STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155621	A. BUILDING -- B. WING	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

(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 Dates: 10/04/23 and 10/05/23 Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510 At this Emergency Preparedness survey, River Bend Nursing and Rehabilitation 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 113 certified beds and had a census of 63 at the time of this visit. Quality Review completed on 10/13/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 2, 2023, to the annual Emergency Preparedness Survey completed on October 5, 2023. The facility respectfully requests a desk review.	
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).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christina Malvern	Administrator	11/07/2023

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

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	*[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			

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	and others. (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			

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	participants of what to do, where to go, and 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			

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	systems and signals and firefighting 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			

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	CMHC must provide emergency 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 review of the Emergency Preparedness plan on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, no documentation of annual Emergency Preparedness training and no documentation to show staff could demonstrate knowledge of the Emergency Preparedness plan was available for review. Based on an interview at the time of record review, the Administrator confirmed there was no documentation of annual Emergency Preparedness plan training and no documentation to show staff could demonstrate knowledge of the Emergency Preparedness plan was available for review. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23.	E 0037	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified by and corrective action taken: All residents have the potential to be affected but none were identified. Initial Emergency Preparedness policy and procedures training was conducted on November 1, 2023 by the Administrator or designee.Community - based exercise, Active Shooter training by the Evansville Police Department, is scheduled for December 4, 2023. The measures or systemic changes that have been put in place to ensure that the deficient	11/02/2023

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			practice does not recur include: The Administrator will be re-educated by the Regional Director of Operations on: (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. The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement tool has been	

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			developed to allow for monitoring of the Emergency Preparedness Policy and Procedures updates as needed and staff in-service requirements. The Administrator or designee will complete the Performance Improvement tool weekly x 3, monthly x 3 then quarterly x 3. The Quality Assurance Committee will review the tools at scheduled meetings with recommendations as needed based on outcomes of the tool. Date Completed: November 2, 2023	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct			

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	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 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			

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	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 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			

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	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 §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			

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	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 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			

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	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, 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			

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	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 (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			

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	155621	A. BUILDING -- B. WING	10/05/2023

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	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. (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			

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	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 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.			

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	*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a 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	E 0039	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: All residents have the potential to be affected but none were identified. A tabletop exercise is scheduled for November 8, 2023 with the Administrator as the Facilitator.	11/02/2023

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	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 in the facility. Findings include: Based on review of the Emergency Preparedness plan on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, the facility was able to provide documentation of a tabletop exercise dated 01/27/23, however, the facility was unable to provide documentation of a community based exercise performed during the past 12 month period. Furthermore, there was documentation provided for a second tabletop exercise, however, there was no date or name of participants provided with the documents provided. This was confirmed by the Administrator during record review. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23.		The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Administrator will be re-educated by the Regional Director of Operations regarding EP Testing Requirements, CFR(s): 483.73(d)(2) The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool has been developed that allows for monitoring of EP Testing Requirements being met. The Administrator, Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed:	

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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			

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

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	2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 2 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications.	E 0041	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: All residents have the potential to be affected but none were identified.	11/02/2023

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	8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the generator inspection reports on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, there was no documentation available to show the emergency generator was inspected/tested weekly during 2 of the most recent 52 week period (two weeks in September). Based on interview at the time of record review, the Maintenance Supervisor said the two weeks in September were missed because of vacation one week and too busy with other things the other week. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 3 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of		Other measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director will be re-educated by the Administrator regarding Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool has been developed to track EPS inspection, testing and maintenance, weekly generator inspections and testing, monthly generator load and the written record that must be kept. The Maintenance Director or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed	

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	NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, there was no monthly generator load test documentation available for 3 of the past 12 months (April, May, and June of 2023) for the emergency generator. Based on interview at the time of record review, the Maintenance Supervisor confirmed there was no emergency generator load test documentation for April, May, and June of 2023 for the emergency generator. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of		based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	

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	Maintenance during the exit conference on 10/05/23.			
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 Dates: 10/04/23 and 10/05/23 Facility Number: 000442 Provider Number: 155621 AIM Number: 100266510 At this Life Safety Code survey, River Bend Nursing and Rehabilitation 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 building consists of two sections; the original portion of the building was a two story, fully sprinklered building determined to be of Type II (222) construction, and the Stocker Addition I and Stocker Addition II were a one story, fully sprinklered building determined to be of Type V (111) construction. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors, and all resident sleeping rooms in the Stocker Addition I and Stocker Addition II, plus battery operated smoke detectors in all resident sleeping rooms in the original two story section. The facility has a capacity of 113 and had a census of	K 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective November 2, 2023, to the annual Emergency Preparedness Survey completed on October 5, 2023. The facility respectfully requests a desk review.	

