STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155717	A. BUILDING -- B. WING	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

(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: 08/29/23 and 08/30/23 Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 At this Emergency Preparedness survey, Alpha Home - A Waters Community was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 86 certified beds. At the time of the survey, the census was 58. The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by: Quality Review completed on 09/05/23	E 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
E 0039 SS=C Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2), 486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §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).			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karl Eck		09/21/2023

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

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	exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct			

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

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

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

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

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

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

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	(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may	E 0039	**E039** – It is the intent of the facility to ensure to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/5/2023 the Administrator/Designee and the Maintenance Supervisor/designee conducted a full scale drill that is community or facility-based annual exercise and completed documentation for the exercise to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:	09/21/2023

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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. 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 of the facility's emergency preparedness binder on 08/29/23 at 11:50 a.m. with the Maintenance Director present, it was noted that the facility conducted three exercises that were all labeled as Table-top exercises, but failed to conduct a full-scale exercise that is community-based or an individual, facility-based functional exercise. Based on an interview at the time of record review, the Maintenance Director advised that he thought all required exercises had been conducted and that he would discuss this finding with the facility Administrator as soon as possible. During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.		a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 9/5/2023-9/10/2023 the Administrator/Designee inserviced the DON/Maintenance Supervisor/designee on the requirement that a full scale drill that is community or facility-based exercise must be conducted annually and documentation retained to meet set standards. b. DON/Maintenance Supervisor/designee will work with the Administrator to ensure a full scale drill that is community or facility-based exercise is conducted and documented to meet set standards. If any issues are discovered, they will be addressed and resolved immediately. c. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and DON/Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and conduct required exercises and make changes as necessary to meet set standards. Those reviews will be documented	

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			as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/21/2023.**	
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			

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	Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 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			

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	155717	A. BUILDING -- B. WING	08/30/2023

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	go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 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	E 0041	**E041**– It is the intent of the facility to ensure to implement the emergency power system	09/21/2023

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	found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on review of the facility's documentation entitled "Emergency Generators - Weekly Test Log" documentation for the most recent twelve-month period with the Maintenance Director during record review on 08/29/23 at 9:34 a.m. the facility was missing several weeks of testing in February of 2023 including 02/13/23, 02/20/23, and 02/27/23. Record review was extremely difficult as many of the dates were scribbled out, changed, and out of sequence in this log. Based on interview at the time of record review, the Maintenance Director advised that many of the aforementioned entries in the log were not completed by him, and the previous Maintenance Man did not keep very good or legible records. During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.		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) to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/21/2023 the Administrator/Designee inserviced the Maintenance Supervisor/designee on the requirement that the weekly test must be conducted on the emergency generator and documented in the facilities Life Safety Binder to meet set standards. b. On 9/21/2023 the Maintenance Supervisor/designee conducted the weekly test to meet set guidelines and documented in the facilities Life Safety Binder to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Maintenance Supervisor/designee will ensure a weekly test is conducted for the emergency generator and documented in the life safety binder to meet set standards. b. The Administrator will monitor adherence to the Emergency Preparedness Policy	

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			Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. At least annually to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/21/2023.**	
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: 08/29/23 and 08/30/23	K 0000	**DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the**	

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	Facility Number: 000376 Provider Number: 155717 AIM Number: 100275510 At this Life Safety Code survey, Alpha Home - A Waters Community 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 fully sprinkled. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors, and in all resident sleeping rooms. The facility has a capacity of 86 and had a census of 58 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one detached storage shed. Quality Review completed on 09/05/23		**facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.**	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility	K 0211	**K211** – It is the intent of the	09/21/2023

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	failed to ensure 1 of 4 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 14 residents, 4 staff and 2 visitors if needing to exit the facility. Findings include: Based on observations made during a tour of the facility on 08/30/23 at 10:10 a.m., the barrier door set on the 100 hall was tested. After the doors were closed and latched into the door frame, the right door, when standing on the 100-hall facing the main entrance to the facility, would not open. After a short time the Maintenance Director worked on the door latching hardware and opened the door. When it was tested a second time, it again would not open without the Maintenance Director making adjustments to the door. Based on an interview at the time of the observation, the Maintenance Director agreed that the barrier doors were not functioning properly and could cause a delay in egress during an emergency event necessitating the evacuation of the 100 Hall. During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		facility to ensure corridor means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/21/2023 the Maintenance Supervisor/designee repaired the barrier door set on the 100 hall to ensure it opens and closes properly to meet set standards. The Administrator verified the work on 9/21/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 9/21/2023 the Maintenance Supervisor/designee inspected all corridors and exit doors and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 9/21/2023 the Administrator/Designee inserviced the Maintenance Supervisor/designee on the requirement that the corridor doors must fully operate at all times to meet set standards. b. Maintenance Supervisor/designee will inspect all corridor doors to ensure they fully operate at all times as a part of the facility's monthly Preventive Maintenance Program and document those inspection results	

