STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155593	A. BUILDING -- B. WING	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDIANA MASONIC HOME HEALTH CENTER	800 FREEMASON PARKWAY FRANKLIN, IN 46131

(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: 12/19/22 Facility Number: 001133 Provider Number: 155593 AIM Number: 200090430 At this Emergency Preparedness survey, Indiana Masonic Home Health 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 167 certified beds. At the time of the survey, the census was 141. Quality Review completed on 12/22/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc (the “facility”) that the findings and allegation contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all State and Federal requirements governing the management of this facility. It is thus submitted as a matter of stature only.	
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

William Pierce | Administrator | 01/06/2023

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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	§485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (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 all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated],			

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	and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to maintain an emergency preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness and Response Policy & Procedures Manual" documentation dated 03/10/21 with the Administrator and the Facility Director of Plant Operations (DPO) during record review from 9:40 a.m. to 1:00 p.m. on 12/19/22, documentation for a complete emergency preparedness program reviewed by the facility within the most recent twelve month period was not available for review. The aforementioned plan was dated as being reviewed on 03/10/21 which was not within the most recent twelve month period. Based on interview at the time of record review, the Administrator stated 03/10/21 was the date of the most recent review of emergency preparedness program documentation. The Administrator provided a "Manual Reviewed" sheet dated "12/19/21" for emergency preparedness program documentation at the end of the tour of the facility at 3:30 p.m. on 12/19/21. This finding was reviewed with the Administrator and the DPO during the exit conference.	E 0004	1) No specific residents were found to be affected by the alleged deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not affected. 3) The facility only failed to update the Emergency Preparedness Plan annual review attestation form; however, the plan had been reviewed, and updated multiple times within 2022. The facility provided to the IDOH LSC surveyor a comprehensive emergency preparedness plan that was tested in live exercises during 2022 that included: District 5 Health Care Coalition Infectious Disease Med Surge (May 12, 2022), Active Threat (July 21,2022) conducted on campus by Vantage Point Consulting, District 5 Health Care Coalition tornado disaster resulting in med surge (December 8, 2022). Additionally, the facility has continuously updated the Emergency Preparedness Plan because of the COVID-19 pandemic that impacted emerging infectious diseases and communications. Records specific to COVID-19 pandemic policies were not requested by surveyor but were available for review. Evidence of the facility participation and plan testing in	01/06/2023

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			emergency exercises in 2022 was provided to the LSC surveyor during the survey. The emergency preparedness plan was reviewed by the Director of Clinical Services and Medical Director with facility Administrator, documented on the Manual Review attestation (ATTACHMENT A dated 12/19/2022). 4) All Emergency Preparedness policies and assessments will continue to be updated and amended as needed, to follow changing CDC, CMS, and IDOH guidance. A performance improvement plan (ATTACHMENT B) was developed to ensure going forward that the emergency preparedness plan is reviewed, and documentation will be available to validate the EPP review. Facility administrator will have responsibility to update and provide the Emergency Preparedness Plan at least annually for Clinical, operational, and Medical Director review. Changes to this plan will be reviewed in monthly QAPI meetings next scheduled for 1/26/2023 (ATTACHMENT C QAPI agenda 1/26/23). To determine any employee training or system testing that may be needed for updated and revised Emergency Preparedness policies for the 2023 calendar year. Routine employee training will continue to be ongoing. Evidence of routine staff	

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			training for 2022 to emergency preparedness for 2022 was provided to the LSC surveyor at the time of survey. 5) Completed 1/6/2023	
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), §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			

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	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, 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			

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	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 which was reviewed within the most recent twelve month period 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). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness and Response Policy & Procedures Manual" documentation dated 03/10/21 with the Administrator and the Facility Director of Plant Operations (DPO) during record review from 9:40 a.m. to 1:00 p.m. on 12/19/22, a documented facility-based and community-based risk assessment reviewed by the facility within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Administrator stated 03/10/21 was the date of the most recent review of emergency preparedness program documentation. The Administrator provided a "Manual Reviewed" sheet dated "12/19/21" for emergency preparedness program documentation at the end of the tour of the facility at 3:30 p.m. on 12/19/21. This finding was reviewed with the Administrator and the DPO during the exit conference.	E 0006	1) No specific residents were found to be affected by the alleged deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not affected. 3) The facility only failed to update the Emergency Preparedness Plan annual review attestation form; however, the facility did have a documented, facility and community-based risk assessment plan. The facility provided to the IDOH LSC surveyor a comprehensive emergency preparedness plan that did include a Hazard Vulnerability Assessment that was tested in live exercises during 2022. The functional exercises included: District 5 Health Care Coalition Infection Disease Med Surge (May 12, 2022), Active Threat (July 21,2022) conducted on campus by Vantage Point Consulting that included 2 hours of staff training, District 5 Health Care Coalition tornado disaster resulting in med surge (December 8, 2022). Additionally, the facility has continuously updated the Emergency Preparedness Plan because of the COVI-19 pandemic. Evidence of the facility participation and plan testing in emergency exercises in 2022 was provided to the LSC surveyor	01/06/2023