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	63 at the time of this survey. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 10/13/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on record review and interview, the facility failed to replace 41 of 41 battery operated smoke alarms in resident sleeping rooms in the Harmony Unit in accordance with NFPA 72. NFPA 72, 2010 Edition, Section 14.4.8.1 states unless otherwise recommended by the manufacturer's published instructions, single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests but shall not remain in service longer than 10 years from the date of manufacture. This deficient practice could affect all residents, staff, and visitors in the Harmony Unit. Findings include: Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, there was no documentation available to show the 41 resident room battery operated smoke alarms have had	K 0100	The corrective action taken for those residents found to have been affected by the deficient practice include: No specific resident was identified. Other residents having the potential to be affected by the same deficient practice have been identified by and corrective action taken: This could affect residents throughout the facility although no specific resident was identified. All battery smoke alarms in the	11/02/2023

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	their batteries changed during the past 12 month period. According to the monthly testing documentation provided, the last time the batteries were changed in the smoke alarms was 09/08/22. This was confirmed by the Maintenance Supervisor at the time of record review. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 2. Based on record review, interview, and observation; the facility failed to ensure documentation was provided for the preventative maintenance of 18 of 18 "temporary" battery operated smoke alarms in resident rooms, the egress corridor, and other adjacent rooms it the Stocker II east smoke compartment. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. This deficient practice could currently affect staff, as well as residents and visitors while in the Stocker II east smoke compartment while in the Physical Therapy gym or Salon. Resident rooms in the Stocker II east smoke compartment are currently not being used. Findings include: Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, there was no documentation available to show that all 18 battery operated smoke alarms in the Stocker II east smoke compartment have been tested for functionality on a monthly basis during the past twelve months. Based on interview at the time of record review, the Regional Director of		facility have been replaced or tested and documentation obtained. The floor, window seal, screen and equipment in the back of the dryer enclosure in the laundry area dryer room was cleaned to remove lint and leaves. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director will be re-educated by the Administrator regarding General Requirements - Other CFR(s): NFPA 101 All battery smoke alarms in the facility have been replaced or tested and documentation obtained. The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool has been developed to ensure all battery operated smoke alarms will be tested for functionality	

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	Maintenance said the battery operated smoke alarms were installed next to the hard wired smoke detectors as a temporary fix when the facility was having trouble with the fire alarm system in that area of the facility. He further confirmed the lack of monthly testing of all 18 battery operated smoke alarms during the past 12 month period. Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, it was confirmed there were battery operated smoke alarms placed next to each hard wired smoke detector in the Stocker II east smoke compartment. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer room enclosure was free of lint and leaves. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the floor, window seal, screen, and equipment in the back of the dryer enclosure within the laundry area was substantially covered with dryer lint and leaves. Based on interview at the time of		monthly. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	

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	observation, the Maintenance Supervisor agreed there was a substantial amount of dryer lint and leaves on the floor, window seal, screen, and equipment within the enclosure behind the dryers, and further said they would increase the cleaning schedule. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or 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			

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	are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS 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 1. Based on observation and interview, the	K 0222	The corrective action taken for	11/02/2023

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	facility failed to ensure the means of egress through 4 of 4 sets of smoke barrier doors/ 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 all residents, staff, and visitors in the Stocker I and Stocker II additions needing to exit the facility. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, all four sets of smoke barrier doors/exit doors were equipped with magnetic locks that required a code on the adjacent keypad to release and open. The codes to open these doors were not posted. This was acknowledged by the Administrator and Maintenance Supervisor at the time of each observation. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 20 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30		those residents found to have been affected by the deficient practice include: No specific resident was identified Other residents having the potential to be affected by the same deficient practice have been identified by and corrective action taken: Codes were posted on all four sets of smoke barrier doors in the facility. The lower level Harmony Unit door next to elevator was adjusted to release after 15 seconds when panic bar is pushed. The Harmony Unit main level southeast exit door to the outside was adjusted so it does not require heavy force to open. This could affect residents throughout the facility but no specific resident was identified. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include:	

