STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155255	A. BUILDING -- B. WING	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

(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: 09/19/22 Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490 At this Emergency Preparedness survey, Celebrate Senior Living of Fort Wayne was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 118 and had a census of 68 at the time of this survey. Quality Review completed on 09/26/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law; or – Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a).			

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

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

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	155255	A. BUILDING -- B. WING	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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

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	155255	A. BUILDING -- B. WING	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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	Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:01 a.m., the EEP had a revision date 04/23/21, no other documentation could be found to show the EPP was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0004	Deficiency- E004 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. A facility form was put in place to show annual review and updates of the Facility Emergency Plan. The current facility plan was reviewed and updated on 9-28-22 by the Administrator and Maintenance Director. 4. The sign off form put in place will be reviewed in QA for 6 months or until a 100% compliance is obtained to ensure any changes/updates have been reviewed and signed off on by the ED and/or designee timely. 5. The above changes will be in place by 10-10-22.	10/10/2022
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency			

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	155255	A. BUILDING -- B. WING	09/19/2022

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

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	155255	A. BUILDING -- B. WING	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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	*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:01 a.m., the EEP Policies and Procedures had a revision date 04/23/21, no other documentation could be found to show the EPP Policies and Procedures were reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Policies and Procedures have been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator	E 0013	Deficiency- E013 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. A facility form was put in place to show annual review and updates of the Facility Emergency Policies and Procedures. The current facility plan was reviewed and updated on 9-28-22 by the Administrator and Maintenance Director. 4. The sign off form put in place will be reviewed in QA for 6 months or until a 100% compliance is obtained to ensure any changes/updates have been reviewed and signed off on by the ED and/or designee timely. 5. The above changes will be	10/10/2022

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CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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	and Maintenance Director during the exit conference.		in place by 10-10-22.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Communication plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:01 a.m., the EEP Communication plan had a revision date 04/23/21, no other documentation could be found to show the EPP Communication plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP	E 0029	Deficiency- E029 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. A facility form was put in place to show annual review and updates of the Facility Emergency Communication Plan. The current facility plan was reviewed and updated on 9-28-22 by the Administrator and Maintenance Director. 4. The sign off form put in place will be reviewed in QA for 6 months or until a 100%	10/10/2022

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	Communication plan has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference		compliance is obtained to ensure any changes/updates have been reviewed and signed off on by the ED and/or designee timely. 5. The above changes will be in place by 10-10-22.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.			

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	*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and			

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	updated at every 2 years. Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Training and Testing plan at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:01 a.m., the EEP Training and Testing plan had a revision date 04/23/21, no other documentation could be found to show the EPP Training and Testing plan was reviewed and updated within the last year. Based on an interview during records review, the Administrator and Maintenance Director stated the documentation to show the EEP Training and Testing plan has been reviewed or updated within the last year could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0036	Deficiency- E036 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. A facility form was put in place to show annual review and updates of the Facility EPP Training and Testing Plan. The current facility plan was reviewed and updated on 9-28-22 by the Administrator and Maintenance Director. 4. The sign off form put in place will be reviewed in QA for 6 months or until a 100% compliance is obtained to ensure any changes/updates have been reviewed and signed off on by the ED and/or designee timely. 5. The above changes will be in place by 10-10-22.	10/10/2022
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).			

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	*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, 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.			

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	(v) Maintain documentation of all emergency preparedness training. (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			

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CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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	whom to contact in case of an emergency. (iv) Maintain documentation of all training. (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			

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	155255	A. BUILDING -- B. WING	09/19/2022

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CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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	equipment. (v) If the emergency preparedness policies 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			

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	preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). 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 all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:11 a.m., no documentation of annual EEP training and no documentation to show staff could demonstrate knowledge of the EPP was available for review. Based on an interview at the time of records review, the Maintenance Director and the Administrator stated annual staff EPP training documentation was not found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0037	Deficiency- E037 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. An all staff in-service is being completed on annual EEP training. In-service completed with department heads on demonstrating comprehension of staff drills and documentation on effectiveness. Education completed by facility Administrator. 4. New hires, annual training and required staff drills will be reviewed in QA for 6 months or until a 100% compliance is obtained to ensure compliance. 5. The above changes will be in place by 10-10-22.	10/10/2022
E 0039 SS=C 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 §416.54(d)(2), §418.113(d)(2), §441.184(d)(2),			

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	§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, 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. (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 set of problem statements, directed			

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	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. *[For PRFTs at §441.184(d), Hospitals at			

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	§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 conduct exercises to test the emergency			

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	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 the emergency procedures. The [LTC facility,			

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	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 that is community-based; or			

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	(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 every 2 years; or.			