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			during the survey. The emergency preparedness plan was reviewed by the Director of Clinical Services and Medical Director with facility Administrator, documented on the Manual Review attestation (ATTACHMENT A, dated 12/19/2022). 4) All Emergency Preparedness policies and assessments which includes the Hazard Vulnerability Assessment, will continue to be updated and amended as needed, to follow changing CDC, CMS, and IDOH guidance. A performance improvement plan (ATTACHMENT B) was developed to ensure going forward that the emergency preparedness plan is reviewed, and documentation will be available to validate the EPP review. Facility administrator will have responsibility to update and provide the Emergency Preparedness Plan which includes the Hazard and Vulnerability Assessment at least annually for Clinical, operational, and Medical Director review in QAPI. Changes to this plan will be reviewed in monthly QAPI meetings next scheduled for 1/26/2023 2023 (ATTACHMENT C QAPI agenda 1/26/23). Routine employee training will continue to be ongoing. Evidence of routine staff training to emergency preparedness for 2022 was provided to the LSC surveyor at	

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			the time of survey.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities:			

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	*[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to review and update its emergency preparedness policies and procedures to include policies and procedures for emerging infectious diseases (EID). The policies and procedures must be reviewed and updated at least annually in	E 0013	1) No specific residents were found to be affected by the alleged deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not	01/06/2023

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	accordance with 42 CFR 483.73(b). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness and Response Policy & Procedures Manual" documentation dated 03/10/21 with the Administrator and the Facility Director of Plant Operations (DPO) during record review from 9:40 a.m. to 1:00 p.m. on 12/19/22, emergency preparedness policies and procedures reviewed within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Administrator stated 03/10/21 was the date of the most recent review of emergency preparedness program documentation. The Administrator provided a "Manual Reviewed" sheet dated "12/19/21" for emergency preparedness program documentation at the end of the tour of the facility at 3:30 p.m. on 12/19/21. This finding was reviewed with the Administrator and the DPO during the exit conference.		affected. 3) The facility only failed to update the Emergency Preparedness Plan annual review attestation form. The facility has a documented Epidemic/Pandemic Preparation and Response section within the Emergency Preparedness Plan that was offered to the LSC surveyor for review. A separate emergency preparedness supplement plan specific to Infectious Diseases and COVID-19 was also available, although the LSC surveyor did not request that material which could have been provided Immediately upon specific request. The facility policies and procedures for infectious diseases and COVID-19 had been reviewed by the facility leadership (Attachment D, manual review attestation form), and the IDOH health survey team in the annual recertification survey conducted on 11/15/2022 and was found to be in substantial compliance. The plan was also reviewed by the IDOH Infection Preventionist on 4/21/2022 who found the plan to be in substantial compliance. Facility emergency preparedness plans were tested in a live exercise during 2022. The functional exercise conducted by the District 5 Health Care Coalition Infection Disease Med Surge on May 12, 2022. Additionally, the facility has continuously updated the Emergency Preparedness	

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			Plan because of the COVI-19 pandemic. Evidence of the facility participation and plan testing in emergency exercises in 2022 was provided to the LSC surveyor during the survey. 4) All Emergency Preparedness policies and assessments which includes those related to emerging infectious diseases will continue to be updated and amended as needed, to follow changing CDC, CMS, and IDOH guidance. A performance improvement plan (ATTACHMENT B) was developed to ensure going forward that the emergency preparedness plan is reviewed, and documentation will be available to validate the EPP annual review. Facility administrator will have responsibility to update and provide the Emergency Preparedness Plan which includes the emerging infectious diseases at least annually for Clinical, operational, and Medical Director review in QAPI next scheduled for 1/26/2023 2023 (ATTACHMENT C QAPI agenda 1/26/23). Changes made to this plan will be reviewed in monthly QAPI meetings to determine any employee training or system testing that may be needed. Routine employee training will continue to be ongoing. Evidence of routine staff training to emergency preparedness for 2022 was provided to the LSC surveyor	

