STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING -- B. WING	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

(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 Dates: 04/24/23, 04/25/23 & 04/26/23 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 At this Emergency Preparedness survey, Hamilton Grove was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 85 beds dually certified for Medicare and Medicaid. At the time of the survey, the census was 69. Quality Review completed on 04/26/23	E 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review in lieu of a post-survey revisit for compliance on or after June 30, 2023. In addition, this provider requests Informal Dispute Resolution of the scope and severity of K 353 as the surveyor's interpretation of both the structure that is the nursing facility and the requirements inaccurate, as further addressed below.	
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),			

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

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	§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 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			

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	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 emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain an Emergency Preparedness Plan (EPP) 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). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Technician #1 and Maintenance Director on	E 0006	It is the practice of Hamilton Grove to maintain an emergency preparedness plan reviewed and updated every two years. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Administrator/designee will update the Emergency Preparedness Plan, including the	06/30/2023

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	04/24/23 at 09:00 a.m., no documentation could be found regarding a documented facility-based and community-based risk assessment utilizing an all-hazards approach. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned issue and stated the facility does have a documented risk assessment, but was unable to be located during the survey.		risk assessment and identified policies. **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/designee will review and present the Emergency Preparedness Plan to the Quality assurance committee for further review and recommendations. This will occur quarterly for the first year and then annually thereafter. Any updates or necessary changes will be made immediately to ensure compliance. In addition, the Director of Maintenance will be educated concerning the requirements to maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years.	
E 0015 SS=F Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(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			

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	section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting.			

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	(3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director and Maintenance Technician #1 on 02/25/23 between 08:45 a.m. and 11:00 a.m., the subsistence needs documentation for the emergency preparedness program was incomplete. The following policies and procedures could not be located: a) Food, water, medical, and pharmaceutical supplies b) Sewage and waste disposal Upon interview at the time of record review, the Maintenance Director stated that these plans are in place for the facility, however documentation was unable to be provided at the time of the survey.	E 0015	It is the practice of Hamilton Grove to develop and implement emergency preparedness policies and procedures based on the emergency plan, which addresses the following subsistence needs for staff and residents, food, water, medical and pharmaceutical supplies, and alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, (B) Emergency lighting, (C) Fire detection, extinguishing, and alarm systems, and (D) Sewage and waste disposal. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Administrator/designee will verify that all appropriate policies are in place. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Emergency Preparedness Plan with the aforementioned policies will be reviewed quarterly	06/30/2023

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			for the first year and then annually thereafter by the Quality assurance committee. In addition, all maintenance personnel and members of the Management Team will be educated in those policies.	
E 0018 SS=F Bldg. --	403.748(b)(2), 416.54(b)(1), 418.113(b)(6)(ii) and (v), 441.184(b)(2), 482.15(b)(2), 483.475(b)(2), 483.73(b)(2), 485.625(b)(2), 485.920(b)(1), 486.360(b)(1), 494.62(b)(1) Procedures for Tracking of Staff and Patients §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.			

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	*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.			

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	*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system to track the location of on-duty staff and sheltered residents in the LTC facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the LTC facility must document the specific name and location of the receiving facility or other location in accordance with 42 CFR 483.73(b) (2). This deficient practice could affect all occupants, Findings include: Based on record review with the Maintenance Director and Maintenance Technician #1 on 04/25/23 between 08:45 a.m. and 11:00 a.m., a policy and procedure that includes a system to track the location of sheltered residents and staff in the LTC facility during an emergency was unavailable for review. Based on interview at the time of record review then again at the exit conference, the Maintenance Director stated that the facility has a policy in place, but was unable to locate the policy at the time of the survey.	E 0018	It is the practice of Hamilton Grove to have policies and procedures in place to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Administrator/designee will verify that all appropriate policies are in place. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Emergency Preparedness Plan with the aforementioned policies will be reviewed quarterly for the first year and then annually	06/30/2023

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			thereafter by the Quality assurance committee. In addition, all maintenance personnel and members of the Management Team will be educated in those policies.	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [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 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.			