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	(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 emergency plan. If the OPO experiences an			

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	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 LTC facility failed analyze the facility's response to and maintain complete documentation of all Emergency Preparedness Program drills. 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 of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a	E 0039	Deficiency- E039 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. In-service completed with department heads on demonstrating comprehension of staff drills and documentation on effectiveness. Education completed by facility Administrator on 9-28-22.	10/10/2022

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	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 records review with the Administrator and Maintenance Director on 09/19/22 at 10:41 a.m., documentation for the annual exercises conducted on 07/09/22 and on 08/19/22 were incomplete. Both exercises did not show if the facility's response was analyzed to ensure the EPP policies were effective. Based on interview at the time of records review, the Administrator and the Maintenance Director stated no documentation for analyzing the LTC facility's response was completed. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		4. Emergency Preparedness Drills required staff drills will be reviewed in QA for 6 months or until a 100% compliance is obtained to ensure compliance. 5. The above changes will be in place by 10-10-22.	

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

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	155255	A. BUILDING -- B. WING	09/19/2022

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CELEBRATE SENIOR LIVING OF FORT WAYNE	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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	482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7,			

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	2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:22 a.m., the generator lacked monthly load testing required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the generator was missing some of the required testing. The findings were reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	Deficiency- E041 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Facility Maintenance Director or designee is now completing the weekly generator testing for under-load and run test. SafeCare contracted for 4 hour load bank testing and fuel sampling test. Maintenance Director and maintenance assistant educated on needed documentation by the facility Administrator. 4. Generator testing will be reviewed in QA for 6 months or until a 100% compliance is	10/10/2022

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			obtained to ensure compliance. 5. The above changes will be in place by 10-10-22.	
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: 09/19/22 Facility Number: 000158 Provider Number: 155255 AIM Number: 100291490 At this Life Safety Code survey, Celebrate Senior Living of Fort Wayne 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, areas open to the corridors, and seven resident rooms on the Rehabilitation Hall. The remaining 57 resident rooms had battery operated smoke detectors. The facility is certified for 118 beds and had a census of 68 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered.	K 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law; or – Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.	

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	Quality Review completed on 09/26/22			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls that separated health care from assisted living was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing,	K 0131	Deficiency- K131 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Penetration in the barrier wall was corrected. The unsealed ends of the pipe sleeves in the wall were corrected. A facility walk through was completed to identify	10/10/2022

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	and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect 20 on rehab-hall. Findings include: Based on observation with the Maintenance Director on 09/19/22 at 1:00 p.m., above the drop ceiling of the separation fire barrier in rehab had two unsealed ends of pipe sleeves in the wall. Based on interview at the time of observation, the Maintenance Director agreed the separation fire barrier had unsealed pipe sleeves through the wall. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		any other needed repairs to barrier walls. 4. Repairs identified will be reviewed in QA for 6 months or until a 100% compliance is obtained to ensure compliance. The above changes will be in place by 10-10-22	
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			

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

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	installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 2 of 9 exit doors were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 15 residents using 2 exits Findings include: Based on observation with the Maintenance Director on 09/19/22 between 12:10 p.m. and 12:30 p.m., the exit doors in therapy and on the rehab-hall were marked as a facility exits, were magnetically locked, and could be opened by entering a four-digit code on the access control pads, but the codes were not posted at the exits. Based on interview at the time of observation, the Maintenance Director agreed the codes to open the two exit doors were not posted by the access control pads.	K 0222	Deficiency- K222 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. The code was posted on the key pad to the identified exit door noted in violation to Egress State requirements. Staff education being completed by facility Administrator and/or designee. 4. Further compliance will be reviewed/discussed in QA for 6 months or until a 100% compliance is obtained to ensure no further exit doors are without codes posted. 5. The above changes will be in place by 10-10-22.	10/10/2022