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	seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect mostly staff while in the lower level Harmony Unit. Findings include: Based on observation on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the lower level Harmony Unit had an outside exit door next to the elevator equipped with delayed egress. When the panic bar on the door was pushed for 15 seconds several times the door did not release from the magnetic hold located at the top of the door. However, the magnetic hold did release the door when the code was pushed on the keypad located next to the door. Based on interview at the time of observation, the Administrator and Maintenance Supervisor acknowledged the exit door did not release when the panic bar was pushed for 15 seconds. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23.		The Maintenance Director was re-educated by the Administrator regarding Egress Doors CFR(s): NFPA 101 Corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed for observations and testing of doors for proper egress. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	

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	3.1-19(b) 3. Based on observation and interview, the facility failed to ensure the means of egress through 1 of over 20 locked exit doors was readily and easily accessible for residents, staff, and visitors. This deficient practice could affect over 20 residents, as well as staff and visitors in the Harmony Unit. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the Harmony Unit main level southeast exit door to the outside required heavy force to open when the door code was pushed on the keypad. The magnetic locks did release when the code was entered, however, the door took heavy force several times to open. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the exit door required heavy force to open. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit			

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	discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed ensure 1 of over 10 exit discharge areas was provided with a hard packed all-weather travel surface. This deficient practice could affect mostly staff and visitors if required to exit through the short hall outside exit door near the Employee Breakroom. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, there was a 15 foot by 15 foot concrete pad outside the lower level Harmony Unit short hall outside exit. There was a 25 to 30 foot grass hill between the concrete pad and east parking lot, a public way. Based on interview at the time of observation, the Administrator and Maintenance Supervisor agreed there was a 25 to 30 foot grass hill to the public way from the concrete pad outside the lower level Harmony Unit short hall exit. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)	K 0271	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: All residents have the potential to be affected but none were identified. The exit sign was removed from the lower level Harmony Unit short hall exit and is not needed as an exit. The exit was not originally on floor plan. All staff were educated on the new egress exit. Other measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director will be	11/02/2023

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			re-educated by the Administrator regarding Discharge from Exits CFR(s) NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was created to monitor outside exits to ensure there is a hard- packed, all-weather travel surface outside of exit. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour			

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	duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 2 of 7 battery powered emergency light sets were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either continuously in operation or shall be capable of repeated automatic operation without manual intervention. This deficient practice could affect mostly staff. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the battery backup light sets at the generator and lower level Harmony Unit south corridor near resident room 104 did not illuminate when tested several times. Based on interview at the time of each observation, the Administrator and Maintenance Supervisor agreed both battery backup light sets mentioned did not illuminate when tested several times. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)	K 0291	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: All residents have the potential to be affected. Other measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director will be re-educated by the Administrator regarding Emergency Lighting CFR(s) NFPA 101 The battery back up light sets at the generator and lower level Harmony Unit south corridor near resident room 104 were replaced.	11/02/2023

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			The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to track and monitor battery powered emergency lighting to ensure the battery complies with the NFPA 70 National Electric Code. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
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			

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	approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 5 of over 20 hazardous area doors, such as a Maintenance shop/office door and storage room doors, were provided with a self-closing devices and would properly close completely and latch. This deficient practice could affect mostly staff, plus residents and visitors while on their way to the Physical Therapy gym. Findings include: Based on observations on 10/05/23 between 10:00	K 0321	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have	11/02/2023

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	a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the following was noted: a. Resident room 411 in the Stocker II addition (currently used as a storage room) had over 30 cardboard boxes full of Dialysis treatment supplies with no self-closer on the door. The door was open at the time of observation. The room was over 50 square feet in size. b. Resident room 101 in the lower level Harmony Unit (currently used as a storage room) had over 30 cardboard boxes full of Dialysis treatment supplies with no self-closer on the door. The door was open at the time of observation. The room was over 50 square feet in size. c. Resident room 106 in the lower level Harmony Unit (currently used as a storage room) had over 40 cardboard boxes full of Dialysis treatment supplies with no self-closer on the door. The door was open at the time of observation. The room was over 50 square feet in size. d. The Maintenance Shop/Office in the lower level Harmony Unit did have a self-closer in the door, however, the doorknob/handle was missing, and the door was damaged causing the door not to close completely and latch. The Maintenance Shop/Office was full of paper, plastic, cardboard, and spray cans, and was over 50 square feet in size. The Maintenance Supervisor said the door was busted open a while back (not sure of time frame) and hasn't been replaced yet. He also said a new door has been ordered. e. The Activities Room/Office door in the lower level of the Harmony Unit was not provided with a self-closing device. This room was full of totes, shelves full of paper, plastic, and cardboard boxes, along with holiday decorations, and was over 50 square feet in size. Based on interview at the time of each observation, the Administrator and Maintenance		been identified and corrective action taken: All residents have the potential to be affected but none identified. Other measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director will be re-educated by the Administrator regarding Hazardous Areas CFR (s): NFPA 101; the 5 hazardous are doors identified were repaired to close properly. Resident room 411 and 106 were cleared of supplies,101 and activities room a self closure was installed. The Maintenance door was repaired The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool has been developed to record observations of hazardous area doors to ensure they have a self closing device and would properly close. Observe	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