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			at the time of survey.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws which was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness and Response Policy & Procedures Manual" documentation dated 03/10/21 with the Administrator and the Facility Director of Plant Operations (DPO) during record review from 9:40 a.m. to 1:00 p.m. on 12/19/22, documentation for a complete emergency preparedness communication plan reviewed by the facility within the most recent twelve month period was not available for	E 0029	1) No specific residents were found to be affected by the alleged deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not affected. 3) The facility only failed to update the Emergency Preparedness Plan annual review attestation form. The facility did have a documented communication plan, identified in the facility Emergency Preparedness Plan as Coordination with Local Emergency Responders and Resources, Key Contacts listed within Section 1: Introduction to	01/06/2023

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	155593	A. BUILDING -- B. WING	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDIANA MASONIC HOME HEALTH CENTER	800 FREEMASON PARKWAY FRANKLIN, IN 46131

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	review. Based on interview at the time of record review, the Administrator stated 03/10/21 was the date of the most recent review of emergency preparedness program documentation. The Administrator provided a "Manual Reviewed" sheet dated "12/19/21" for emergency preparedness program documentation at the end of the tour of the facility at 3:30 p.m. on 12/19/21. This finding was reviewed with the Administrator and the DPO during the exit conference. .		the Emergency Management Plan, and Section III: Emergency Preparedness Collaboration. These areas reflect the facility policies and procedures for communications, contacts, and coordination of information sharing in accordance with 42 CFR 483.73(c). The emergency preparedness plan was reviewed by the Director of Clinical Services and Medical Director with facility Administrator, documented on the Manual Review attestation (ATTACHMENT A dated 12/19/2022). The functional exercises the facility participated in for 2022 included: District 5 Health Care Coalition Infection Disease Med Surge (May 12, 2022), Active Threat (July 21,2022) conducted on campus by Vantage Point Consulting that included 2 hours of staff training, District 5 Health Care Coalition tornado disaster resulting in med surge (December 8, 2022).Evidence of the facility participation and plan testing in emergency exercises in 2022 was provided to the LSC surveyor during the survey. These live exercises allowed for the review of the facility communication plan and the coordination of services with outside community partners. Facility administrator attends monthly the District 5 Health Care Coalition meetings that allows emergency management	

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			networking and collaboration among health care providers (acute care, LTC, Home Health, Health Departments (State and County), and emergency responders). 1) All Emergency Preparedness policies and assessments including those related to emergency preparedness plan communications, will continue to be updated and amended as needed, to follow changing CDC, CMS, and IDOH guidance. A performance improvement plan (ATTACHMENT B) was developed to ensure going forward that the emergency preparedness plan is reviewed, and documentation will be available to validate the EPP annual review. Facility administrator will have responsibility to update and provide the Emergency Preparedness Plan which includes the communication plan, at least annually for Clinical, operational, and Medical Director review in QAPI next scheduled for 1/26/20232023 (ATTACHMENT C QAPI agenda 1/26/23) . Changes made to this plan will be reviewed in monthly QAPI meetings to determine any employee training or system testing that may be needed for updated and revised Emergency Preparedness policies. Routine employee training will continue to be	

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			ongoing. Evidence of routine staff training to emergency preparedness for 2022 was provided to the LSC surveyor at the time of survey.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training			

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	and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			