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	The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0227 SS=E Bldg. 01	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 Based on observation and interview, the facility failed to ensure 1 of 1 exit discharge ramp with handrails was readily accessible and safe to use at all times. LSC Section 7.2.5.4.1 states guards complying with Section 7.2.2.4 shall be provided for ramps, Section 7.2.5.4.2 states handrails complying with Section 7.2.2.4 shall be provided along both sides of a ramp run with a rise greater than 6 in. (150 mm). This deficient practice could affect 25 residents evacuated from the southwest hall and smoking area. Findings include: Based on an observation with the Maintenance Director on 09/19/22 at 12:35 p.m., the handrails for the exit ramp from southwest hall were loose, broken from their supports, and could be pushed back and forth. This condition made the handrails unsteady for someone using the handrails for support. Based on an interview at the time of observation, the Maintenance Director stated the railing was loose and needed repaired. The finding was reviewed with the Administrator and Maintenance Director during the exit	K 0227	1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Handrail will be replaced. Staff education being completed by facility Administrator and/or designee on handrail requirements and completing maintenance work orders if/when identified. 4. Work orders will be reviewed/discussed in QA for 6 months or until a 100% compliance is obtained to ensure timely repairs. 5. The above changes will be in place by 10-10-22.	10/10/2022

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	conference. 3.1-19(b)			
K 0321 SS=E 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	K 0321	Deficiency- K321	10/10/2022

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	failed to ensure 1 of 1 laundry/maintenance rooms which contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 09/19/22 at 12:12 p.m., in the laundry/maintenance room which contained fuel fired hot water heaters had a 2-inch unsealed gap around a drywall patch above the hot water heater in the maintenance closet. Based on interview at the time of the observation, the Maintenance Director agreed the laundry/maintenance room contained an unsealed gap in the ceiling. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Unsealed gap around drywall in laundry/maintenance room was corrected. Staff education being completed by facility Administrator with the Maintenance Director and Maintenance assistant. 4. Work orders will be reviewed/discussed in QA for 6 months or until a 100% compliance is obtained to ensure timely repairs. 5. The above changes will be in place by 10-10-22.	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for			

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	integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice could affect 5 in the therapy gym. Findings include: Based on observation with the Maintenance Director on 09/19/22 at 12:25 p.m., in the therapy gym there was a smoke detector next to an air return where air flow would prevent proper operation of the detector. The detector was about 12 inches from the vent. Based on interview at the time of observation, the Maintenance Director agreed the smoke detector was in the direct airflow from the return and was within 12 inches of the vent. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0341	Deficiency- K341 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Smoke detector was moved away from the air return. 4. Smoke detectors audit will be reviewed/discussed in QA for 6 months or until a 100% compliance is obtained to ensure no other concerns are identified on location. 5. The above changes will be in place by 10-10-22.	10/10/2022
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program			

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	complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice affects all occupants in the facility. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:01 a.m., no documentation was provided regarding a visual inspection of the fire alarm system six months after the annual fire alarm inspection conducted on 12/23/21. Based on interview at the time of records review, the Maintenance Director agreed a visual inspection of the fire alarm system was due by 06/23/22 and stated the inspection was not conducted by the previous Maintenance Director.	K 0345	Deficiency- K345 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Visual fire inspection of the fire alarm system was completed by Safecare. 4. Required inspections will be reviewed in QA for 6 months or until a 100% compliance is obtained to ensure no further delays. 5. The above changes will be in place by 10-10-22.	10/10/2022

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	155255	A. BUILDING 01 B. WING	09/19/2022

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	This finding was reviewed with the Administrator and Maintenance 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 Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air	K 0353	Deficiency- K353 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. The monitoring form was put in place for the weekly dry pipe gauge checks and monthly wet pipe gauge and valve checks. This monitoring form will be maintained by the Maintenance	10/10/2022

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	pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:19 a.m., there was no weekly dry pipe gauge checks and no monthly wet pipe gauge and valve checks for the past 12 months. During an interview at the time of record review, the Maintenance Director stated the documentation of gauge and valve checks were lost by the previous Maintenance Director and could not be found. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Director or designee. 4. The monitoring form will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 10-10-22.	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on interview and observation; the facility failed to ensure 1 of 2 rehabilitation patient treatment areas were not open to the corridor. LSC 19.3.6.1 states corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5 (see also 19.2.5.4), 19.3.6.1 (7)	K 0361	Deficiency- K361 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the	10/10/2022