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	*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure Emergency Preparedness Plan (EPP) includes the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Director on 04/25/23 between 08:45 a.m. and 11:00 a.m., the provided EPP did not address the use of volunteers in an emergency. Based on interview at the time of records review, the Maintenance Director stated that the facility does not have a specific policy for the use of volunteers.	E 0024	It is the practice of Hamilton Grove to use staff members in case of an emergency. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Administrator/designee will verify that an appropriate policy is in place that speaks to staffing strategies and the non-use of volunteers during an emergency. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Emergency Preparedness Plan with the aforementioned policies will be reviewed quarterly for the first year and then annually thereafter by the Quality	06/30/2023

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			assurance committee.	
E 0032 SS=C Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(3), 441.184(c)(3), 482.15(c)(3), 483.475(c)(3), 483.73(c)(3), 484.102(c)(3), 485.625(c)(3), 485.68(c)(3), 485.727(c)(3), 485.920(c)(3), 486.360(c)(3), 491.12(c)(3), 494.62(c)(3) Primary/Alternate Means for Communication §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(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]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management	E 0032	It is the practice of Hamilton Grove to maintain an emergency preparedness communication plan. No residents were adversely affected by this alleged deficient	06/30/2023

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	agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Maintenance Director on 04/25/23 between 08:45 a.m. and 11:00 a.m., the EPP provided did not address primary and alternate means for communication. Based on interview at the time of records review, the Maintenance Director stated there is a primary and alternate means of communication but agreed the plan did not address primary and alternate means for communication.		practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Administrator/designee will update the communication plan to ensure it includes primary and alternate means for communicating with the following: (1) LTC facility's staff and (2) Federal, State, tribal, regional, or local emergency management agencies. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Maintenance, maintenance department, and Management Team will be educated on the emergency communications policy. The policy will be reviewed quarterly for the first year and then annually thereafter by the Quality assurance committee.	
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC 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 annually. The			

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	communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID 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. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.73(c)(8). This deficient practice could affect all occupants. Findings include: Based on review of the facility's Emergency Preparedness Plan (EPP) with the Maintenance Director on 04/25/23 between 08:45 a.m. and 11:00 a.m., the emergency preparedness plan failed to include a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned issue and stated that the facility has a policy in place, but was unable to be located at the time of the survey.	E 0035	It is the practice of Hamilton Grove to share with residents and family members as appropriate elements of the emergency preparedness plan. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Administrator/designee will communicate to residents and family members via written means information concerning the emergency preparedness plan. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The communication policy will be updated to include an annual	06/30/2023

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			communication with residents and family members about the emergency preparedness plan. The policy will be reviewed quarterly for the first year and then annually thereafter by the Quality assurance committee.	
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)			

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	Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or 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,			

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	1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on records review with the Maintenance Technician #1 and Maintenance Director on 02/24/23 between 09:33 a.m. and 1:40 p.m., the generator lacked weekly inspections required by	E 0041	It is the practice of Hamilton Grove for the generators to be inspected weekly. The Life Safety inspection noted that Hamilton Grove failed to inspect the generator four times during the year. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/30/2023

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	LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Technician #1 acknowledged missing weekly visual inspections..		**practice;** The Administrator/designee will educate the director of maintenance and the maintenance technician on the weekly inspections of the generator. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** An audit will be completed by the Administrator/designee for the weekly inspection logs for the generator. Weekly for 13 weeks until substantial compliance is achieved. Results will be reviewed by QAPI, and results will be reported in QAPI.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a) which resulted in Immediate Jeopardy. Immediate Jeopardy cited at K353 Survey Dates: 04/24/23, 04/25/23 & 04/26/23 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 At this Life Safety Code survey, Hamilton Grove was not found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012	K 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review in lieu of a post-survey revisit for compliance on or after June 30, 2023.	

