closing device. Based on interview at the time of the observations, the Executive Director and the Maintenance Director	K 0374	**The therapy office door inside the therapy room was equipped with a self closing device. Training provided to maintenance staff on importance of door closers and smoke barrier wall doors. Residents utilizing the therapy gym have the potential to be affected.** **The maintenance director/designee will perform Monthly audits to ensure facility is in compliance.** **The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.**	07/29/2022

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	agreed the Therapy Office door was not equipped with a self closing device. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			
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 junction boxes were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect over 12 residents, staff and visitors in the vicinity of Room 228. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the electrical junction box mounted above the suspended ceiling on the smoke barrier	K 0511	A cover plate was installed on the electrical junction box mounted above the suspended ceiling on the smoke barrier wall by room 228 All residents residing in the corridor where room 228 is located have the potential to be affected.**The maintenance director/designee will perform weekly audits to ensure facility is in compliance.The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.**	07/08/2022

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	wall by Room 228 was without a cover which exposed the spliced electrical wiring in the junction box. Based on interview at the time of the observations, the Executive Director agreed the aforementioned electrical junction box location did not have its cover plate installed which exposed the spliced electrical wiring in the junction box. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms.	K 0711	**The written fire safety plan floor plan documentation was updated to identify the location of fire doors, fire barrier walls, smoke doors, or smoke barrier walls in the facility.** **All residents have the potential to be affected.**	07/15/2022

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	5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Emergency Preparedness Policy Manual" documentation dated 06/08/22 with the Executive Director during the exit conference from 5:00 p.m. to 6:00 p.m. on 06/22/22, the written fire safety plan floor plan documentation did not consistently identify the location of fire doors, fire barrier walls, smoke doors or smoke barrier walls in the facility. The aforementioned emergency preparedness documentation contained multiple floor plans each with differing locations of smoke barrier walls in the facility. Based on interview at the time of the exit conference, the Executive Director agreed the different floor plans for the facility did not consistently state a smoke barrier wall was or was not located by the Payroll Office. In addition, the Executive Director could not locate all 9 items listed in NFPA 101, Section 19.7.2.2 in the written fire safety plan in the emergency preparedness documentation for the facility. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)		**The fire safety plan will be updated to include all 9 items listed in NFPA 101 section 19.7.2.2.** **The fire safety plan will be reviewed, approved and updated as necessary by members of the QAA committee annually.**	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations			

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	Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on record review, observation and interview; the facility failed to ensure smoking materials were deposited into ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design in 1 of 3 outdoor areas where smoking was taking place. This deficient practice could affect over 5 staff and visitors in the vicinity of the outdoor staff smoking area at the ambulance entrance on the northwest side of the facility.	K 0741	**All cigarette butts were removed from the ambulance entrance and along the concrete path and mulch as well as outside the ambulance entrance doors. Staff education to be provided.** **All residents have the potential to be affected.** **The maintenance**	07/22/2022

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	Findings include: Based on review of "Smoking Policy" documentation with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, assessed residents and staff are allowed to smoke in designated outdoor smoking areas. Based on interview at the time of record review, the Maintenance Director stated assessed residents and staff are allowed to smoke only in designated outdoor areas. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, well over 50 cigarette butts were strewn on the ground outside the facility all along the concrete path of the ambulance entrance as well as in the mulch area just outside the ambulance entrance doors. Ashtrays and metal containers with self-closing cover devices into which ashtrays can be emptied of noncombustible material and safe design were provided at this outdoor location where staff smoking was taking place but extinguished cigarette butts were not consistently deposited into the designated containers. Based on interview at the time of the observations, the Executive Director and the Maintenance Director agreed cigarette butts were deposited on the ground all along the ambulance entrance path outside the building and in the mulch area and were not consistently deposited into the ashtrays and metal containers with self-closing cover devices into which were provided at this outdoor location where staff smoking was taking place. This finding was reviewed with the Executive Director during the exit conference.		**director/designee will perform daily audit to ensure facility is in compliance and that all cigarette butts are disposed of properly.** **Results of the audits will be brought to QAPI monthly for six months or until 100% compliance is achieved and address any concerns immediately.**	

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	3.1-19(b)			
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in enclosures housing electrical apparatus in 2 of over 2 electrical rooms. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A)(1), (2) and (3). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect 15 vent unit residents. Findings include: Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, soiled linen and trash carts were stored directly underneath the wall mounted electrical	K 0911	**All obstructions were removed from under the wall mounted electrical panel identified as EMEQ-L-2 in the Brookshire soiled linen room with the attic access door across from the nurse's station. Staff education to be provided.** **All residents have the potential to be affected.** **The maintenance director/designee will perform weekly audits to ensure facility is in compliance.** **The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately.**	07/15/2022