(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
	Supervisor acknowledged the lack of self-closing devices on the storage room doors and the damaged door to the Maintenance Shop/Office. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 3.1-19(b)		doors to rooms with supplies to ensure there is a working self closure. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under			

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	18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook top for 1 of 1 stove/oven in the Physical Therapy gym was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect up to 5 residents, staff and visitors in the Physical Therapy room. Findings include:	K 0324	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could effect all residents involved in therapy but none identified. A deactivation switch was installed for the stove in therapy gym. The Maintenance Director will be re-educated by the Administrator regarding Cooking Facilities CFR (s): NFPA 101. The corrective action taken to monitor	11/02/2023

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	Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, there was a cooktop stove/oven in Physical Therapy gym. The stove/oven was not being used at the time of observation and the power to the stove/oven was on. Based on interview at the time of observation, the Maintenance Supervisor confirmed the cooktop stove/oven was not deactivated when not in use, furthermore, the Maintenance Supervisor said he didn't think there was a deactivation switch for the Physical Therapy gym stove/oven other than unplugging it from the receptacle. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)		performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to observe appliances in the therapy gym that require a shut off switch. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tool at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2			

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	Indicate flame spread rating(s). Based on observation and interview, the facility failed to ensure 1 of 8 smoke compartments was provided with a complete interior finish with a flame spread rating of Class A or Class B for a sprinklered facility. LSC 3.3.90.4 defines interior wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. A.3.3.90.2 states interior finish is not intended to apply to surfaces within spaces such as those that are concealed or inaccessible. This deficient practice could affect mostly laundry staff. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, there was a one foot by four foot section of the laundry room dryer enclosure where the drywall had been removed exposing wood studs. This was acknowledged by the Maintenance Supervisor at the time of observation, furthermore, the Maintenance Supervisor said the wood studs did not have a flame spread rating as far as he knew. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)	K 0331	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could effect mostly laundry staff. Drywall was replaced in the one foot by four foot section of laundry room dryer enclosure and wood studs now enclosed. The wood studs were finished with a Class A or B interior finish. The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: The Maintenance Director was re-educated by the Administrator on Interior Wall and Ceiling Finish CFR(s): NFPA 101	11/02/2023

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			A Performance Improvement Tool that tracks observation of laundry room walls to ensure proper fire rating for interior finish and non-exposed wood studs. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
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 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			

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	1. Based on record review and interview, the facility failed to ensure documentation was available to show that 27 of 102 smoke detectors were sensitivity tested within the past 24 months. NFPA 72, National Fire Alarm Code, 2010 Edition, Section 14.4.5.3.1 states detector sensitivity shall be checked within 1 year of installation, and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or areas where nuisance alarms show an increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the methods: (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/fire alarm control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range. (5) Other calibrated sensitivity method acceptable to the authority having jurisdiction. Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced. The detector sensitivity cannot be tested or measured using any spray device that administers an unmeasured concentration of aerosol into the detector. This deficient practice could affect all residents, staff, and visitors in the facility.	K 0345	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect all residents, staff, and visitors in the facility. On 10/4/23, all 27 smoke detectors that previously failed sensitivity testing passed. Recommendations by the facility's fire alarm system vendor were put into place. The 8 heat detectors were replaced. The time and date were updated on the main panel fire alarm system. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the Administrator on Fire Alarm System -	11/02/2023

