STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155653	A. BUILDING -- B. WING	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARBOR HEALTH & REHAB	5025 MCCOOK AVE EAST CHICAGO, IN 46312

(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: 09/04/2024 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 At this Emergency Preparedness survey, Harbor Health & Rehab was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 106 beds which are dually certified for Medicare and Medicaid. At the time of the survey, the census was 58. Quality Review completed on 09/10/24	E 0000		
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 provide complete documentation for the first and second exercises of choice to test the Emergency Preparedness Plan (EPP). The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation	E 0039	**E039** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the***	09/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Craig Clemons	Administrator	09/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING -- B. WING	09/04/2024

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	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 facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 09/04/24 between 09:08 a.m. and at 12:07 p.m., documentation for a full-scale tornado exercise completed within the past 12 months was presented, however the exercise did not include an after action report nor included all staff. The exercise only consisted of the Maintenance Director. Furthermore, no second exercise of choice within the past 12 months could be located during the survey. Based on interview at the time of record review, the Maintenance Director acknowledged the lack of documentation and further stated that the facility is in the process of doing a full-scale exercise for a disaster in the		***statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified: Maintenance Director participated in Full Scale Exercise on 5/21/2024. Ful Scale Exercise & After Action Report was reviewed with IDT and additional staff members on 9/16/2024. Facility is in compliance with emergency preparedness** **Facility enacted emergency response plan to a real event that occurred on 7/15/2024. Facility response and after action report was reviewed with IDT and additional staff members on 9/12/2024. Facility is in compliance with emergency preparedness.** **2) How the facility identified other residents:** **Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** **The Maintenance Director or Designee will complete generator monthly 30 minutes under load testing and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be**	

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	155653	A. BUILDING -- B. WING	09/04/2024

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	future to make up the missing one, however he confirmed that there was lack of documentation. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference.		**re-educated on emergency preparedness requirements. The Maintenance Director is responsible for compliance. 4)How the corrective actions will be monitored: The Administrator/Designee will review the emergency preparedness binder annually to ensure facility is in compliance with emergency preparedness for full scale and tabletop exercises. The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.542(e), 485.62 Hospital CAH and LTC Emergency Power Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and Maintenance Director on 09/04/24 between 09:08 a.m. and 12:07 p.m., the generator lacked monthly load testing required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director acknowledged	E 0041	**E 041- Hospital CAH and LTC Emergency Power** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The***	09/20/2024

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	155653	A. BUILDING -- B. WING	09/04/2024

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	the lack of documentation and further stated he was unaware where the documentation could be as that was before his time at the facility. The finding was reviewed with the Administrator and Maintenance Director at the exit conference.		***plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified: Facility unable to locate missing documentation. Monthly generator load testing is occurring and documentation completed.** **2) How the facility identified other residents Visitors, staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.** **2) Measures put into place/ System changes: Maintenance Director will complete monthly load testing and will document and keep current log of testing. The Maintenance Director will be re-educated on the Preventative Maintenance Program.** **The Maintenance Director is responsible for compliance.** **4) How the corrective actions will be monitored: The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100%**	

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	155653	A. BUILDING -- B. WING	09/04/2024

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			compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
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: 09/04/2024 Facility Number: 000108 Provider Number: 155653 AIM Number: 100267410 At this Life Safety Code Survey, Harbor Health & Rehab 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 two story facility determined to be of Type II (222) construction was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and in areas opened to the corridors. Battery operated smoke detectors are installed in all resident sleeping rooms. The building is partially protected by a diesel powered emergency generator. The facility has 106 beds which are dually certified for Medicare and Medicaid and a census of 58 at the time of this survey	K 0000		

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	155653	A. BUILDING 01 B. WING	09/04/2024

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	All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except two detached storage sheds. Quality Review completed on 09/10/24			
K 0300 SS=E Bldg. 01	NFPA 101 Protection - Other Based on observation and interview, the facility failed to ensure 1 of over 30 battery operated smoke alarms installed in resident sleeping rooms were not over ten years old 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 approximately 20 residents and staff. Findings include: Based on observations with the Maintenance Director on 09/04/24 during a tour of the facility from 12:16 p.m. to 1:32 p.m., manufacturer's documentation affixed to the battery operated smoke alarm installed above the door in resident sleeping room 217 was listed as 05/23/2006 respectively. Based on interview at the time of observation, the Maintenance Director agreed the aforementioned smoke alarm was over 10 years old and further stated he was aware of two other smoke alarms which were the same type. This finding were reviewed with the Administrator	K 0300	**K 300** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified: The maintenance director completed audit & testing all of battery operated smoke detectors in facility. 3 smoke detectors were replaced as they exceeded 10 year manufacture date.** **2) How the facility identified**	09/20/2024

