STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155807	A. BUILDING -- B. WING	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RURAL HEALTH CARE CENTER	1747 N RURAL ST INDIANAPOLIS, IN 46218

(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: 10/04/22 Facility Number: 000388 Provider Number: 155807 AIM Number: 100454140 At this Emergency Preparedness survey, Rural Health Care Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 50 certified beds. At the time of the survey, the census was 40. Quality Review completed on 10/11/22 The requirement at 42 CFR Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0006 SS=F Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Olivia Winston	Administrator	12/20/2022

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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	§485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed,			

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	and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). In the Survey & Certification memo QSO: 19-06-ALL dated 02/01/19, the Centers for Medicare and Medicaid Services (CMS) updated Appendix Z of the State Operations Manual to reflect changes to add emerging infectious diseases to the definition of all-hazards approach and stated "Planning for using an all-hazards approach should also include emerging infectious	E 0006	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility emergency preparedness plan has been updated to include a reevaluated and documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment · how other residents having the potential to be affected by the	10/28/2022

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	disease (EID) threats. Examples of EIDs include Influenza, Ebola, Zika Virus and others". This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 02/04/22 with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/04/22, a documented facility-based and community-based risk assessment addressing emerging infectious disease (EID) threats was not available for review. EID was not included in the current "Hazard Vulnerability Assessment (HVA)" for the facility. Based on interview at the time of record review, the Administrator agreed emergency preparedness program documentation did not address emerging infectious diseases (EID) as part of the facility-based and community-based risk assessment as mandated by the CMS Survey & Certification memo QSO: 19-06-ALL. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference.		same deficient practice will be identified and what corrective action(s) will be taken; This alleged deficiency has the potential to affect all Residents. The facility emergency preparedness plan has been updated to include a reevaluated and documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents and (2) included strategies for addressing emergency events identified by the risk assessment · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Administrator or designee will complete a monthly review of the facility emergency preparedness risk assessment to ensure that the assessment reflected the facilities current emergency state. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Results will be brought to QAPI by the Maintenance Director or designee for follow up and review x 6 months, or until 100% compliance is achieved. · by what date the systemic	

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			changes for each deficiency will be completed. 10/28/22	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance]			

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	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 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			

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	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, observation and interview; the facility failed to implement the emergency power system inspection, testing and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Weekly Generator System Checks & Testing" documentation with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/04/22, weekly generator inspection documentation after 06/20/22 was not available for	E 0041	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Weekly generator system documentation and monthly generator system documentation have been completed and are up to date. Weekly generator system documentation and monthly generator system documentation will be included going forward and has been maintained for the safety of all resident's post Life Safety Survey and will continue to be maintained weekly and monthly. · how other residents having	10/28/2022

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	review. In addition, based on review of "Monthly Generator System Checks & Testing" monthly load testing documentation for the facility's natural gas fired emergency generator for September 2022 was also not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Director agreed weekly and monthly load testing documentation for the aforementioned periods in 2022 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, the facility has one natural gas fired emergency generator located outside the building near the smoking shed. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference.		the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This alleged deficiency has the potential to affect all Residents. Weekly generator system documentation and monthly generator system documentation have been completed and are up to date. Weekly generator system documentation and monthly generator system documentation will be included going forward and has been maintained for the safety of all resident's post Life Safety Survey and will continue to be maintained weekly and monthly. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director or designee will complete a monthly review x 6 months of the facility emergency preparedness risk assessment to ensure that the assessment reflected the facilities current emergency state. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Results will be brought to QAPI by the Maintenance Director or designee for follow up and review x 6 months, or until 100%	

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			compliance is achieved. - · by what date the systemic changes for each deficiency will be completed. 10/28/22	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/04/22 Facility Number: 000388 Provider Number: 155807 AIM Number: 100454140 At this Life Safety Code survey, Rural Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors installed in all resident sleeping rooms. The facility has a capacity of 50 and had a census of 40 at the time of this visit.	K 0000		