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	Findings include: Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, the facility was able to produce a smoke detector sensitivity report dated 09/19/23, however, the report indicated that 27 of 102 smoke detectors failed. In the remarks section for each failed smoke detector it said, "No power-Local Battery Smoke Alarm added next to detector". This same statement was also stated on quarterly fire alarm system inspection/testing reports dated 09/13/22 and 06/20/23. The quarterly fire alarm system report dated 12/08/22 indicated that all smoke detectors had a "pass" in the pass/fail column. Based on interview at the time of record review, the Regional Director of Maintenance confirmed the smoke detector sensitivity testing report from 09/19/23 had 27 of 102 smoke detectors listed as failed due to no power to those smoke detectors at the time of sensitivity testing. The Regional Director of Maintenance further said the facility has had trouble with the fire alarm system off and on during the past year or more. He said he just became aware of the issues with the fire alarm system, and it has now been corrected. Based on interview on 10/05/23 at 10:15 a.m., the Regional Director of Maintenance said the facility's fire alarm system inspection vendor retested the 27 failed smoke detectors for sensitivity on the evening of 10/04/23 and all 27 smoke detectors passed, however, there was no report available to review. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on		Testing and Maintenance CFR(s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to record sensitivity testing for smoke detectors completed timely and to review and implement recommendations from the facility's fire alarm system company. This tool will also record observations of date and time of the main fire panel. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	

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	10/05/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure recommendations by the facility's fire alarm system vendor were addressed during the past four quarterly inspections of 8 of 8 heat detectors connected to 1 of 1 fire alarm system. NFPA 72, National Fire Alarm Code, the 2010 Edition, at 14.6.2.4 requires a record of all inspections, testing, and maintenance shall be provided that includes the following information regarding tests and all the applicable information requested in Figure 14.6.2.4: (1) Date (2) Test frequency (3) Name of property (4) Address (5) Name of person performing inspection, maintenance, tests, or combination thereof, and affiliation, business address, and telephone number (6) Name, address, and representative of approving agency (ies) (7) Designation of the detector(s) tested (8) Functional test of detectors (9)*Functional test of required sequence of operations (10) Check of all smoke detectors (11) Loop resistance for all fixed-temperature, line-type heat detectors (12) Functional test of mass notification system control units (13) Functional test of signal transmission to mass notification systems (14) Functional test of ability of mass notification system to silence fire alarm notification appliances (15) Tests of intelligibility of mass notification system speakers			

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	(16) Other tests as required by the equipment manufacturer's published instructions (17) Other tests as required by the authority having jurisdiction (18) Signatures of tester and approved authority representative (19) Disposition of problems identified during test (e.g., system owner notified, problem corrected/successfully retested, device abandoned in place) This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, the facility's past four quarterly fire alarm system inspection/testing reports stated "Recommend replacing due to age" in the remarks column next to each of the facility's eight heat detectors. Based on interview at the time of record review, the Regional Director of Maintenance acknowledged the remarks next to the inspection of the eight heat detectors and said he was not aware of the issues with the heat detectors but would correct the situation as soon as possible. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time and date			

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	information in accordance with the requirements of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on an observation and interview during a tour of the facility with the Administrator and Maintenance Supervisor on 10/05/23 at 11:39 a.m., the date and time on the main fire alarm control panel was incorrect. The display on the main fire alarm control panel indicated the time to be 12:44 a.m. which was over eleven hours different than the actual local time. Furthermore, the date on the panel showed it to be 05/01/2009 and not the correct date of 10/05/2023. Based on interview at the time of observation, the Maintenance Supervisor indicated he was not aware of the discrepancy and would speak with the fire alarm inspection company to get the time and date set correctly. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)			
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the			

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	shutdown until the fire alarm system has been returned to service. 9.6.1.6 1. Based on record review and interview, the facility failed to provide a complete written policy for the protection of 63 of 63 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants in the facility. Findings include: Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, the facility provided fire watch documentation from the Emergency Preparedness plan, however, it was incomplete. The plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway. Based on an interview at the time of record review, the Administrator agreed the fire watch policy lacked the previously mentioned information. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 2. Based on interview, the facility was unable to provide fire watch documentation for the protection of 63 of 63 residents. This deficient practice could affect all resident, staff, and	K 0346	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect all occupants of the facility but none identified. A written policy was developed for the event of fire alarm system being out of service for more than four hours in a twenty-four hour period. Fire watch documentation was updated to include contacting the Indiana Department of Health with the weblink for contacting the Incident Reporting System located on the IDOH Gatway. Fire watch documentation from 10/3/23 cannot be located. The measures or systemic	11/02/2023