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	and Maintenance Director during the exit conference. 3.1-19(b)		**other residents Visitors, staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.** **2) Measures put into place/ System changes: Maintenance Director will complete quarterly inspections and will document and keep current log of inspections. Any battery operated smoke detector that fail operability tests or exceeds 10 year manufacture date will be immediately replaced. The Maintenance Director will be re-educated on the Preventative Maintenance Program.** **The Maintenance Director is responsible for compliance.** **4) How the corrective actions will be monitored: The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0324 SS=E	NFPA 101 Cooking Facilities			

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Bldg. 01	Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen fire suppression system was inspected semiannually. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.2.1 states Maintenance of the fire-extinguishing systems and listed exhaust hoods containing a constant or fire-activated water system that is listed to extinguish a fire in the grease removal devices. Hood exhaust plenums, and the exhaust ducts shall be made by properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction at lease every six months. This deficient practice could affect staff in the kitchen and approximately 15 residents who use the adjoining dining room. Findings include: Based on record review with the Maintenance Director and Administrator on 09/04/24 between 09:08 a.m. and 12:07 p.m., the only documentation of semiannual kitchen suppression system inspection available for review was dated 08/29/23. No other documentation could be presented to indicate the system has been inspected six months after 08/29/23. Based on interview at the time of record review, the Maintenance Director acknowledged the lack of documentation and further stated that the kitchen suppression system had been inspected the night previous, but documentation had been missing to indicate the kitchen suppression system had been inspected semiannually. The finding was discussed with the Maintenance Director and Administrator at exit conference.	K 0324	**K 324** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified:** **Facility unable to locate missing documentation.** **Contracted vendor conducted repairs and inspection on kitchen fire suppression system on 9/3/24. Kitchen fire system has been inspected and is in compliance.** **2) How the facility identified other residents** **Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.** **2) Measures put into place/ System changes:** **Maintenance Director will ensure that kitchen fire suppression is inspected semi-annually and that records**	09/20/2024

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	3.1-19(b)		**of inspections are completed and retained. The Maintenance Director will be re-educated on the Preventative Maintenance Program. The Maintenance Director is responsible for compliance.** **4) How the corrective actions will be monitored:** **The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler systems in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires	K 0353	**K353** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because***	09/20/2024

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	records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on record review of with Maintenance Director on 02/13/19 between 09:08 a.m. to 12:17 p.m., the annual sprinkler report dated 07/16/24 under the deficiencies section on page one of the report; indicated that "tested at the interface (-10) glycerine and (-47) glycol. No signs or placards indicating that the solution in question is a factory premix solution." Also, the report indicated that "No records onsite indicating that the solution in question is a factory premix solution. Recommend recharging with the proper "listed" solution and add signs and placards." Based on interview at the time of record review, the Maintenance Director acknowledged the sprinkler issues and further stated that the work was done and completed by the time of the survey, however they could not provide documentation during the time of the survey. The finding was discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		***it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified: Sprinkler system inspection documentation obtained indicating type of antifreeze in sprinkler system. Facility has contracted with vendor to perform 5-year internal inspection that includes replacement of antifreeze.** **2) How the facility identified other residents** **Staff, visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.** **2) Measures put into place/ System changes:** **Maintenance Director will ensure that sprinkler system is inspected, tested, and maintained. Records will be completed, maintained, and made readily available. The Maintenance Director will be re-educated on the Preventative Maintenance Program. The Maintenance Director is responsible for compliance.** **4) How the corrective actions will be monitored:** **The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months**	

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			or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 1. Based on observation and interview, the facility failed to ensure 1 of 30 resident room corridor doors on the second floor was provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately three residents and staff. Findings include: Based on observation with the Maintenance Director on 09/04/24 between 09:08 a.m. and 12:07 p.m., the corridor door to resident room 210 latched into the frame, however the door took over three tries to finally properly latch. After testing the door again after it latched, the door returned to not latching. Based on interview at the time of observation, the Maintenance Director confirmed that the door had issues latching and would try and fix the latching hardware. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 doors to the corridor from	K 0363	**K363** The facility requests paper compliance for this citation. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1)Immediate actions taken for those residents identified: The corridor door to resident room 210 was adjusted to ensure proper closure.	09/20/2024