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	155272	A. BUILDING 01 B. WING	06/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

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	panel identified as "CCP-4" in the soiled linen room by Room 200. Concentrators and soiled linen and trash carts were stored directly underneath the wall mounted electrical panel identified as "EMEQ-L2" in the Brookshire soiled linen room with the attic access door across from the nurse's station. Each electrical panel was affixed with signage stating not to store items in front of or underneath each panel and each electrical panel contained isolated circuit breakers supporting vent unit bed locations. Based on interview at the time of the observations, the Executive Director agreed access and working space was not maintained in front of the two wall mounted electrical panels at the aforementioned locations. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			
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.			

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	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, observation and interview; the facility failed to document emergency generator monthly load testing for 3 months of the most recent 12 month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and	K 0918	**The new maintenance director does conduct monthly load testing of the generator**All residents have the potential to be affected.The maintenance director will conduct monthly load testing of the generator and record the results in TELS.The Maintenance Director/Designee will bring results of the audits to QAPI for six months or until 100% compliance is achieved and address any concerns immediately. Buckeye Power Sales, our vendor will run a 4hr load test above 75% on our generator Annual load bank testing will be documented as being conducted pursuant to NFPA 110. This could affect all residents, staff	07/29/2022

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	shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Monthly Generator Exercise and Inspection (under load)" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, monthly load testing documentation for the facility's diesel fired emergency generator for the three month period of March 2022 through May 2022 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility 3 to 4 weeks ago and monthly load testing documentation for the three month period of March 2022 through May 2022 lapsed because of staff turnover. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the facility has a diesel fired emergency generator located outside of the building on the northwest side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 110 kW. This finding was reviewed with the Executive Director during the exit conference.		and visitors. The maintenance director/designee will complete monthly audits to ensure annual supplemental load testing was conducted pursuant to NFPA 110 by Buckeye. The maintenance director or designee, after completing monthly audits will report to the QAPI committee on a quarterly basis to ensure total run time for the test at greater than 75% load was greater than one hour. The current maintenance director does conduct weekly generator exercise and inspection (no load) and records the results. All residents have the potential to be affected. This could affect all residents, staff and visitors. The maintenance director will conduct weekly generator exercise and inspection (noload) and record the results The results will be reviewed by the Administrator monthly for 6 months or until compliant and the results reported through QAPI.	

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	3.1-19(b) 2. Based on record review, observation and interview; the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads (Load Bank Test) at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Monthly Generator Exercise and Inspection (under load)" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, monthly load testing documentation for the			

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	facility's diesel fired emergency generator prior to March 2022 indicated the lowest load kW achieved during any monthly load test was 34%. Monthly load testing documentation for the facility's diesel fired emergency generator for the three month period of March 2022 through May 2022 was not available for review. Based on review of the generator contractor's "3 Phase Load Bank Test(1)" documentation dated 09/15/21 with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, annual supplemental load testing documentation indicated supplemental load bank testing did not exceed 70 percent of the EPS nameplate kW rating for any amount of time during the 90 minute annual load bank test. Based on interview at the time of record review, the Maintenance Director stated additional annual load bank testing documentation was not available for review. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the facility has a diesel fired emergency generator located outside of the building on the northwest side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 110 kW. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b) 3. Based on record review, observation and interview; the facility failed to ensure a written record of weekly inspections for the emergency generator set was maintained for 13 weeks of the most recent 52 week period. This deficient practice could affect all residents, staff and			

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	visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Weekly Generator Exercise and Inspection (no load)" documentation for the most recent twelve month period with the Executive Director and the Maintenance Director during record review from 9:20 a.m. to 12:50 p.m. on 06/22/22, weekly inspection documentation for the facility's diesel fired emergency generator for the 13 week period of 03/17/22 through 06/21/22 was not available for review. Based on interview at the time of record review, the Maintenance Director stated he started working at the facility 3 to 4 weeks ago and weekly generator inspection documentation for the 13 week period of 03/17/22 through 06/21/22 lapsed because of staff turnover. Based on observations with the Executive Director and the Maintenance Director during a tour of the facility from 1:30 p.m. to 5:00 p.m. on 06/22/22, the facility has a diesel fired emergency generator located outside of the building on the northwest side of the property. The manufacturer's nameplate rating for the generator indicated the generator was rated at 110 kW. This finding was reviewed with the Executive Director during the exit conference. 3.1-19(b)			