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	visitors. Findings include: Based on interview on 10/04/23 at 10:00 a.m., the current Administrator indicated the facility's former Administrator performed a fire watch on 10/03/23 between 9:00 a.m. and 4:45 p.m. due to a problem with the fire alarm system. The Administrator said the documented fire watch forms could not be located to prove a fire watch was performed. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)		changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director and Administrator were re-educated by the Regional Director of Operations regarding Fire Alarm System-Out of Service, CFR9) NFPA 101. The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed that tracks fire watch documentation completion when there is an issue with the fire alarm system. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed:	

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RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

(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
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K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to ensure 1 of 2 automatic sprinkler piping systems was inspected every five years in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 14.2.1 states an inspection of piping and branch line conditions shall be conducted every 5 years by opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. Alternative nondestructive examination methods shall be permitted. Non-metallic pipe shall not be required to be inspected internally. Section 4.3.1 states records shall be made for all inspections,	K 0353	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect all	11/02/2023

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	tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice affects all residents, staff, and visitors in the Harmony Unit. Findings include: Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, documentation of an internal inspection of the wet sprinkler system in the Harmony Unit performed within the most recent five year period was not available for review. Based on interview at the time of record review, the Regional Director of Maintenance confirmed documentation of an internal inspection of the wet sprinkler system within the most recent five year period was not available for review. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 fire department connections were in accordance with NFPA 25, 2011 Edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Section 13.7.1 requires fire department connections to be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly.		occupants of the Harmony unit but none were identified. The automatic sprinkler system piping system was inspected and documentation obtained. FDC signage was posted on the Stocker addition and Harmony unit. The four spare sprinkler heads were secured in their own spot maintained in a properly temped sprinkler cabinet with a special sprinkler wrench. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the Administrator on Sprinkler System - Maintenance and Testing CFR (s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to track observations of the sprinkler cabinet to ensure temperature and proper storage of	

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	(3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all occupants. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the facility's two fire department connections (FDC's) were located at two separate sides of the facility, one on the Stocker additions and one on the Harmony Unit. There was no FDC signage provided at the fire department connections, and further, there was no FDC signage at the front of the building for the responding fire department to lead them to the two FDC's for easy identification. Based on interview at the time of each observation, this was acknowledged by the Maintenance Supervisor who agreed there should be FDC signage at each FDC and the front of the facility. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 2 sprinkler systems spare sprinkler cabinets were properly maintained. NFPA 25, Standard for the Inspection, Testing,		spare heads. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	

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	and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the Harmony Unit. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the spare sprinkler cabinet in the Harmony Unit sprinkler riser room had four spare sprinkler heads that were laying loosely and not in slots, which could cause breakage to the sprinkler heads if falling out when opening the cabinet door. Based on interview at the time of observation, the Maintenance Supervisor acknowledged there were four spare sprinkler heads in the spare sprinkler cabinet laying loose and not secured in their own slots. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)			

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K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of 63 of 63 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and	K 0354	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken. This practice could affect all occupants in the facility but none were identified. A written policy was developed containing procedures to be followed in the	11/02/2023

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	functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, the facility provided fire watch documentation from the Emergency Preparedness plan, however, it was incomplete. The plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway. Based on an interview at the time of record review, the Administrator agreed the fire watch policy lacked the previously mentioned information. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)		event of the automatic sprinkler service has to be put out of service for 10 hours or more in a 24 hour period. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the Administrator regarding Sprinkler System - Out of Service CFR(s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to observe policies for sprinkler system that is out of service. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed	

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			based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
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 observation and interview, the facility failed to ensure 2 of at least 8 areas open to the corridor were separated from the corridor by a partition capable of resisting the passage of smoke as required in a sprinklered building or met an Exception per 19.3.6.1(7). LSC 19.3.6.1(7) states that spaces other than patient sleeping rooms, treatment rooms, and hazardous areas shall be open to the corridor and unlimited in area, provided: (a) The space and corridors which the space opens onto in the same smoke compartment are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4, and (b) Each space is protected by an automatic sprinklers, and (c) The space does not to obstruct access to required exits. This deficient practice could affect mostly staff, plus residents and visitors while on the way to the Physical Therapy gym. Findings include:	K 0361	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect mostly staff, plus residents and visitors while on the way to the physical therapy gym. The Stocker II nurses	11/02/2023