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	the MDS/social work office and 2nd floor med room would completely resist the passage of smoke. 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 resisiting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to ressit 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 for the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or flames in window assemblies. This deficient practice could affect approximately 40 residents, as well as staff and visitors Findings include: Based on observation on 09/04/24 between 12:16 p.m. and 1:32 p.m. during a tour of the facility with the Maintenance Director, the MDS/Social Service		Penetrations in doors were sealed for MDS/Social Services office and 2nd floor med room 2) How the facility identified other residents: Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. 3) Measures put into place/ System changes: The Maintenance Director or Designee will complete monthly visual inspection of doors to ensure proper operation and that there is no penetration. Findings will be documented on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee. The Maintenance Director is responsible for compliance. 4)How the corrective actions will be monitored: The Administrator will review the Preventative Maintenance Worksheets monthly.	

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	office located on the first floor contained a circular door penetration that was approximately 1/4" in diameter. Furthermore, the 2nd floor med room, behind the nurses desk, the door to the room contained a half-moon shaped penetration above the door handle measuring approximately 1/4". Based on interview at the time of observations, the Maintenance Director confirmed that the doors contained penetrations and would get those taken care of. The finding was reviewed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 09/04/24 between 09:08 a.m. and 12:07 p.m., in the staff smoking area on the first floor, approximately 20 cigarette butts were discovered on the ground, improperly discarded, around the smoking area in the grass. Based on interview at the time of observation, the Maintenance Director confirmed that the cigarette butts were not properly discarded and would get that taken care of.	K 0741	**K741** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1) Immediate actions taken for those residents identified: Cigarette butts were cleaned and properly discarded in**	09/20/2024

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	155653	A. BUILDING 01 B. WING	09/04/2024

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**smoking area.** **2) How the facility identified other residents** **Staff, visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.** **2) Measures put into place/ System changes:** **Maintenance Director/designee will audit smoking area weekly for 6 months to ensure that cigarette butts are discarded properly into the noncombustible container that is provided in the smoking area.** **4) How the corrective actions will be monitored:** **The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview, the facility failed to ensure annual inspection and testing of 4 of 4 fire door assemblies in two stairwells were completed in accordance of LSC 19.1.1.4.1.1 communicating	K 0761	**K761** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of***	09/20/2024

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	openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position.		***compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **4 missing fire door inspections were completed. Fire door inspection currently in compliance.** **2) How the facility identified other residents:** **Staff,visitors and residents that reside at the facility have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** **The Maintenance Director will complete annual inspections and maintain records for inspection/review. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator/designee** **The Maintenance Director is responsible for compliance.**	

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	(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Administrator and Maintenance Director on 09/04/24 between 09:08 a.m. and 12:07 p.m., documentation had been provided indicating that annual fire door inspections had been completed in June of 2024, however the fire door inspections were missing for four (4) stairwell doors. Based on observation during a tour of the facility, the facility contained two stairwells with a total of four fire doors. Based on interview at the time of observation and record review, the Maintenance Director confirmed that the door inspections were missing and further stated that he does visually check them everyday for proper operation, however he does not document the inspections on an annual basis. The finding was discussed with the Administrator and Maintenacne Director at exit conference. 3.1-19(b)		**4)How the corrective actions will be monitored:** **The Administrator will review the Preventative Maintenance worksheets annually.** **The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 5 of the last 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving	K 0918	**K918** **The facility requests paper compliance for this citation.** ***This Plan of Correction is the center's credible allegation of***	09/20/2024

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	the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. 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. This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 09/04/24 between 09:08 a.m. and 12:07 p.m., no documentation for the months of September 2023 through January 2024 were available for review to show the diesel generator set in service was exercised under load at least once monthly, for a minimum of 30 minutes. Based on an interview at the time of record review, the Maintenance Director confirmed that the documentation was missing and further stated that it was before his employment date and was unaware if the inspections had been completed. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		***compliance.*** ***Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*** **1)Immediate actions taken for those residents identified:** **Facility unable to locate documentation from September through January 2024. Generator load testing being completed monthly and in compliance with documentation post January 2024.** **2) How the facility identified other residents:** **Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice.** **3) Measures put into place/ System changes:** **The Maintenance Director or Designee will complete generator monthly 30 minutes under load testing and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the**	

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			Preventative Maintenance Program by the Administrator /designee. **The Maintenance Director is responsible for compliance.** **4)How the corrective actions will be monitored:** **The Administrator will review the Preventative Maintenance worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	