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	edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The building was surveyed with Chapter 19 Existing Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a monitored fire alarm system with smoke detection in corridors, areas open to the corridor, and hardwired smoke detectors in all resident rooms. A 2-hour occupancy barrier separates the assisted living portion and a business occupancy section from the healthcare part of the building. A bathing area and physical therapy for healthcare residents both are located outside of the 2-hour wall located within the business area of the building which was then surveyed as part of healthcare. The facility has a capacity of 85 and had a census of 69 at the time of this survey. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 04/26/23		In addition, this provider requests Informal Dispute Resolution of the scope and severity of K 353 as the surveyor's interpretation of both the structure that is the nursing facility and the requirements inaccurate, as further addressed below.	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be			

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	permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall			

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	be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure the means of egress through 5 of 8 exit doors in the facility were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. LSC 7.2.1.5.3 requires if provided, locks shall not require of a key, a tool, or special knowledge or effort for operation from the egress side. This deficient practice could affect all residents and staff. Findings include: Based on observation with the Maintenance Technician #1 and Maintenance Director on 04/24/23 between 1:43 p.m. and 4:55 p.m., The following findings were found: a) The emergency exit doors next to the Activities Director's office was magnetically locked and required a 4-digit code but was not posted at the exit. b) The emergency exit doors next to the laundry area was magnetically locked and required a	K 0222	It is the practice of Hamilton Grove for egress doors in the Long-term Health Care building not be equipped with a latch or a lock that requires the use of a tool or key from the egress side. It is also the practice of Hamilton Grove for doors in the Long-term Health Care building to be arranged to be opened readily from the egress side whenever the building is occupied. We disagree with the use of the healthcare occupancy chapter for doors in the service/support building. 0bjection to the interpretation that a thumb-turn device does not comply with the requirements. Objection to the inspector's interpretation that door locking arrangements are not permitted on exit doors (exterior doors and Horizontal Exits). Section 19.2.2.2.3 NFPA 101 permits doors within the required means of egress shall be permitted to be subject to locking. Doors from any room which are	06/23/2023

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	4-digit code but was not posted at the exit. c) The emergency exit doors next to the employee entrance/exit was magnetically locked and required a 4-digit code but was not posted at the exit. d) The emergency exit doors next to room 1128 was magnetically locked and required a 4-digit code, but the code was not clearly marked or posted e) The emergency exit doors near resident room 1110 was magnetically locked and required a 4-digit code, but the code was not clearly marked or posted. Based on interview at the time of observation, the Maintenance Director and Maintenance Technician #1 agreed the codes to the doors were not posted nor clearly marked. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 restrooms for the physical therapy office were able to open from the inside if locked. LSC 19.2.2.1 states doors complying with 7.2.1 shall be permitted. 7.2.1.5.1 Door leaves shall be arranged to be opened readily from the egress side whenever the building is occupied. This deficient practice could approximately 10 residents and staff. Findings include: Based on observation with the Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., the restroom door in the physical therapy office was locked with a padlock from the outside and there was no release from the inside to open the door if lock with the pad lock. This condition could trap a person inside the restroom if locked from the outside. Based on interview at		not required for egress may be locked. Section 19.2.2.2.4 NFPA 101 permits doors within a required egress to have a latch or lock, provided the latch or lock does not require the use of a tool or key from the egress side. A thumb-tum lock requires no tool or key or special knowledge to operate. The nursing facility at Hamilton Grove is divided by fire Walls in accordance with NFPA 221 and by definition forms separate buildings for the purpose of Construction Classification. These same Fire Walls serve as Horizontal Exits as defined by Section 7.2.4 of NFPA 101. The cross-corridor doors in these Horizontal Exits meet the requirements of Section 7.2.1. By definition the Horizontal Exit is the Exit for occupants with the building (see Section 7.2.4.1 NFPA 101). Section 19.1.2.4 permits Exit through a Horizontal Exit into other contiguous occupancies that do not conform to health care egress provisions. The service/support building meets this exception. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	

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	the time of observation, the Maintenance Technician #1 agreed the restroom door could be locked with a padlock and could not open from the inside when locked. 3.1-19(b)		Although Hamilton Grove believes in it within guidelines, we note the doors mentioned on letter a,b,d, and e have the 4-digit code posted. The door mentioned in letter c is located in the staff lounge, to which residents are not allowed. In addition, the lounge is located in the service/support building. In the meanwhile, the four-digit code has been posted on all the doors mentioned in the report. Responding to point number 2, the identified lock has been removed to allow the door to be open from either side. **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 will verify that the 4-digit code is displayed by each door identified. He will do weekly checks for the next three months, moving to monthly checks for the following three, and report to the Quality assurance committee.	
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather			