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	All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except one detached wooden shed providing facility storage. Quality Review completed on 10/11/22			
K 0225 SS=E Bldg. 01	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure 1 of 1 exit discharges with stairs were provided with handrails. LSC 7.2.2.4.1.6 states existing stairs shall be permitted to have a handrail on one side only. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the main entrance. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, three of the six steps in the exit discharge stair at the main entrance by the sidewalk by the street were not provided with a handrail. The stair still had hardware affixed to the concrete steps to insert the posts for where a former handrail had been in place. Based on interview at the time of the observations, the Maintenance Director agreed the exit discharge was not provided with a handrail for three of the six steps of the stairs. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference.	K 0225	Based on observation and interview, the facility failed to ensure 1 of 1 exit discharges with stairs were provided with handrails. LSC 7.2.2.4.1.6 states existing stairs shall be permitted to have a handrail on one side only. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility from the main entrance. · what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility has received 3 bids to repair the handrail and is currently awaiting the repair. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could affect over 20 residents, the facility has received 3 bids to repair the handrail and is currently awaiting	10/28/2022

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	3.1-19(b)		the repair. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director or designee will complete a monthly visual check x 6 months to ensure the handrail is in proper condition and working properly. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Results will be brought to QAPI by the Maintenance Director or designee for follow up and review x 6 months, or until 100% compliance is achieved. · by what date the systemic changes for each deficiency will be completed. 10/28/22	
K 0227 SS=E Bldg. 01	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12. 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10 Based on observation and interview, the facility failed to ensure 1 of 3 exit discharges with drop-offs and ramps were provided with curbs,	K 0227	· what corrective action(s) will be accomplished for those residents found to have been	10/28/2022

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	walls or railings. LSC 7.2.5.3.3 states ramps and landings with drop-offs shall have curbs, walls, railings, or projecting surfaces that prevent people from traveling off the edge of the ramp. Curbs or barriers shall be not less than 4 inches in height. This deficient practice could affect over 20 residents, staff and visitors if needing to use the exit by Room 26. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, the exit discharge by Room 26 had a landing with a drop off from the top of the landing to the grass below and also had a ramp which was not provided with a curb, wall or railing for the ramp. Both the landing and the ramp still had hardware affixed to the concrete landing and ramp to insert the posts for where a former handrail had been in place. Based on interview at the time of the observations, the Maintenance Director agreed the exit discharge was not provided with a curb, a wall or a railing at the drop off and for the ramp. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)		affected by the deficient practice; The facility has received 3 bids to repair the exit ramp and is currently awaiting the repair. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could affect over 20 residents, staff and visitors if needing to use the exit by Room 26. The facility has received 3 bids to repair the exit ramp and is currently awaiting the repair. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director or designee will complete a monthly visual check x 6 months to ensure the ramp is in proper condition and working properly. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Results will be brought to QAPI by the Maintenance Director or designee for follow up and review x 6 months, or until 100% compliance is achieved. · by what date the systemic changes for each deficiency will be completed. 10/28/22	

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(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
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 1. Based on record review, observation and interview; the facility failed to document monthly testing for all battery backup lights in accordance with LSC 7.9. Section 7.9.3.1.1 states testing of emergency lighting systems shall be permitted to be conducted as follows: (1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, except as otherwise permitted by 7.9.3.1.1(2). (2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered. (4) The emergency lighting equipment shall be fully operational for the tests required by 7.9.3.1.1(1) and (3). (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Battery Operated Emergency Light Test Log for (Year) - 2022" documentation with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/04/22, ten battery operated lights	K 0291	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - 30 second duration of the functional testing of Battery Operated Emergency Lights and Monthly Exit and Emergency Light Check documentation will be included going forward and has been maintained for the safety of all resident's post Life Safety Survey and will continue to be maintain monthly. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - This deficiency has the potential to affect all residents. The maintenance director or designee will complete weekly rounding will be conducted by the maintenance director/designee to ensure that all battery-operated Emergency Lights and Monthly Exit and Emergency Light Checks are functional and working properly.	10/28/2022

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	155807	A. BUILDING 01 B. WING	10/04/2022