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			as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/21/2023.**	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire			

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	alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review with the Maintenance Director on 08/29/23 at 9:26 a.m., no documentation could be provided regarding a fire drill for the fourth quarter (October, November. and December) of 2022 on the day shift. Based on interview at the time of record review, the Maintenance Director acknowledged that there was no additional available fire drill documentation available for review at the time of this survey. During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 3.1-51(c)	K 0712	**K712** – It is the intent of the facility to ensure to conduct fire drills on each shift for all 4 quarters to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/21/2023 the Administrator/Designee inserviced the Maintenance Supervisor/designee on the requirement that fire drills must be conducted at unexpected times under varying conditions at least quarterly on each shift and documented to meet set standards. b. On 9/21/2023 the Maintenance Supervisor/designee conducted a fire drill for each of the three shifts and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the drills on 9/21/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were.	09/21/2023

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			3. **MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will ensure fire drills are conducted at unexpected times under varying conditions at least quarterly on each shift and that documentation be retained in the facility's Life Safety Binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as	

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			deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/21/2023.**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.			

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	18.7.4, 19.7.4 1) Based on observation and interview, the facility failed to ensure 1 of 1 facility main entrance area was maintained by disposing cigarette butts in a provided metal or noncombustible container with self-closing cover devices. This deficient practice could affect as many as 4 residents, 10 staff, and 6 visitors using the main entrance/exit. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/30/23 at 9:47 a.m., the main entrance to the facility had over 50 cigarette butts disposed on the ground. Furthermore, there was no noncombustible container with self-closing cover device for cigarette butt disposal in the area. Based on interview at the time of observation, the Maintenance Director agree the cigarette butts were on the ground and that there was no noncombustible container with self-closing cover device for cigarette butt disposal in the area. During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on observations and interview, the facility failed to ensure employees were smoking in a designated area where approved containers were available and in use. This deficient practice could affect as many as 4 residents, 10 staff, and 6 visitors using the main entrance/exit. Findings include:	K 0741	**K741** – It is the intent of the facility to ensure facility main entrance area is maintained by disposing cigarette butts in a provided metal or noncombustible container with self-closing cover devices and to ensure employees are smoking in a designated area where approved containers are available and in use to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/21/2023 the Maintenance Supervisor/Housekeeping Supervisor/designee picked up the cigarette butts disposed on the ground at the main entrance to meet set standards. The Administrator verified the work on 9/21/2023. b. On 9/21/2023 the Administrator/Designee inserviced Maintenance Director on the requirement that smoking is allowed in a designated area only and cigarette butts must be put in the metal container with a self-closing device to meet set standards. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. The facility has only one smoking area. 3. **MEASURES TO PREVENT**	09/21/2023

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	Based on observations made upon my arrival at the facility on 08/29/23 at 9:03 a.m. and again on 08/30/23 at 9:07 a.m. two female employees were immediately outside the main entrance to the facility smoking cigarettes on both days. Furthermore, there were no approved containers with self-closing lids available for use, nor was this the facility's designated smoking area. Based on an interview just before the start of record review on 08/29/23 and again on 08/30/23, when the Maintenance Director was asked if the main entrance was a designated smoking area, he answered that it was not and agreed that employees should not be smoking in unauthorized areas. During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**REOCCURRENCE**: a. Maintenance Supervisor/designee and Housekeeping Supervisor/designee will inspect the main entrance of the facility to ensure cigarette butts are not present and that all employees are smoking in the designated area only as a part of the facility's Smoking Policy and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Smoking Policy and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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K 0761 SS=E Bldg. 01	Based on observation, record review, and interview; the facility failed to ensure annual inspection and testing of 5 of 5 fire door assemblies were completed in accordance with LSC 19.1.1.4.1.1 Communicating 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.	K 0761	**This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/21/2023.** **K761** – It is the intent of the facility to ensure annual inspection and testing of all fire door assemblies are completed in accordance of LSC 19.1.1.4.1.1 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/21/2023 the Maintenance Supervisor/designee conducted the annual inspection for the fire door assemblies including the door to the oxygen transfilling room and documented those inspection results on the Annual Door Inspections log to meet set standards. The Administrator verified the inspections and documentation on 9/21/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 9/21/2023 the Administrator/corporate Property Manager inserviced the	09/21/2023