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	travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 6 exit discharge had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect any staff in the break room and any residents exiting through the breakroom area. Findings include: Based on observations during a tour of the facility with the Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., the emergency exit door leading from the breakroom discharged to a small concrete stoop and did not lead to the public way. The rest of the path to the public way was an uneven walking surface consisting primarily of grass. Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the exit discharge did not lead to the public way and agreed the door was used as an emergency exit and was provided with exit signage above the door. 3.1-19(b)	K 0271	It is the practice of Hamilton Grove to provide a level walking surface with respect to changes in elevation and shall be maintained free of obstructions in our Long-term Health Care building. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Although Hamilton Grove believes the present Exit in the staff lounge, in which no residents are allowed, is within the guidelines for its service/support building. In the meanwhile, Hamilton Grove is reaching out to several contractors for an estimate on the use of either concrete or asphalt to provide an all-weather packed level walking surface. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** Hamilton Grove will add an all-weather-packed level walking surface to the identified area.	09/05/2023
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire			

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	155672	A. BUILDING 01 B. WING	04/26/2023

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	barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 storage rooms in the Occupational Therapy storage room had large amounts of combustible storage and was greater than 50 square feet was protected as a hazardous area. This deficient practice could affect approximately 10 staff and residents. Findings include:	K 0321	It is the practice of Hamilton Grove for hazardous areas in the Long-term Health Care building to be protected by a fire barrier. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those**	06/30/2023

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	Based on observation during a tour of the facility with Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., the Occupational therapy corridor storage room contained over 10 boxes of supplies and was greater than 50 square feet making this a hazardous area. The storage room was not protected as a hazardous area because the corridor door to the room was not self-closing or automatic closing. Based on interview at the time of observation, the Maintenance Technician #1 agreed the storage room contained large amount of combustible storage, was larger than 50 square feet, and the corridor door to the room was not self-closing. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 laundry rooms which is a hazardous area containing fuel fired equipment and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice could staff in the service hall. Findings include: Based on observations during a tour of the facility with the Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., the laundry room, a hazardous storage room that was greater than 50 square feet, was equipped with self-closing device but did not latch into the frame when tested. Based on interview at the time of observation, the Maintenance Technician #1 agreed the room contained fuel fired equipment, was larger than 50 square feet, and acknowledged the door would		**residents found to have been affected by the deficient practice;** When the building is provided with an automatic sprinkler system, the area is to be separated from the other spaces by smoke-resisting partitions and doors. The doors are to be self-closing or automatic closing. The code does not require positive latching of the doors. If the door assembly closes completely and does not resist the passage of smoke, then there is no violation. Although Hamilton Grove believes in it within the guidelines in the two examples provided, the following action will be taken: · A self-closing device will be installed in the door to the occupational therapy storage room. · A self-closing device and a latch will be installed in the laundry doors. The deadbolt will be removed. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The corrective actions listed in the previous question will result in the deficiency being corrected and not recurring.	

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	not completely latch into the frame. 3.1-19(b)			
K 0353 SS=L Bldg. 01	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 1. Based on record review and interview, the facility failed to ensure a full hydrostatic flush was performed on 1 of 1 automatic sprinkler piping systems that resulted in Immediate Jeopardy to residents who rely on the protection of an automatic sprinkler system to receive an unobstructed flow of water for effective control and extinguishment of fire. NFPA 25, 2011 edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems Section 14.3.2 requires systems shall be examined for internal obstructions where conditions exist that could cause obstructed piping. Section 14.3.3, states if an obstruction investigation indicates the presence of sufficient	K 0353	The five-year inspection by Ryan Fireprotection identified a buildup of sediments in our systems. It was recommended to flush the systems. A quote was received on 01/26/22, and no action had been taken at the time of the Life Safety inspection. **Residents at Risk** Facility Wide **What**	06/30/2023