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	states spaces, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area. This deficient practice could affect 5 residents. Findings include: Based on observation with the Maintenance Director on 09/19/22 at 1:01 p.m., therapy equipment was set up and being used in the dining room which was open to the corridor. Based on interview at the time of observation, the Maintenance Director and the Administrator stated the therapy took place in the back of the dining room which was open to the corridor. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		cited deficiency. 3. Therapy equipment and treatments were moved back to the therapy gym. Staff education being completed. 4. Education will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 10-10-22.	
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			

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	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 permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 50 room corridor doors on the southwest wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect 12 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 09/19/22 at 10:01 a.m., the corridor door to room # 2 did not latch into the frame when	K 0363	Deficiency- K363 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Door was corrected to latch. An audit was completed and found no other concerns. 4. Audits will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be	10/10/2022

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	tested. Based on interview at the time of observation, the Maintenance Director stated the corridor door would not latch into the door frame. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		in place by 10-10-22.	
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 observation and interview, the facility failed to ensure penetrations through 1 of 4 smoke barrier walls smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits,	K 0372	Deficiency- K372 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. The corridor door on southwest unit was fixed. Audit completed and found no other concerns. 4. Audit will be reviewed in QA for 6 months or until a 100%	10/10/2022

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	pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 30 residents in one two smoke compartments. Findings include: Based on observation with the Maintenance Director on 09/19/22 at 1:20 p.m., in the attic Hope Springs smoke wall there was an unsealed 2x4 inch hole around a pipe. Based on interview at the time of observation, the Maintenance Director agreed there were unsealed penetrations in the Hope Springs smoke barrier. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		compliance is obtained. 5. The above changes will be in place by 10-10-22.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors			

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	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 2 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 40 residents in three smoke compartments. Findings include: Based on observation with the Administrator and Maintenance Director on 09/19/22 at 11:32 a.m., the sets of smoke barrier doors to the North and South halls had the door coordinating devices removed allowing the door leaf with the astragal to close first. This condition creates a one-inch gap between the doors when shut. Based on interview during the time of observations, the Maintenance Director acknowledge the 2 set of smoke doors require door coordinating devices and stated the coordinating devices must have been removed by the previous Maintenance Director. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0374	Deficiency- K374 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. North and South hall door coordinating device are scheduled to be replaced by facility vendor, SafeCare. 4. Work orders will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 10-10-22.	10/10/2022

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K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 4 electrical outlet boxes in room 409 was securely fastened in place. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 406.5 states Receptacles shall be mounted in boxes or assemblies designed for the purpose, and such boxes or assemblies shall be securely fastened in place unless otherwise permitted elsewhere in this Code. This deficient practice could affect 2 residents in the room 409. Findings include: Based on observation with the Maintenance Director on 09/19/22 at 1:08 p.m., in the hall by the main nurse's station there was a receptacle pulled out from the wall exposing metal terminals. Based on interview at the time of observation, the Maintenance Director agreed the electrical receptacle was pulled away from the wall exposing metal terminals. This finding was reviewed with the Administrator and Maintance Director during the exit conference. 3.1-19(b)	K 0511	Deficiency- K511 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. The outlet identified by the nurses' station was corrected. An audit was conducted and found no other issues. 4. Work orders will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 10-10-22.	10/10/2022

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct fire drills or documented orientation training on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver (03/24/20 - 06/07/22) states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and patients. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 10:01 a.m., the following shifts were missing	K 0712	Deficiency- K712 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Fire drills have been conducted with current Maintenance Director and Administrator. Staff education being completed on requirements for fire drills. 4. Fire drills will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 10-10-22.	10/10/2022