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	155717	A. BUILDING 01 B. WING	08/30/2023

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	(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 fully 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. (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 occupants. Findings include: Based on record review with the Maintenance Director on 08/29/23 at 9:26 a.m., an annual inspection of the fire door assemblies was available for review, but specific doors needing an inspection were omitted. When asked if the door to the oxygen transfilling room was inspected, the Maintenance Director stated that it had not. Based on interview at the time of record review, the Maintenance Director agreed that the door to the oxygen transfilling room had not been inspected during the annual fire rated door inspection.		Maintenance Supervisor/designee on the requirement that annual testing & inspections of fire door assemblies, including the door to the oxygen transfilling room, must be conducted to ensure proper operation and documented on the Annual Door Inspections log to meet set standards. b. Maintenance Supervisor/designee will conduct the annual inspection of fire door assemblies, including the door to the oxygen transfilling room, to ensure proper operation and document the inspection results on the Annual Door Inspection log as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly	

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	During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/21/2023.**	
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			

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	accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 3 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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 residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director on 08/29/23 at 9:26 a.m., documentation of weekly generator testing for three weeks in February of 2023 was not available for review. These were the weeks of 02/13/23, 02/20/23, and 02/27/23. Based on an interview at the time of record review, the Maintenance Director	K 0918	**K918**– It is the intent of the facility to ensure a written record of weekly inspections for the facility's emergency generator is maintained to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/21/2023 the Administrator inserviced the Maintenance Supervisor/designee on the requirement to perform the weekly emergency generator inspection and document the results to meet set standards. b. On 9/21/2023 the Maintenance Supervisor/designee performed the weekly emergency generator inspection and documented the results in the facilities Life Safety Binder to meet set standards 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were.	09/21/2023

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	acknowledged the aforementioned missing weekly generator testing adding that many of the aforementioned entries in the log were not completed by him, and the previous Maintenance Man did not keep very good or legible records. During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Maintenance Supervisor/designee will ensure weekly inspections on the emergency generator are conducted and documented in the life safety binder to meet set standards. b. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 1. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 9/21/2023.**	
K 0923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container			

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Bldg. 01	Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.			

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	11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 2 of 18 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 16 residents, 4 staff, and 2 visitors in the vicinity of oxygen storage and transfilling room. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 08/30/23 at 10:15 a.m., two small green portable oxygen cylinders were standing upright on the floor of the oxygen storage and transfilling room and were not chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged the two oxygen cylinders were standing upright on the floor of the oxygen storage and transfilling room and neither was chained or supported in a proper cylinder stand or cart. During the exit conference with the facility Administrator and the Maintenance Director on 08/30/23 at 12:30 p.m., no additional information or evidence could be provided contrary to this deficient finding.	K 0923	**K923** – It is the intent of the facility to ensure cylinders of nonflammable gases such as oxygen are properly secured from falling to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 9/21/2023 the Maintenance Supervisor/Director of Nursing/designee properly secured the two green portable oxygen cylinders that were standing upright on the floor of the oxygen room to meet set standards. The Administrator verified the work on 9/21/2023. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 9/21/2023 DON/Maintenance Supervisor/designee checked all areas of the facility and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 9/21/2023 the Administrator inserviced the DON/Maintenance Supervisor on the requirement that cylinders of nonflammable gases such as oxygen must be properly secured from falling to meet set standards. b. The Director of Nursing/Maintenance Supervisor will check cylinders of	09/21/2023

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	3.1-19(b)		nonflammable gases such as oxygen on a weekly basis to ensure they are properly secured from falling as a part of the facility's Oxygen Policy and Procedures Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Oxygen Policy & Procedures schedule and validate the Oxygen Policy & Procedures are in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is**	

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