STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155003	A. BUILDING -- B. WING	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MASON HEALTH CARE CENTER	900 PROVIDENT DRIVE WARSAW, IN 46580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/17/24 Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600 At this Emergency Preparedness survey, Mason Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 105 and had a census of 68 at the time of this survey. Quality Review completed on 09/23/24	E 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418 Plan Based on All Hazards Risk Assessment Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2).	E 0006	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. The hazard and vulnerability assessment tool has been reviewed, updated, and added to all emergency preparedness	10/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rukiya Brooks	Administrator	10/04/2024

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

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	This deficient practice could affect all resident, staff and visitors. Findings include: Based on record review and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 9:15 a.m. to 11:54 a.m. on 09/17/24, a Kaiser Permanente Hazard Vulnerability Analysis (HVA) document was provided by the DPO. The DPO stated he used the risks identified on the pre-printed form and used his judgement to determine the impact on the facility. The facility was not able to provide evidence to show the HVA was facility-based or community-based. Furthermore, the Emergency Preparedness plan (EP) did not contain plans, policies or procedures for all of the hazards identified in the HVA. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference.		binders. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
E 0007 SS=F Bldg. --	403.748(a)(3), 416.54(a)(3), 418.113(a)(EP Program Patient Population Based on record review and interview, the facility failed to ensure the emergency preparedness plan addressed resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in accordance with 42 CFR 483.73(a)(3). This deficient practice could affect all residents, staff and visitors. Findings include:	E 0007	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. The facility assessment that describes the patient population and services the facility can offer in an emergency has been added to all the emergency preparedness binders. The organizational chart that describes the delegation of authority and succession have	10/21/2024

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	Based on record review and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 9:15 a.m. to 11:54 a.m. on 09/17/24, the Emergency Preparedness (EP) plan failed to address persons at-risk or the type of services the LTC facility has the ability to provide in an emergency. During interview the Administrator and Regional Director of Property Management both requested clarification about the requirement. The facility's EP binder contained a copy of Appendix Z from the SOM. The Administrator and Regional Director of Property Management reviewed the specific section of Appendix Z and were not able to provide evidence that the EP addressed the aforementioned requirements. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference.		been reviewed, updated as needed, and added to all the emergency preparedness binders. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
E 0009 SS=F Bldg. --	403.748(a)(4), 416.54(a)(4), 418.113(a)(Local, State, Tribal Collaboration Process Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.73(a)(4). This deficient practice could affect all occupants. Findings include:	E 0009	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. The emergency preparedness risk assessment has been reviewed and updated to reflect local, state, and tribal collaborations with the facility. It will be added to all the emergency preparedness binders. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA	10/21/2024

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	Based on record review and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 9:15 a.m. to 11:54 a.m. on 09/17/24, the facility was unable to provide documentation which ensured the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Based on interview at the time of record review, the DPO provided written agreements with vendors and other facilities; however, was unable to provide documentation of collaboration with government emergency preparedness officials. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference.		review and the plan of action will be adjusted accordingly.	
E 0032 SS=F Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all residents, staff and visitors. Findings include:	E 0032	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. The alternative method of communication for the facility has been specified by highlighting the option “runners” on each policy in each emergency preparedness binder. The staff will be in-serviced	10/21/2024

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	Based on record review and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 9:15 a.m. to 11:54 a.m. on 09/17/24, the Emergency Preparedness Communication Plan provided primary means for communication but failed to identify what means of alternate communications the facility would use. Several examples of alternate means of communications were listed but did not identify which means would or could be used by the facility. Based on interview at the time of records review, the Administrator and Regional Director of Property Management agreed the plan listed CB/Ham radio, Satellite phones and other alternate means of communications that the facility did not have available. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference.		on the meaning by October 21st. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements 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	E 0039	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. A collaboration with the fire department was completed on 9/30/24 and the appropriate report was completed, and signature was obtained from the fire department. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA	10/21/2024

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	from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 9:15 a.m. to 11:54 a.m. on 09/17/24, the facility was able to provide documentation of a table-top exercise; however, was unable to provide documentation of a full-scale community-based exercise, a facility-based functional exercise or an actual natural or man-made emergency that required activation of the emergency plan. Based on record review and interview, the Administrator and DPO provided documentation of the local fire department conducting training for fire safety. The		review and the plan of action will be adjusted accordingly.	