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	Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Preparedness and Response Policy & Procedures Manual" documentation dated 03/10/21 with the Administrator and the Facility Director of Plant Operations (DPO) during record review from 9:40 a.m. to 1:00 p.m. on 12/19/22, the facility's emergency preparedness training and testing program documentation was not reviewed within the most recent twelve month period. Based on interview at the time of record review, the Administrator stated 03/10/21 was the date of the most recent review of emergency preparedness program documentation. The Administrator provided a "Manual Reviewed" sheet dated "12/19/21" for emergency preparedness program documentation at the end of the tour of the facility at 3:30 p.m. on 12/19/21. This finding was reviewed with the Administrator and the DPO during the exit conference.	E 0036	1) No specific residents were found to be affected by the alleged deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not affected. 3) The facility only failed to update the Emergency Preparedness Plan annual review attestation form; however, the plan has been reviewed, and updated multiple times within 2022. The facility did provide to the IDOH LSC surveyor a comprehensive emergency preparedness plan that was tested in live exercises during 2022 that included: District 5 Health Care Coalition Infection Disease Med Surge (May 12, 2022), Active Threat (July 21,2022) conducted on campus by Vantage Point Consulting, District 5 Health Care Coalition tornado disaster resulting in med surge (December 8, 2022). Additionally, the facility has continuously updated the Emergency Preparedness Plan because of the COVI-19 pandemic. Evidence of the facility participation and plan testing in emergency exercises in 2022 was provided to the LSC surveyor during the survey. The emergency preparedness plan was reviewed by the Director of Clinical Services and Medical Director with facility Administrator, documented on the Manual Review attestation (ATTACHMENT A dated	01/06/2023

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			12/19/2022). All Emergency Preparedness policies and assessments will continue to be updated and amended as needed, to follow changing CDC, CMS, and IDOH guidance. Facility administrator will monitor and provide the Emergency Preparedness Plan at least annually for Clinical, operational, and Medical Director review in QAPI next scheduled for 1/26/20232023 (ATTACHMENT C QAPI agenda 1/26/23). Changes to this plan will be reviewed in monthly QAPI meetings to determine any employee training or system testing that may be needed for updated and revised Emergency Preparedness policies. Routine employee training will continue to be ongoing. Evidence of routine staff training to emergency preparedness for 2022 was provided to the LSC surveyor at the time of survey.	
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)			

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

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	reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 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			

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	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: a. Based on record review with the Administrator and the Facility Director of Plant Operations (DPO) from 9:40 a.m. to 1:00 p.m. on 12/19/22, weekly emergency generator inspection documentation for the most recent 52 week period was not available for review. Based on interview at the time of record review, the DPO stated the facility has two emergency generators and stated facility maintenance staff perform visual inspections for each of the two emergency generators on a weekly basis but agreed weekly inspection documentation was not available for review. Based on observations with the Administrator and the DPO during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/19/22, the two diesel fired emergency generators for the facility located outside the building each had an affixed nameplate indicating the generator was rated at 300 kW. b. Based on observations with the Administrator and the Facility Director of Plant Operations	E 0041	1) No specific residents were found to be affected by the alleged deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not affected. 3) Facility maintenance department has implemented a new weekly generator and annunciator panel inspection checklist for documenting weekly emergency generator inspections Zone 1 &2 (ATTACHMENT E). The remote emergency stop button on generators 1 & 2 are now labeled (ATTACHMENT F) to indicated “Emergency Stop”. The generator fuel supply sample was collected for analysis on 12/29/2022 by an outside contractor Premier Energy (ATTACHMENT G), test analysis is expected to be returned on 1/13/2023. The 36-month emergency generator four-hour continuous operational test was completed on 1/3/2023 (ATTACHMENT H) with no performance issues identified. 4) The Facility Director of Plant Operations has responsibility for coordinating and scheduling required generator inspections,	01/06/2023

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	(DPO) during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/19/22, the two diesel fired emergency generators for the facility located outside the building each had an affixed nameplate indicating the generator was rated at 300 kW. A remote emergency stop button was located on the exterior of the weather proof shell for each the two emergency generators but each remote emergency stop button was not labeled. Based on interview at the time of the observations, the DPO agreed the remote manual stop stations were not labeled. c. Based on record review with the Administrator and the Facility Director of Plant Operations (DPO) from 9:40 a.m. to 1:00 p.m. on 12/19/22, documentation of an annual fuel quality test for the facility's two diesel fired emergency generators was not available for review. Based on interview at the time of record review, the DPO stated the facility has two diesel fired emergency generators and agreed documentation of an annual fuel quality test for the diesel fired emergency generators was not available for review. d. Based on record review with the Administrator and the Facility Director of Plant Operations (DPO) from 9:40 a.m. to 1:00 p.m. on 12/19/22, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's two diesel fired emergency generators was not available for review. Based on interview at the time of record review, the DPO stated the facility has two diesel fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Administrator and the DPO during a tour of		system service when needed, and record keeping that supports the inspections and system services completed.	