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	were noted in the facility. Monthly functional testing documentation for August 2022 and September 2022 for the ten battery operated lights was not available for review. In addition, annual 90-minute functional testing documentation for the ten battery operated lights in the facility within the most recent twelve month period was also not available for review. Based on interview at the time of record review, the Administrator agreed monthly and annual functional testing documentation for all ten battery operated lights for the aforementioned periods was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, ten battery operated lighting systems were noted in the facility and each battery operated light functioned when its respective test button was pushed except for the battery operated light located in the corridor outside Room 16 and outside Room 21. This finding was reviewed with the Business Office Manager 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 10 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff and visitors.		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; - Weekly rounding will be conducted by the maintenance director/designee to ensure that all battery-operated Emergency Lights and Monthly Exit and Emergency Light Check are functional and working properly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - Results will be brought to QA by maintenance director for follow up and review for 6months, or until 100% compliance is achieved. By what date the systemic changes for each deficiency will be completed. - 10/28/22	

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	Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, ten battery operated lighting systems were noted in the facility and each battery operated light functioned when its respective test button was pushed except for the battery operated light located in the corridor outside Room 16 and outside Room 21. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned two battery powered emergency lighting systems each failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 1. Based on record review, observation and interview; the facility failed to ensure documentation for the preventative maintenance of all battery operated smoke alarms in resident rooms was complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained.	K 0300	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Preventative maintenance of all battery-operated smoke alarms documentation post life safety	10/28/2022

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	NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, 29.10 Maintenance and Tests states fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Weekly Smoke Detector Check" documentation dated 02/04/22 with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/04/22, resident room battery operated smoke detector preventive maintenance documentation for the four month period of January 2022 through March 2022 and after 08/22/22 was not available for review. Based on interview at the time of record review, the Administrator agreed testing documentation for battery operated smoke detectors for the aforementioned periods in 2022 was not available for review. In addition, annual smoke detector cleaning documentation for the most recent twelve month period was also not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, manufacturer's documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the ceiling in resident sleeping Room 10 and in resident sleeping Room 12 stated to test the device weekly and to clean the device annually. This finding was reviewed with the Business		code recertification has been maintained for the safety of all residents and will continue to be maintain and tested in accordance with the manufacturer's published instructions and per the requirements of chapter 14 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - This deficiency has the potential to affect all residents. No resident was affected. Weekly review will be conducted by the maintenance director/designee to ensure that all documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms is complete and up to date. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; - Weekly review will be conducted by the maintenance director/designee to ensure that all documentation for the preventative maintenance of all battery-operated smoke alarms in resident rooms is complete and up to date. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what	

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	Office Manager and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to replace 2 of over 20 battery operated smoke alarms installed in resident sleeping rooms 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 over 10 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, manufacturer's documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the ceiling in resident sleeping Room 10 stated the unit was manufactured 02/17/12. An installation date of 07/26/12 was written on the back of each device. Manufacturer's documentation affixed to the Kidde Model i9010 battery operated smoke alarm installed on the ceiling in resident sleeping Room 12 stated the unit was manufactured 03/17/12. An installation date of 07/26/12 was also written on the back of the device. Each battery operated smoke alarm stated "replace unit within 10 years of installation date". Based on interview at the time of the observations, the Maintenance Director agreed the two smoke alarms were each more than ten years old.		quality assurance program will be put into place; and Results will be brought to QA by maintenance director for follow up and review for 6months, or until 100% compliance is achieved. By what date the systemic changes for each deficiency will be completed. - 10/28/22	

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	This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0343 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Notification Fire Alarm - Notification 2012 EXISTING Positive alarm sequence in accordance with 9.6.3.4 are permitted in buildings protected throughout by a sprinkler system. Occupant notification is provided automatically in accordance with 9.6.3 by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. 19.3.4.3, 19.3.4.3.1, 19.3.4.3.2, 9.6.4, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 19.3.4.3.2 Emergency Forces Notification and LSC 9.6.1.3. LSC 19.3.4.3.2 states fire department notification shall be accomplished in accordance with LSC 9.6.4. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance	K 0343	· **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The fire alarm system trouble mode status has been investigated and is repaired. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** This deficient practice could affect all residents, staff and visitors, The fire alarm system trouble mode status has been investigated and	11/08/2022