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	Administrator and DPO believed that training qualified as a full-scale community-based exercise but failed to meet the requirements of an exercise. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference.			
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on record review and interview, the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. Findings include: Based on record review and interview with the	E 0041	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. HFA has requested updated documentation from the gas company confirming its responsibility of providing natural gas to the generator during an emergency. Once it is received, the documentation will be added to all the emergency preparedness binders. The Maintenance Supervisor/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	10/21/2024

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	Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 9:15 a.m. to 11:54 a.m. on 09/17/24, the facility's emergency generator had a natural gas fuel source. The facility provided a letter of reliability dated May 21, 2018 from NIPSCO, the utility providing the natural gas; however, the letter did not include all of the required information. There was no statement that there was a low likelihood of an interruption with a description as to why that was true. The letter was not authored by a technical person who had the technical knowledge to make those statements. The letter was authored by the Commercial & Industrial Accounts Manager who was not an engineer and there was no explanation of the author's job responsibilities to confirm that they had the technical knowledge to make the required statements. This finding was discussed with the Administrator, Regional Director of Property Management, and DPO during record review. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 09/17/2024 Facility Number: 000003 Provider Number: 155003 AIM Number: 100290600	K 0000	We at the facility are hereby respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a post survey revisit. We are willing to submit any and all documentation as requested to assure our credible compliance with the deficiencies noted in the following	

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	At this Life Safety Code survey, Mason Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V(111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and in the resident sleeping rooms. The facility has a capacity of 105 and had a census of 68 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/23/24		CMS-2567. We are hereby providing our plan of correction. Submission of this Plan of correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	
K 0211 SS=F Bldg. 01	NFPA 101 Means of Egress - General 1.) Based on observation and interview, the facility failed to ensure the means of egress through 5 of 5 exit doors in the facility 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.	K 0211	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. The door codes on all five exits are posted with numerical numbers only. The hanging light fixtures will be replaced by October 21st in the activity room and assisted dining room to meet the height requirements. The Maintenance Supervisor/designee report of monitoring will be forwarded to the	10/21/2024

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	Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, exit doors from the facility were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not clearly understood by residents, staff and visitors without a clinical diagnosis. The door codes were posted using a combination of Arabic numbers, Roman numerals and text. During tour of the facility a visitor was unable to exit the facility without assistance and stated: "I never figure out how to get out." And "This is a Hotel California, you can check-in, but you can never check-out." Based on interview at time of observation, the Administrator, stated she believes the code is understandable. 2.) Based on observation and interview, the facility failed to ensure means of egress in 2 of 2 activity dining rooms were continuously maintained free of obstructions in 1 of 6 smoke compartments. LSC 19.2.1 states every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. LSC 7.1.5.1 Means of egress shall be designed and maintained to provide headroom in accordance with other sections of this Code, and such headroom shall be not less than 7 ft 6 in. (2285 mm), with projections from the ceiling not less than 6 ft 8 in. (2030 mm) with a tolerance of ?3?4 in. (?19 mm), above the finished floor, unless otherwise specified by any of the following: (1) In existing buildings, the ceiling height shall be not less than 7 ft (2135 mm) from the floor, with projections from the ceiling not less than 6 ft 8 in. (2030 mm) nominal above the floor.		Administrator for monthly QA review and the plan of action will be adjusted accordingly.	