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	the facility from 1:00 p.m. to 3:30 p.m. on 12/19/22, the facility has two diesel fired emergency generators located outside the building. Manufacturer's nameplate rating for each generator stated the generator was rated at 300 kW. These findings were reviewed with the Administrator and the DPO during the exit conference.			
K 0000 Bldg. 04	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: 12/19/22 Facility Number: 001133 Provider Number: 155593 AIM Number: 200090430 At this Life Safety Code survey, Indiana Masonic Home Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC). Building 04 was surveyed using Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type II (111) construction and fully sprinklered except for the attic which was constructed of non-combustible or limited combustible materials. The facility has a fire alarm system with smoke	K 0000	The submission of this plan of correction does not indicate an admission by the Indiana Masonic Home, Inc (the “facility”) that the findings and allegation contained herein are an accurate and true representation of the quality of care and services provided to the residents of the Indiana Masonic Home, Inc. This facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all State and Federal requirements governing the management of this facility. It is thus submitted as a matter of stature only.	

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	detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 167 and had a census of 141 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 12/22/22			
K 0353 SS=F Bldg. 04	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be	K 0353	1) No specific residents were found to be affected by the alleged deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not affected.	01/06/2023

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	inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Section 13.3.2.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents and staff in the facility. Findings include: Based on review of the sprinkler system inspection contractor's "Sprinkler Inspection Certificate" documentation dated 10/25/22 with the Administrator and the Facility Director of Plant Operations (DPO) from 9:40 a.m. to 1:00 p.m. on 12/19/22, monthly sprinkler gauge and sprinkler system control valve and fire department connection inspection documentation for eleven months of the most recent twelve month period was not available for review. Based on interview at the time of record review, the DPO stated the sprinkler system inspection contractor only provides to the facility written documentation of sprinkler tests and inspections done on an annual basis which was done during the most recent twelve month period on 10/25/22. The DPO stated the contractor performs quarterly inspections but does not provide to the facility written documentation of the date and the results of those inspections. The DPO also stated facility maintenance staff performs weekly visual		3) Facility maintenance department has implemented a new Monthly Sprinkler Systems inspection form that includes a monthly inspection of the sprinkler gauge, sprinkler system control valve, and the fire department connection. A copy of the week one January 2023 completed inspection form for Zone 1&2 are included as :(ATTACHMENT I). The inspection will be completed by the Plant Operations Director or his qualified designee weekly. 4) The Facility Director of Plant Operations has responsibility for completing or coordinating and scheduling required sprinkler system inspections, system service when needed, and record keeping that supports the sprinkler inspections and system services completed. 5)	

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	inspections of sprinkler system gauges and control valves but agreed weekly inspection documentation was not available for review. Based on observations with the Administrator and the Facility Director of Plant Operations (DPO) during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/19/22, the facility has supervised wet sprinkler systems. The sprinkler system inspection contractor had affixed a hanging tag to the sprinkler system riser indicating quarterly inspections were conducted during the most recent twelve month period on 12/16/21, 03/23/22, 06/20/22 and 10/25/22. This finding was reviewed with the Administrator and the DPO during the exit conference. 3.1-19(b)			
K 0754 SS=E Bldg. 04	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent.			

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	18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure mobile soiled linen or trash receptacles with total container capacity of greater than 32 gallons stored in 3 of over 10 corridors were located in a room protected as a hazardous area when not attended. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Administrator and the Facility Director of Plant Operations (DPO) during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/19/22, two unattended 32 gallon soiled linen receptacles and one unattended 32 gallon trash collection receptacle each partially filled with soiled linen or trash were stored next to one another in the corridor outside Room 1351. Three unattended 32 gallon soiled linen receptacles and one unattended 32 gallon trash collection receptacle each partially filled with soiled linen or trash were also stored next to one another in the corridor outside Room 1335. Four unattended 32 gallon soiled linen receptacles and one unattended 32 gallon trash collection receptacle each partially filled with soiled linen or trash were also stored next to one another in the corridor outside Room 2135. The receptacles were not stored in a room protected as a hazardous area when not attended. Based on interview at the time of the observations, the DPO agreed the receptacles were not stored in a room protected as a hazardous area when unattended. This finding was reviewed with the Administrator and the DPO during the exit conference. 3.1-19(b)	K 0754	1) No specific residents were found to be affected by the alleged deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not affected. 3) The nursing department has removed the soiled linen and trash receptacles from the service hallway and have placed them in the soiled utility room. The receptacles will be used in the hallway only when attended and providing patient care. Once patient care has been completed the receptacles will be returned to the soiled utility room for storage. The nursing department managers and administrator will visually verify the receptacles are compliant where properly stored in the soiled utility room when not in use during routine daily walking rounds. Non-nursing managers will inform nursing department managers if they observed the receptacles stored outside the soiled utility room to allow immediate intervention.	01/06/2023