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	Director during the initial walk through of the facility at 9:15 a.m. on 10/04/22, the main fire alarm control panel located at the nurse's station was in the trouble mode and was silenced. Based on interview at the time of the observations, the Maintenance Director stated he started working at the facility within the last week or two. The Maintenance Director stated the fire alarm system works but has been in the trouble mode and silenced when he started working at the facility. The Maintenance Director stated he believed the source of the trouble was a phone line issue but was not sure if it was both phone lines or just one line. At 1:00 p.m. on 10/04/22 during a tour of the facility, the Maintenance Director contacted the off-premises fire alarm monitoring company, Central Security, to put the system on test in order to activate the fire alarm system to see if the system worked. Based on interview with the Central Security receptionist at 1:00 p.m., the fire alarm system has not sent a signal to the monitoring entity since January 2022. The Maintenance Director activated a manual fire alarm box by the exit door to the outside of the facility by Room 26 at 1:05 p.m. which activated the fire alarm system, sounded all horn/strobes in the building and released all doors which were equipped with magnetic releasing devices set to release with fire alarm system activation. Based on interview with the same Central Security receptionist at 1:10 p.m., the facility's fire alarm system did not send an alarm signal for the manual fire alarm box activation. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)		has been repaired. · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Weekly review will be conducted by the maintenance director/designee to ensure that the fire alarm system is not in trouble mode and is being maintained in accordance with LSC 19.3.4.3.2 · **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Results will be brought to QA by maintenance director for follow up and review for 6months, or until 100% compliance is achieved. · **by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, the Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** 11/8/22	

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K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 1 oxygen storage and transfilling rooms in accordance with LSC 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in Section 8.5.5.2 and Section 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice	K 0351	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The sprinkler heads are no longer obstructed in the oxygen storage and transfilling room. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by	10/28/2022

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	could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the main entrance to the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, stacked cardboard boxes were stored on the floor up against the wall up to the sidewall mounted sprinkler installed in the oxygen storage and transfilling room by the main entrance to the facility. The box storage in the room obstructed the sprinkler spray pattern of the sprinkler in the room. Based on interview at the time of the observations, the Maintenance Director agreed the box storage in the room would obstruct the sprinkler spray pattern. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)		the main entrance to the facility. The sprinkler heads are no longer obstructed in the oxygen storage and transfilling room. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Director or designee will complete a weekly visual review of the oxygen storage and transfilling room to ensure that sprinkler heads are not obstructed. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Results will be brought to QAPI by the Maintenance Director or designee for follow up and review x 6 months, or until 100% compliance is achieved. · by what date the systemic changes for each deficiency will be completed. 10/28/22	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material			

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	capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the resident sleeping	K 0363	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corridor door of room 12 has	10/28/2022

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	Room 12. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, three separate one half inch in diameter holes were noted above the door handle for the corridor door to resident sleeping Room 12 and would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the corridor door to resident sleeping Room 12 would not resist the passage of smoke. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)		been repaired. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the resident sleeping Room 12. The corridor door of room 12 has been repaired. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Monthly review x 6 months will be conducted by the maintenance director/designee to ensure the corridor is in good repair and will maintain resistance of passage of smoke. · how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Results will be brought to QA by maintenance director for follow up and review for 6months, or until 100% compliance is achieved. · by what date the systemic changes for each deficiency will be completed. 10/28/22	

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K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure electrical receptacles in 1 of 3 electrical outlet boxes in resident sleeping Room 18 were properly wired and grounded in accordance with NFPA 70. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition at 406.4 General Installation Requirements states receptacle outlets shall be located in branch circuits in accordance with Part III of Article 210. General installation requirements shall be in accordance with 406.4(A) through (F). (A) Grounding Type. Receptacles installed on 15- and 20-ampere branch circuits shall be of the grounding type. Grounding-type receptacles shall be installed only on circuits of the voltage class and current for which they are rated, except as provided in Table 210.21(B)(2) and Table 210.21(B)(3). Exception: Nongrounding-type receptacles installed in accordance with 406.4(D). (B) To Be Grounded. Receptacles and cord connectors that have equipment grounding conductor contacts shall have those contacts connected to an equipment grounding conductor. Exception No. 1: Receptacles mounted on portable and vehicle-mounted generators in accordance with 250.34.	K 0511	· what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The electrical receptacle in Resident sleeping room 18 has been repaired. · how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This deficient practice could affect 2 residents, staff and visitors in resident sleeping Room 18. The electrical receptacle in Resident sleeping room 18 has been repaired. · what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Weekly review will be conducted by the maintenance director/designee to ensure electrical receptacles are properly wired and grounded. · how the corrective action(s)	10/28/2022