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	Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the Stocker II Nurses' Station (not currently being used), and the lower level Harmony Unit lounge (next to the Nurses' Station and not currently being used) were open to the corridor without direct supervision from a 24 hour station (i.e., Nurses' Station). Furthermore, LSC 19.3.6.1(7) was not met because the Stocker II Nurses' Station and lower level Harmony Unit lounge were not protected by an electrically supervised automatic smoke detection system. Based on interview at the time of each observation, the Administrator and Maintenance Supervisor agreed these areas were not provided with an electrically supervised automatic smoke detector or a door to the egress corridor and were not directly supervised by a 24 hour station (i.e., Nurses' Station). This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)		stations and lower level Harmony Unit lounge, had the electronic fire/smoke surveillance system repaired. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the Administrator on Corridors - - Areas Open to Corridor CFR(s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to track observations of the facility to ensure all areas are covered by an electronic fire watch system. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with	

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			recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are 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,			

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	unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 50 resident room corridor doors would close completely and latch, and resist the passage of smoke. This deficient practice could affect up to 10 residents, as well as staff and visitors. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, room 215 corridor door did not close completely and latch into its door frame. The upper half of the door was hitting the door frame not allowing it to close fully. There was a 1 to 2 inch gap between the door and door frame when closed fully. Based on interview at the time of observation, the Maintenance Supervisor agreed resident room 215 door did not close completely and latch and was not smoke resistant when closed fully. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23.	K 0363	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect up to 10 residents but none were identified, as well as staff and visitors. Room 215 corridor doors were adjusted by the Maintenance Director to close completely and latch into its door frame. The measures or systemic changes that have	11/02/2023

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	3.1-19(b)		been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated on Corridor-Doors CFR(s):NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed record observations of facility doors to ensure they latch properly. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
K 0372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke			

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Bldg. 01	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 2 of 4 smoke barrier walls in the Stocker I and II additions were protected to maintain the smoke resistance of the smoke barriers. 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. This deficient practice could affect at least 30 or more residents, as well as staff and visitors. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the following was noted: a. The smoke barrier wall above the smoke barrier doors between the Stocker I and Stocker II addition near resident room 311 had a four inch square hole penetrating the wall with a few wire running through it that were not proper fire stopped. b. The smoke barrier wall above the smoke barrier doors between Stocker II east and west corridors	K 0372	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect all occupants in the facility but none were identified. The holes in smoke barrier were repaired. The measures or systemic changes that have been put in place to ensure that	11/02/2023

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	had a four inch square hole penetrating the wall with a few wire running through it that were not proper fire stopped. Based on interview at the time of each observation, the Maintenance Supervisor said the openings through the smoke barrier walls would be filled with a proper fire stop material as soon as possible. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)		the deficient practice does not recur include: The Maintenance Director was re-educated on Subdivision of Building Spaces - Smoke Barrier CFR(s): NFPA 101 by the Administrator. The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to record observations of the facility fire walls to ensure they are properly repaired. Any issues will be addressed immediately. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	

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	155621	A. BUILDING 01 B. WING	10/05/2023

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K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 2 set of smoke barrier doors which swing in the same direction and equipped with an astragal have a properly functioning coordinator to ensure the door which must close first always closes first. This deficient practice could affect mostly staff while in the lower level of the Harmony Unit. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, the set of smoke barrier doors on the lower level Harmony Unit between the north and south corridors closed in the same direction with an astragal attached to one of the doors. There was a door coordinator attached to the door frame, however, it did not function correctly when tested because the rubber wheel was hitting the door to low. When tested, there was a six inch gap	K 0374	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect mostly staff while in the lower level of the Harmony Unit. The smoke barrier door was adjusted to ensure the door that is supposed to close first	11/02/2023

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	between the doors when closed fully due to the faulty coordinator. Based on interview at the time of observation, the Administrator and Maintenance Supervisor agreed the coordinator did not allow the set of smoke barrier doors to function as designed. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)		always does. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the Administrator on Subdivision of Building Spaces - Smoke Barrier CFR(s):NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to track observations of the smoke barrier doors to ensure they close properly. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will	

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			be completed: November 2, 2023	
K 0711 SS=E Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 26 of 26 residents in the Harmony North and South Units to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire	K 0711	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect the 26 residents on the Harmony North and South Units. A written fire safety plan was developed	11/02/2023

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	Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Fire Emergency Procedure" on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, the plan did not address staff response to battery powered smoke alarms located in resident sleeping rooms on the Harmony North and South units. Based on interview at the time of record review, the Administrator acknowledged and agreed that the Fire Emergency Procedure did not address staff response to battery powered smoke alarms located in the Harmony North and South unit resident sleeping rooms. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)		addressing NFPA 101, 2012 edition, Section 19.7.2.2 and the Fire Emergency procedure was updated to include staff response to battery powered smoke alarms. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Administrator was re-educated by the Regional Director of Operations regarding Evacuation and Relocation Plan CFR(s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool that will record Evacuation and Relocation plan and the staff response to it. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at	