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	This deficient practice affects residents, staff and visitors in 1 of 6 smoke compartments who work and use the activity dining rooms across from the back nurses' station. Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, two (2) activity dining rooms which were adjacent to each other and accessible to each other through double doors, contained more than 12 hanging light fixtures which measured 5 ft 11 in. from the floor. Based on interview at the time of observation, the Director of Maintenance acknowledged the height of the light fixtures and stated they would have to be replaced. These findings were reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b)			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1.) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2* Cooking appliances requiring protection shall not be moved, modified,	K 0324	No residents were negatively affected by this practice. The kitchen staff have the potential to be affected by this practice. The maintenance director has created identification markers on the kitchen floor to ensure that the appliances are returned to the approved design location if moved. The kitchen staff will be in-serviced	10/21/2024

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	or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff only. The findings include: Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, cooking appliances including a gas burner stove and oven with a flat-top grill was located under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and cleaning. Based on interview with the kitchen staff and the DPO, the facility was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning. 2.) Based on observation and interview, the facility failed to maintain 1 of 1 kitchen extinguishing system in accordance with NFPA		on floor markings to ensure that appliances are returned to the approved design location if moved. The maintenance director and/or designee will randomly audit the location of the appliances weekly for four weeks then every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. The remote pull station was repositioned 42 to 48 inches from the floor in the kitchen. The Maintenance Director/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	

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	96, Standard for Ventilation and Fire Protection of Commercial Cooking Operations, Section 10.5.1 states A readily accessible means for manual activation shall be located between 42 inches and 48 inches above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. Additionally, NFPA 101, Life Safety Code, 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall be either maintained or removed. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management (RDPM), and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, the ANSUL "Remote Pull Station" was mounted at 63 inches above the floor next to the door leading out of the kitchen to the dining room. Based on interview at time of observation, the RDPM discussed the location of the pull station and acknowledged the height when measured with a tape measure. These findings were reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b)			
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance 1.) Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition.	K 0345	No residents were negatively affected by this practice. All residents, staff, and visitors in the	10/21/2024

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	NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, there was a yellow light illuminated for trouble and silenced on the fire alarm annunciator panel at the front nurses' station and the main fire control panel. At the time of observation, the fire alarm system was tested with a pull station near the back nurses' station. The fire alarm system actuated the audible alarm, however, the yellow trouble and silenced lights stayed illuminated when the system was reset. The alarm monitoring company was contacted by the DPO. The alarm monitoring company acknowledged receiving the alarm. The DPO then contacted the facilities sprinkler service by telephone. Based on telephone interview with the Deficiency, Sales and Project manager from the sprinkler service company, he stated the trouble was due to a faulty sensor on the sprinkler system. He also stated repairs were scheduled for the morning of 09/18/24. 2.) Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors.		facility have the potential to be affected by this practice. The faulty sensor has been repaired and the fire panel no longer displays troubled or silenced. The maintenance director and/or designee will randomly check the fire alarm annunciator panel to ensure the system is not in trouble or silenced mode weekly for four weeks then every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. The Maintenance Director/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	

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	Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) at 1:31 p.m. on 09/17/24, the fire control panel time indicated 12:32 p.m. Based on interview at time of observation the DPO acknowledged the time on the fire control panel was incorrect. These findings were reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b)			
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 activity supplies closet located in the MDS office in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect staff only. Findings include:	K 0351	No residents were negatively affected by this practice. All staff have the potential to be affected by this practice. Supplies stacked that obstructed the sprinkler head have been removed and red tape has been placed on the walls to mark the height limit for supplies in the closet. The maintenance director and/or designee will randomly check the closet in the MDS office to ensure that supplies are stacked below 18inches from the sprinkler head weekly for four weeks, then every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. The Maintenance Director/designee	10/21/2024