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	documentation of a completed fire drill or documented orientation training: a) Third shift in the third quarter of 2021 b). All shifts in the fourth quarter of 2021. c). Second and third shifts in the first quarter of 2022 d) All shifts in the second quarter of 2022 Based on interview at the time of record review, the Maintenance Director agreed there were missing fire drills and staff has not been trained in the fire safety procedures and stated fire were not conducted by the previous Maintenance Director. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)			
K 0761 SS=E Bldg. 01	Based on observation and interview, the facility failed to conduct annual testing of 1 of 1 rolling fire doors and 1 of 1 separation fire doors in accordance with NFPA 80 5.2.1 which requires fire door assemblies to be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect 25 residents in the main dining room. Findings include: Based on observation with the Maintenance Director on 09/19/22 between 11:30 a.m. and 12:30 p.m., there was a rolling fire door/window between the kitchen and dining room and the tag on the	K 0761	Deficiency- K761 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. The rolling fire door inspection was being scheduled prior to the survey on 9-19-22. The inspection is scheduled 10-7-22 with SafeCare. 4. Required Life Safety inspections will be reviewed in QA for 6 months or until a 100% compliance is obtained.	10/10/2022

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	rolling fire door indicated the last annual test was performed on 10/13/20. Also, there was no annual inspection for the fire door that separated health care and assisted living. Based on interview at the time of observation, the Maintenance Director stated the fire rolling door/window has not been inspected since October of 2020 and no inspection documentation could be found for the separation fire door. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		5. The above changes will be in place by 10-10-22.	
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 for 2 of 2 electrical room panels. 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 access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment,	K 0911	Deficiency- K911 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Items found stored in front of the electrical panels are being moved to an appropriate storage room. Staff education being completed by facility Administrator.	10/10/2022

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	servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A)(1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A) (1) which the minimum clear distance is 3 feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater. In all cases, the work space shall permit at least a 90 degree opening of equipment doors or hinged panels. 110.26(A)(3) states the work space shall be clear and extend from the grade, floor, or platform to a height of 61?2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could all residents due to the access to the building's life safety electrical panel was blocked. Findings include: Based on observations with the Maintenance Director on 09/19/22 at 12:58 p.m. the life safety electrical panels and equipment electrical panels in the laundry mechanical room were blocked from access with items stored in front of the panels. Based on interview at the time of the observations, the Maintenance Director agreed items were stored within the working space in front of the electrical panels. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		4. Storage areas will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 10-10-22.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155255	A. BUILDING 01 B. WING	09/19/2022

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K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on observation, records review, and interview the facility failed to maintain 1 of 1 diesel	K 0918	Deficiency- K918	10/10/2022

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	power generators in accordance with NFPA 99 2012 Chapter 6 which requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 09/19/22 at 11:01 a.m., the following required testing documentation was not available for review: a.) Generator exercised under load monthly for a minimum of 30 minutes. b.) Generator inspected weekly. c.) Generator annual fuel quality test for diesel generators. d.) Battery powered generator task lighting testing for 30 seconds monthly. c.) Battery powered generator task lighting testing for 90 minutes minute annually. Based on observation at 11:15 a.m., the battery powered light at the generator did not work when tested. Based on an interview at the time of record review and observation, the Maintenance Director stated the inspection and testing documentation for the generator was lost by the previous Maintenance Director, no other generator paperwork could be found, and the battery powered light at the generator was not working. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. 3. Facility Maintenance Director or designee is now completing the weekly generator testing for under-load and run test. SafeCare is contracted for the 4hour load bank testing and fuel sampling test. The battery powered generator light was repaired. Maintenance Director and maintenance assistant was educated on needed documentation and functioning of the battery powered generator lighting. 4. Generator testing will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 10-10-22.	

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K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord power strips in patient care locations met the required UL rating of 1363A or 60601-1. This deficient practice can affect 5 residents in the therapy gym. Findings include: Based on observations during a tour of the facility with the Maintenance Director on 9/19/22 at 12:26 p.m., a power strip was in use in the therapy gym where resident care was provided that did not	K 0920	Deficiency- K920 1. No residents were affected by the cited deficiency. 2. No residents were identified for potential to be affected by the cited deficiency. The power strip not meeting the required rating was removed from the therapy gym. Audit was completed and no further power strip not meeting the required rating were found.	10/10/2022

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	meet 1363A or 60601-1. Based on interview at the time of observation, the Maintenance Director agreed a power strip was in use in a resident care area and did not meet 1363A or 60601-1. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		3. The appropriate power strip with required UL rating was provided to the therapy department. Staff education being completed by the Administrator. 4. The Audit will be reviewed in QA for 6 months or until a 100% compliance is obtained. 5. The above changes will be in place by 10-10-22.	