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			the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
K 0712 SS=C 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 ensure fire drills were held at varied times for 1 of 3 employee shifts during 3 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, 3 of 4 second shift (evening) fire drills were performed between 3:00 p.m. and 3:14 p.m. Based on	K 0712	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective	11/02/2023

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	interview at the time of record review, the Administrator acknowledged the times the second shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 3.1-51(c)		action taken: This practice could affect all residents. A fire drill was held on all shifts. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the Administrator regarding Fire Drills CFR(s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to track fire drills. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will	

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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.			

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	6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for 1 of 1 generator was maintained for 2 of 52 weeks. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of the generator inspection reports on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, there was no documentation available to show the emergency generator was inspected/tested weekly during 2 of the most recent 52 week period (two weeks in September). Based on interview at the time of record review, the Maintenance Supervisor said the two weeks in September were missed because of vacation one week and too busy with other things the other week.	K 0918	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect all residents but none were identified. Generator and load testing was completed. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the Administrator regarding Electrical Systems -- Essential Electric System Maintenance and Testing CFR(s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is:	11/02/2023

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	This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b) 2. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 3 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff, and visitors. Findings include:		A Performance Improvement Tool was developed to track generator and load testing. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	

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	Based on record review on 10/04/23 between 9:30 a.m. and 4:15 p.m. with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance present, there was no monthly generator load test documentation available for 3 of the past 12 months (April, May, and June of 2023) for the emergency generator. Based on interview at the time of record review, the Maintenance Supervisor confirmed there was no emergency generator load test documentation for April, May, and June of 2023 for the emergency generator. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23. 3.1-19(b)			
K 0920 SS=D 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			

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	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 in the Generator transfer room was used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect one or two staff. Findings include: Based on observations on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with the Administrator and Maintenance Supervisor, there was a power strip in the Generator transfer room used to power a running box fan. The power strip cord was secured but the power strip was dangling. This condition could put stress on the power strip. Based on interview at the time of observation, the Maintenance Supervisor agreed the power strip was dangling. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23.	K 0920	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect all residents but none were identified. The extension cord was removed from the Generator transfer room. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the	11/02/2023

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	3.1-19(b)		Administrator regarding Electrical Equipment -- Power Cords and Extension Cords CFR(s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to track observations of in-properly used extension cords. The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous			

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RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

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	Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations where transfilling occurs was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.5.2.3.1 states oxygen transfilling locations shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire resistive construction. (2) The area is mechanically vented, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. Section 11.5.3.2.3 states in health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no smoking language shall not be required. This deficient practice could affect mostly staff while in the lower level of the Harmony Unit north corridor. Findings include: Based on observation on 10/05/23 between 10:00 a.m. and 2:00 p.m. during a tour of the facility with	K 0927	The corrective action taken for those residents found to have been affected by the deficient practice include: A specific resident was not identified in the survey. Other residents having the potential to be affected by the same deficient practice have been identified and corrective action taken: This practice could affect all residents but none were identified. The hole in the ceiling in the oxygen transfilling room was repaired. The measures or systemic changes that have been put in place to ensure that the deficient practice does not recur include: The Maintenance Director was re-educated by the	11/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 01 B. WING	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	the Administrator and Maintenance Supervisor, the ceiling in the oxygen transfilling room had a six inch hole where a water leak has occurred. The hole in the ceiling above the liquid oxygen tanks prevented the oxygen transfilling room from maintaining a one hour fire resistive barrier. Based on interview at the time of observation, the Maintenance Supervisor confirmed there was a hole in the ceiling of the oxygen transfilling room. This finding was reviewed with the Administrator, Maintenance Supervisor, and Regional Director of Maintenance during the exit conference on 10/05/23 3.1-19(b)		Administrator regarding Gas Equipment -- Transfilling Cylinders CFR(s): NFPA 101 The corrective action taken to monitor performance to assure that compliance through Quality Assurance is: A Performance Improvement Tool was developed to track observations of the oxygen rooms to ensure the ceiling and walls are not damaged.The Maintenance Director, or designee, will complete the PI tool weekly x 3, monthly x 3, then quarterly x 3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the on the outcomes of the tool. The date the systemic change will be completed: November 2, 2023	