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	Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, the activity supplies closet located in the MDS office had a shelf with cardboard boxes stacked to within 10 inches of a sprinkler head. Based on interview at the time of observation, the DPO stated the boxes did appear to be within 10 inches of the sprinkler head. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b)		report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation, and interview; the facility failed to ensure 2 of 2 sprinkler heads in the laundry room covered with lint were replaced or cleaned in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element	K 0353	No residents were negatively affected by this practice. The laundry staff have the potential to be affected by this practice. Lint was removed from the sprinkler heads in the laundry room. The maintenance director and/or designee will randomly audit the sprinklers located in the laundry room to ensure they are not covered in lint weekly for four weeks, then every other week for four weeks, then monthly thereafter. Any concerns noted will receive immediate follow-up. The Maintenance Director/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of	10/21/2024

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	(5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect two staff in the Laundry room. Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, the two sprinklers located in the laundry room dryer area were covered with lint. Based on interview, the DPO acknowledged the lint during observation and then brushed off the lint from the sprinkler heads. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b)		action will be adjusted accordingly.	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 2 of 3 portable fire extinguishers in the maintenance office were installed in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 Edition. Section 6.1.3.4 states portable fire extinguishers other than wheeled extinguishers shall be installed using any of the following means. (1) Securely on a hanger intended for the	K 0355	No residents were negatively affected by this practice. The Director of Plant Operations has the potential to be affected by this practice. The portable fire extinguishers were removed from the floor and placed in a cabinet in the maintenance office. The Maintenance Director/designee	10/21/2024

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	extinguishers. (2) In the bracket supplied by the extinguisher manufacture. (3) In a listed bracket approved for such purpose. (4) In a cabinet or wall recess. This deficient practice affects the Director of Plant Operations only. Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, two 2.5 lbs. dry chemical ABC portable fire extinguishers located in the maintenance office were sitting on the floor. Based on interview at the time of observation, the DPO stated he did not know what the extinguishers were for and that the extinguisher vender had performed annual maintenance recently. This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b)		report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric 1.) Based on record review and interview, the facility failed to ensure that the emergency generator had a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC Section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA	K 0511	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. The electric receptacle in the medication room at the back nurse's station and main dining	10/21/2024

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	110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 9:15 a.m. to 11:54 a.m. on 09/17/24, the facility's emergency generator had a natural gas fuel source. The facility provided a letter of reliability dated May 21, 2018 from NIPSCO, the utility providing the natural gas; however, the letter did not include all of the required information. There was no statement that there was a low likelihood of an interruption with a description as to why that was true. The letter was not authored by a technical person who had the technical knowledge to make those statements. The letter was authored by the		room have been replaced with a GFCI protection. The Maintenance Director/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	

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	Commercial & Industrial Accounts Manager who was not an engineer and there was no explanation of the author's job responsibilities to confirm that they had the technical knowledge to make the required statements. This finding was discussed with the Administrator, Regional Director of Property Management, and DPO during record review. 2.) Based on observation and interview, the facility failed to ensure 1 of 2 electrical receptacles within 18 inches of a sink located in the medication room at the back nurses' station was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable.			

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	Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff while at the hand washing sink in the Dining Room. Findings include:			

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	Based on observation and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, there were two electric receptacles within two feet of the hand washing sink in the medication room at the back nurses' station. 1 of 2 electric receptacle was not provided with ground fault circuit interrupters (GFCI). This was confirmed by the DPO at the time of observation. These findings were reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills under varying conditions according to LSC 101 19.7.1.6 and LSC 4.7.4 which require drills be conducted at unexpected times under varying conditions. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Administrator, Regional Director of Property Management, and Director of Plant Operations (DPO) from 9:15 a.m. to 11:54 a.m. on 09/17/24, the "Fire Drill Report" indicated 12 of 12 fire drills conducted were all conducted between the 20th and 31st of each month. In the first quarter of 2024 fire drills were conducted on: first shift at 9:01 a.m.	K 0712	No residents were negatively affected by this practice. All residents, staff, and visitors in the facility have the potential to be affected by this practice. Corrective action cannot be taken as the alleged deficiency occurred in the past. HFA/designee will audit the dates of the fire drills monthly to ensure that they occur at varied times under varying conditions. Any concerns noted will receive immediate follow-up. The Maintenance Director/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will	10/21/2024