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	155807	A. BUILDING 01 B. WING	10/04/2022

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	Exception No. 2: Replacement receptacles as permitted by 406.4(D). (C) Methods of Grounding. The equipment grounding conductor contacts of receptacles and cord connectors shall be grounded by connection to the equipment grounding conductor of the circuit supplying the receptacle or cord connector. The branch-circuit wiring method shall include or provide an equipment grounding conductor to which the equipment grounding conductor contacts of the receptacle or cord connector are connected. Informational Note No. 1: See 250.118 for acceptable grounding means. Informational Note No. 2: For extensions of existing branch circuits, see 250.130. This deficient practice could affect 2 residents, staff and visitors in resident sleeping Room 18. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, two of two electrical receptacles in the wall mounted outlet box under the window in resident sleeping Room 18 were each found to have a "hot neutral" when tested with an Ideal Industries UL listed circuit tester testing device. Based on interview at the time of the observations, the Maintenance Director agreed the testing device showed the aforementioned electrical receptacles needed repair. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Results will be brought to QA by maintenance director for follow up and review for 6months, or until 100% compliance is achieved. · by what date the systemic changes for each deficiency will be completed. 10/28/22	

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K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) Projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches.	K 0711	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - The fire safety plan was revised to cover the location of fire doors for evacuation purposes. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - All residents, staff, and visitors have the potential to be affected. None were affected. The fire safety plan was revised to cover the location of fire doors for evacuation purposes. What measures will be put into	10/28/2022

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	(b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan-Emergency Job Tasks: Fire" documentation dated 02/04/22 with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/04/22, the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. The aforementioned fire safety plan is part of the facility's Emergency Preparedness Program documentation which was documented as the most recent review occurring on 02/04/22. Based on interview at the time of record review, the Administrator agreed the written fire safety plan did not address the relocation of wheeled equipment during a fire or similar emergency. Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, Hoyer lifts were stored in the corridor up against the wall outside Room 1, Room 8 and Room 15 and were not in use. A wheelchair also not in use was stored in the corridor outside Room 8. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference.		place and what systemic changes will be made to ensure that the deficient practice does not recur; - The Maintenance director or designee shall monitor monthly that the fire safety plan has been reviewed and all staff have been in-serviced on 12-14-18 on proper policy and procedure during a fire or evacuation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - Results will be brought to QA by maintenance director for follow up and review for 6months, or until 100% compliance is achieved. By what date the systemic changes for each deficiency will be completed. - 10/28/22	

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	3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 1. Based on record review and interview, the facility failed to document quarterly fire drills or staff training documentation on fire drill procedures on the second shift for 1 of 4 quarters and on the third shift for 2 of 4 quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Chosen Healthcare Fire Drill/Report" documentation with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/04/22, documentation of a second shift fire drill or staff training documentation on fire drill procedures in the second quarter (April, May, June) 2022 was not available for review. In addition, documentation of a third shift fire drill or staff training documentation on fire drill procedures in the fourth quarter (October,	K 0712	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Facility has maintained documentation of all fire drills and documentation of activation of the fire alarm system for fire drills conducted between 6:00am and 9:00pm post survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - This deficient practice affects all residents, staff and visitors. None were affected. Audit of fire drills compliance to schedule, and documentation of	10/28/2022