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K 0918 SS=F Bldg. 04	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1. Based on record review, observation and interview; the facility failed to ensure a written	K 0918	1) No specific residents were found to be affected by the alleged	01/06/2023

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	record of weekly inspections for the facility's two emergency generators was maintained for 52 weeks of the most recent 52 week period. 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 Administrator and the Facility Director of Plant Operations (DPO) from 9:40 a.m. to 1:00 p.m. on 12/19/22, weekly emergency generator inspection documentation for the most recent 52 week period was not available for review. Based on interview at the time of record review, the DPO stated the facility has two emergency generators and stated facility maintenance staff perform visual inspections for each of the two emergency generators on a weekly basis but agreed weekly inspection documentation was not available for review. Based on observations with the Administrator and the DPO during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/19/22, the two diesel fired emergency generators for the facility located outside the building each had an affixed nameplate indicating the generator was rated at 300 kW. This finding was reviewed with the Administrator		deficient practice. 2) All residents have potential to be affected by the alleged deficient practice but were not affected. 3) Facility maintenance department has implemented a new weekly generator and annunciator panel inspection checklist for documenting weekly emergency generator inspections for documenting weekly emergency generator inspections Zone 1 &2 (ATTACHMENT E). The remote emergency stop button on generators 1 & 2 are now labeled (ATTACHMENT F) to indicated “Emergency Stop”. The generator fuel supply sample was collected for analysis on 12/29/2022 by an outside contractor Premier Energy (ATTACHMENT G). The 36-month emergency generator four-hour continuous operational test was completed on 1/3/2023 (ATTACHMENT H) with no performance issues identified. 4) The Facility Director of Plant Operations has responsibility for coordinating and scheduling required generator inspections, system service when needed, and record keeping that supports the inspections and system services completed.	

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	and the DPO during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 2 of 2 remote manual stops for emergency generators for the facility were labeled in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 15.5.1.3 states emergency generators and standby power system, where required for compliance with this code, shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 edition, 5.6.5.6 states all installations shall have a remote manual stop station of a type to prevent inadvertent or unintentional operation located outside the room housing the prime mover, where so installed, or elsewhere on the premises where the prime mover is located outside the building. The remote manual stop station shall be labeled. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Administrator and the Facility Director of Plant Operations (DPO) during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/19/22, the two diesel fired emergency generators for the facility located outside the building each had an affixed nameplate indicating the generator was rated at 300 kW. A remote emergency stop button was located on the exterior of the weather proof shell for each the two emergency generators but each remote emergency stop button was not labeled. Based on interview at the time of the observations, the DPO agreed the remote manual stop stations were not labeled.			

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This finding was reviewed with the Administrator and the DPO during the exit conference.

3.1-19(b)

3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, staff and visitors.

Findings include:

Based on record review with the Administrator and the Facility Director of Plant Operations (DPO) from 9:40 a.m. to 1:00 p.m. on 12/19/22, documentation of an annual fuel quality test for the facility's two diesel fired emergency generators was not available for review. Based on interview at the time of record review, the DPO stated the facility has two diesel fired emergency generators and agreed documentation of an annual fuel quality test for the diesel fired emergency generators was not available for review.

This finding was reviewed with the Administrator and the DPO during the exit conference.

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	3.1-19(b) 4. Based on record review, observation and interview; the facility failed to document 36 month period emergency generator testing for 2 of 2 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Administrator and the Facility Director of Plant Operations (DPO) from 9:40 a.m. to 1:00 p.m. on 12/19/22, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's two diesel fired emergency generators was not available for review. Based on interview at the time of record review, the DPO stated the facility has two diesel fired emergency generator and agreed documentation of			

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	supplemental load testing for four hours within the most recent three year period was not available for review. Based on observations with the Administrator and the DPO during a tour of the facility from 1:00 p.m. to 3:30 p.m. on 12/19/22, the facility has two diesel fired emergency generators located outside the building. Manufacturer's nameplate rating for each generator stated the generator was rated at 300 kW. This finding was reviewed with the Administrator and the DPO during the exit conference. 3.1-19(b)			