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	material to obstruct pipe or sprinklers, a complete flushing program shall be conducted by qualified personnel. This deficient practice affects all residents, staff and visitors in the facility. This deficiency resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 04/24/23 at 11:07 a.m. when it was learned the efficiency of the sprinkler system was potentially impaired due to corrosion products and foreign material. The Immediate Jeopardy began when review of the sprinkler vendor Fire Protection report dated 11/17/21 indicated the facility was made aware of this impaired efficiency of the sprinkler system which in the event of a fire, if the first sprinklers to open were obstructed or plugged, the fire in that area cannot be extinguished or controlled by prewetting of adjacent combustibles. In such a situation, the fire can grow to an uncontrollable size, resulting in a threat to the residents, greater fire damage and the structural integrity of the building, depending on the number of obstructed/plugged sprinklers and fire severity. The facility also did not conduct a fire watch during the time of the impaired efficiency of the sprinkler system. The Maintenance Director, Maintenance Technician #1 and the Administrator were notified of the Immediate Jeopardy on 04/24/23. The Immediate Jeopardy was removed on 04/26/23 at 9:04 a.m. when the facility implemented a fire watch, but the facility remained out of compliance with no actual harm with potential for more than minimal harm that is not Immediate Jeopardy as the facility still needed to complete a flush of the remaining sprinkler system. Findings include: Based on review of sprinkler system inspection		**corrective action(s) will be taken:** Hamilton Grove received a quote from Ryan Fireprotection Inc. for flushing the two dry systems at Hamilton Grove. The quote was approved. Ryan Fireprotection Inc has indicated that it will start the work on the week of May 15, 2023, with a finish date no later than the week of July 3, 2023. Hamilton Grove has contacted Ryan Fireprotection Inc and requested an expedited startup date sooner than May 15. Beginning immediately until the completion of the project, Hamilton Grove will implement a fire watch until the flushing of the pipes has been completed. Concerning item #2, Hamilton Grove believes we had the required number of sprinkler heads plus two extras that were not located in the appropriate location. Ryan Fireprotection Inc has been contracted to verify that Hamilton Grove has the required sprinkler heads. Hamilton Grove will follow up on their recommendation concerning the number of sprinkler heads. Concerning item #3, all IT wires	

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	reports on 04/24/23 between 9:33 a.m. and 1:45 p.m. with the Maintenance Director and Maintenance Technician #1 present, the Sprinkler System vendor 5-year Internal Inspection of Sprinkler Piping and Valves dated 11/17/21 for 1 of 4 dry pipe sprinkler systems stated "The end of a main flushing connection had some rust chunks and build up that could cause problems to discharge of a sprinkler head." Under the Recommendations section of the report, the Sprinkler System Vendor stated "I recommend that this system be flushed out soon. The debris could cause serious problems." Based on interview at the time of record review, the Maintenance Director said a full flush of the sprinkler system has not been performed since the report was given to the facility due to getting the finances approved. Furthermore, a quote from Sprinkler System vendor to perform the sprinkler system flush was available for review during record review. The quote was dated 01/26/22 with an expiration date of 03/28/22. No updated quote from the sprinkler company was available for review The lack of the dry pipe sprinkler system hydrostatic flush conducted as a recommendation after the Internal Pipe Inspection was conducted was acknowledged by the Maintenance Director on 04/24/23 at 12:00 p.m. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems were provided with spare sprinklers, a spare sprinkler cabinet large enough to fit all spare sprinkler heads, and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six)		taped to the sprinkler system have been removed. **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/designee will educate the Director of Maintenance and the maintenance department personnel on the appropriate number of sprinkler heads, not taping wires to the sprinkler system and the importance of implementing the fire-sprinkler 5-year inspection recommendation promptly. The Director of Maintenance or its designee will conduct a monthly audit of the number of sprinkler heads and a walk-through of the sprinkler system to verify they are not wires taped. Reports will be submitted quarterly to the Quality assurance committee for the next four quarters. **Why the Scope and Severity Should be Changed as this Alleged Deficiency Does Not Constitute an Immediate Jeopardy.** While there was a recommendation to flush the systems, the failure to immediately implement that recommendation did not place Hamilton Grove's residents at any increased risk of harm and certainly not Immediate Jeopardy.	

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	shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observation with the Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., the spare sprinkler cabinet in the riser room near the Maintenance Shop was not large enough to contain all sprinkler heads and prevent damage to the sprinkler heads. When the cabinet in riser room was opened, the cabinet contained 3 more sprinkler heads than spots available. Furthermore, within the spare sprinkler head cabinet, one intermediate rated sidewall sprinkler head and one intermediate rated pendant sprinkler head were in the cabinet, the required number of spares needed for the facility was not met. Based on interview at the time of the observations, the Maintenance Technician #1 agreed the cabinet was not large enough to contain all spare sprinkler heads and there were not enough spares per sprinkler head type. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected		There was sufficient, functional, fire suppression regardless of any alleged buildup, and the outside vendor did not advise the system would not work absent the recommended flush. Hamilton Grove, therefore, seeks a reduction in the scope and severity of this alleged deficiency.	