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	on 01/25/24, second shift at 8:37 p.m. on 2/20/24, and third shift at 10:09 p.m. on 3/28/24. In the second quarter of 2024 fire drills were conducted on: first shift at 1:10 p.m. on 4/25/24, second shift at 2:09 p.m. on 5/29/25, and on third shift at 4:55 a.m. on 6/27/24. In the third quarter of 2024 fire drills were conducted on: first shift at 8:10 a.m. on 7/26/24, and on second shift at 9:10 p.m. on 8/28/24. In the third quarter of 2023 a third shift fire drill was conducted at 10:15 p.m. on 9/29/23. In the fourth quarter of 2023 fire drills were conducted on: first shift at 1:26 p.m. on 10/27/23, second shift at 2:10 p.m. on 11/30/23, and on the third shift at 5:40 a.m. on 12/31/23. Based on interview at the time of record review, the DPO acknowledged the dates and times of fire drills that This finding was reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b) 3.1-51(c)		be adjusted accordingly.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens 1.) Based on observation and interview, the facility failed to ensure 1 of 1 lounge in the 100 hall did not use a multi-plug adaptor as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 5 residents, staff and visitors in the 100 hall.	K 0920	No residents were negatively affected by this practice. Residents, staff, and visitors in the facility have the potential to be affected by this practice. The power strips used for the fireplace, located in a resident's room, and used in the back nurses' station pantry have been removed. The maintenance director/designee will inspect residents' room/pantries/lounge areas for	10/21/2024

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	Findings include: Based on observation during initial tour at time of entrance with the Director of Plant Operations (DPO) from 8:57 a.m.to 9:15 a.m. on 09/17/24, an electric faux fireplace with the heating element disabled was plugged into a multi-plug flexible-cord power strip Based on observation and interview with the Administrator, Regional Director of Property Management (RDPM), and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, the power strip had been removed. Based on interview, the RDPM stated the power strip was probably used because no electrical receptacle was close enough to plug into. During observation the DPO moved the fireplace close enough to a receptacle to plug it in and demonstrate the heating element had been removed or otherwise disabled. 2.) Based on observation and interview, the facility failed to ensure a power strip in 1 of 13 resident rooms met UL rating of 1363A or 60601-1. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. This deficient practice affects 1 resident, staff and visitors. Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management (RDPM), and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on		power strips weekly for four weeks, then every other week for four weeks, then monthly thereafter. Any power strips located will be immediately removed. The Maintenance Director/designee report of monitoring will be forwarded to the Administrator for monthly QA review and the plan of action will be adjusted accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155003	A. BUILDING 01 B. WING	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	09/17/24, a motorized-wheelchair battery charger, 2 phone type chargers and a television were plugged into and supplied power by a power strip that did not have a label indicating it meets the UL rating of 1363A or 60601-1. Based on interview at the time of observation, the RDPM inspected the power strip and stated the UL code was not clear but did not indicate it was of an approved type. 3.) Based on observation and interview, the facility failed to ensure 1 of 1 flexible cord was not used as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects staff only. Findings include: Based on observation and interview with the Administrator, Regional Director of Property Management (RDPM), and Director of Plant Operations (DPO) from 1:15 p.m. to 3:45 p.m. on 09/17/24, a surge protector was found powering a microwave oven in the pantry room located behind the back nurses' station. Based on interview, the DPO confirmed the improper use of a surge protector but was unable to explain why it was in use. These findings were reviewed with the Administrator, Regional Director of Property Management, and Director of Plant Operations at the exit conference. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155003	A. BUILDING 01 B. WING	09/17/2024

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