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	November, December) 2021 and in the third quarter (July, August, September) 2022 was also not available for review. Based on interview at the time of record review, the Administrator stated the facility operates three shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures for the aforementioned shifts and quarters was not available for review. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to adequately document quarterly fire drills conducted on the: a. first shift for 2 of 4 quarters. b. second shift for 1 of 4 quarters. LSC Section 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on review of "Chosen Healthcare Fire Drill/Report" documentation with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/04/22, documentation for the first shift fire drill conducted on 12/06/21 and on 04/08/22 did not include the time of day the drill was conducted. Documentation for the second shift fire drill conducted on 02/09/22 also did not include the time of day the drill was conducted. Based on interview at the time of record review, the Administrator stated the facility operates three shifts per day and agreed documentation for the		activation of the fire alarm system will be monitored monthly by maintenance director and/or designee. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; - Maintenance director has been in-serviced on fire-drill schedule and documentation of activation of the fire alarm system for fire drills conducted between 6:00am and 9:00pm. Audit of fire drills compliance to schedule, and documentation of activation of the fire alarm system will be monitored monthly by maintenance director and/or designee - How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - Results will be brought to QA by maintenance director for follow up and review for 6months, or until 100% compliance is achieved. - By what date the systemic changes for each deficiency will be completed. - 10/28/22	

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	aforementioned fire drills did not include the time of day the drill was conducted. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels			

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	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, observation and interview; the facility failed to document emergency generator weekly inspections for 14 weeks of the most recent 52 week period and failed to document monthly load testing for 1 month of the most recent 12 month period to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems. NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 8.4.1 states an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. Section 8.4.2.4 states spark-ignited generator sets shall be exercised at least once a month with the available EPSS load for 30 minutes or until the water temperature and the oil pressure have stabilized. NFPA 110, Section 8.3.4 states a permanent record of EPSS inspections, tests, exercising, operation, and repairs shall be maintained and readily available. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Weekly Generator System Checks & Testing" documentation with the Administrator and the Maintenance Director during record review from 9:20 a.m. to 11:55 a.m. on 10/04/22, weekly generator inspection documentation after 06/20/22 was not available for review. In addition, based on review of "Monthly	K 0918	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; - Weekly Generator System & Testing emergency generator load testing and monthly generator load documentation has been completed and will continue to be maintained to ensure compliance. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - This deficient practice could affect all residents, staff and visitors in the facility. None were affected. The maintenance director or designee will complete a weekly generator system & testing emergency generator load test audit and monthly generator load testing audit to ensure compliance. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	10/28/2022

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	Generator System Checks & Testing" monthly load testing documentation for the facility's natural gas fired emergency generator for September 2022 was also not available for review. Based on interview at the time of record review, the Administrator and the Maintenance Director agreed weekly and monthly load testing documentation for the aforementioned periods in 2022 was not available for review. Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, the facility has one natural gas fired emergency generator located outside the building near the smoking shed. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)		- Maintenance director has been in-serviced on 12-14-18 on weekly generator system & testing emergency generator load testing documentation. Maintenance director in serviced on 12-19-18 on monthly generator load documentation. The maintenance director or designee will complete a weekly generator system & testing emergency generator load test audit and monthly generator load testing audit to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - Results will be brought to QA by maintenance director for follow up and review for 6months, or until 100% compliance is achieved. By what date the systemic changes for each deficiency will be completed. - 10/28/22	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container 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.			

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	>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. 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 a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, Section 11.3.2.3 requires oxidizing gases	K 0923	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/28/2022

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	such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect over 20 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by the main entrance to the facility. Findings include: Based on observations with the Maintenance Director during a tour of the facility from 11:55 a.m. to 1:20 p.m. on 10/04/22, stacked cardboard boxes were stored up against one liquid oxygen storage container in the oxygen storage and transfilling room by the main entrance to the facility. A total of six 'E' type oxygen cylinders and one liquid oxygen storage container were stored in the room. Based on interview at the time of the observations, the Maintenance Director agreed the box storage in the room was less than five feet from the liquid oxygen container in the room. This finding was reviewed with the Business Office Manager and the Maintenance Director during the exit conference. 3.1-19(b)		- The 'E' type oxygen cylinder was immediately picked up off of the floor and supported in a proper cylinder cart. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; - This alleged deficient practice could affect over 20 staff and visitors in the vicinity of the nurse's station. No staff or residents were affected. The maintenance director completed an audit of properly secured cylinders of nonflammable gasses with no others found. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; - The maintenance director or designee will complete a weekly audit of properly secured cylinders of nonflammable gasses. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and - Results will be brought to QA by maintenance director for	

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			follow up and review for 6months, or until 100% compliance is achieved. By what date the systemic changes for each deficiency will be completed. - 10/28/22	