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	and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.2.2 requires sprinkler piping shall not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice could affect approximately 12 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., the laundry room in the service corridor had wires taped to the sprinkler pipe around the room. Furthermore, the main fire alarm control panel room contained electrical wires that were taped and supported by a sprinkler line within the room. Based on interview at the time of observation, the Maintenance Technician #1 agreed wires were wrapped around and taped to a sprinkler pipe. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler heads in the bathing room were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive			

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	element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 4 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m. The bath area near resident room 1119 had one loaded sprinkler head covered in lint and a foreign substance. Based on interview at the time of observation, the Maintenance Technician #1 confirmed the aforementioned sprinkler heads showed dirt accumulation and loading and would need cleaning. 3.1-19(b)			
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 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			

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	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 2 of 5 corridor doors were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 10 staff. Findings include: Based on observation with the Maintenance Director on 04/24/23 from 1:45 p.m. to 4:35 p.m., the corridor doors into the occupational therapy office and the physical therapy offices in the business section were propped open with kick stands. Furthermore, the Physical Therapy office doors were not positively latching when closed.	K 0363	It is the practice of Hamilton Grove not to use kickstands to prompt doors open. As noted in K222, we disagree with the use of the healthcare occupancy regulations in the service/support building. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The kickstands were immediately removed. In addition, a latching	06/30/2023

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	Based on interview at the time of observation, the Maintenance Technician #1 acknowledged the aforementioned corridor doors would not close unless the kickstands were placed up or positively latching. 3.1-19(b)		door mechanism will be installed in the door mentioned. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Maintenance or its designee will educate the Physical Therapy Office staff concerning the not use of kickstands at Hamilton Grove.	
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 Based on record review and interview, the facility failed to conduct quarterly fire drills for 2 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the "Fire Drill/Disaster Drill Record" form with the Maintenance Director and the Maintenance Technician #1 on 04/24/23	K 0712	It is the practice of Hamilton Grove to hold quarterly fire drills. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Director of Maintenance or its designee will educate all the	06/30/2023

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	between 9:33 a.m. and 1:40 p.m., there was no documentation for a third shift fire drill in the second quarter of 2022. Additionally, there was no documentation for a third shift fire drill in the third quarter of 2022. Based on interview at the time of record review, the Maintenance Director agreed that the two fire drills were missing and stated that the fire drills were not conducted for those times. 3.1-19(b) 3.1-51(c)		maintenance personnel on the Fire Drills requirements. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** Each quarter for the next 12 months, a report will be taken to the Safety Committee, documenting compliance with the quarterly fire drills.	
K 0754 SS=E Bldg. 01	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. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure trash receptacles in 1 of 6 corridors were maintained in accordance with 19.7.5.7. This deficient practice could affect approximately 20 residents and staff.	K 0754	It is the practice of Hamilton Grove to ensure that trash receptacles in the Long-Term Health Care building are maintained in accordance with regulations.	06/30/2023

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	Findings include: Based on observations during a tour of the facility with the Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., there were two 33-gallon soiled linen/waste carts plus approximately five 10-gallon waste containers in the corridor next to the occupational therapy gym. Based on interview at the time of observation, the Maintenance Technician #1 agreed that there was excessive waste storage in the corridor and stated they should be moved. 3.1-19(b)		As noted in K222, we disagree with the use of the healthcare occupancy regulations in the service/support building. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The two wasted carts identified were immediately moved. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Maintenance or its designee will educate the Health Care Nursing Staff, Laundry, and Housekeeping staff concerning the proper use of soil linen and/or trash collection receptacles. The maintenance Director/Designee will conduct rounds in the Healthcare Building 3 times a week for the first 30 days, twice a week for the next 30 days, and once a week for the next 30 days to ensure compliance. The results will be submitted monthly to the Quality Assurance Committee until 100% compliance is achieved.	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters			

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	Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview, the facility failed to ensure 2 of 2 portable space heaters were not used in the facility. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observations during a tour of the facility with the Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., two portable space heaters were located in the Occupational therapy gym and under the nurse's station across from room 1145. Based on interview during record review, the Maintenance Director stated that space heaters were not permitted in the facility or within patient care areas. During an interview later with the Maintenance Technician #1 at each observation, he agreed that the space heaters were present and removed them upon observation. 3.1-19(b)	K 0781	It is the practice of Hamilton Grove is the policy and practice of Hamilton Grove to prohibit the use of portable space heaters in all health care occupancies with the exception of non-sleeping areas where staff and employees are located, provided the heating elements of such devices do not exceed 212 degrees F. (100 degrees C). No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Both space heaters identified were immediately removed. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Maintenance or its designee will educate the Physical Therapy Office staff and the Health Care Nursing staff; The Maintenance Director/Designee will review both Healthcare Assembly and Service	06/30/2023

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			Support building during weekly rounds to ensure there are no portable heaters present. He will note this in his weekly report, which will be reviewed by the Administrator/Designee. The weekly report will be submitted to the Quality Assurance Committee monthly for 90 days, then Quarterly thereafter or until 100% compliance is achieved. The Date by which the systemic changes will be completed is June 30, 2023	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a			

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	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 and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 5 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on records review with the Maintenance Director and Maintenance Technician #1 on 04/24/23 between 09:33 a.m. and 1:40 p.m., the following weekly inspections for the generator could not be located: a) The week of April 17th-April 21st of 2022. b) The week of January 23rd-January 27th of 2023. c) The week of June 6th-June 10th of 2022. d) The week of June 13th-June 17th of 2022. Based on an interview at the time of record review, the Maintenance Director and Maintenance	K 0918	It is the practice of Hamilton Grove for the generators to be inspected weekly. The Life Safety inspection noted that Hamilton Grove failed to ensure a written record of weekly inspections for the generator was maintained for 5 of 52 weeks. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The Administrator/designee will educate the director of maintenance and the maintenance technicians on the weekly inspections of the generator. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** An audit will be completed by the Administrator/designee for the weekly inspection logs for the	06/30/2023

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	Technician #1 acknowledged the aforementioned issue and stated the inspections were conducted, but documentation was not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was allowed a 5-minute cool down period after a load test. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110, 6.2.10 Time Delay on Engine Shutdown requires that a minimum time delay of 5 minutes shall be provided for unloaded running of the Emergency Power Supply (EPS) prior to shut down. This delay provides additional engine cool down. This time delay shall not be required on small (15 kW or less) air-cooled prime movers. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on record review with the Maintenance Director and Maintenance Technician #1 on 04/24/23 between 09:33 a.m. and 1:40 p.m., the generator monthly log documented the generator was tested monthly for at least 30 minutes under load, however, the following months did not document a cool down time following its load test: a) July 2022 b) October 2022 through January 2023 Based on interview at the time of record review, the Maintenance Technician acknowledged the aforementioned condition. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b) 3. Based on record review and interview, the		generator. Weekly for 13 weeks until substantial compliance is achieved. Results will be reviewed by QAPI, and results will be reported in QAPI.	

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	facility failed to document the transfer time to the alternate power source on the monthly load tests for 3 of the past 12 months to ensure the alternate power supply was capable of supplying service within 10 seconds. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 04/24/23 between 09:33 a.m. and 1:40 p.m. with the Maintenance Director and Maintenance Technician #1, the Monthly Generator Logs were reviewed over the past year and lacked the transfer time from normal power to emergency power for the months of April, May, and July of 2022. Based on interview at the time of record review, the Maintenance Technician #1 acknowledged the aforementioned issue and agreed the transfer times were not documented on those reports. 3.1-19(b)			
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are			

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	used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect approximately 3 staff and an unknown number of residents. Findings include: Based on observations during a tour of the facility with the Maintenance Technician #1 on 04/24/23 between 1:45 p.m. and 4:35 p.m., in the Maintenance Office, a power strip was plugged into and supplied power by another power strip. Based on interview at the time of observation, the Maintenance Technician agreed a power strip was supplying power to another power strip. 3.1-19(b)	K 0920	It is the practice of Hamilton Grove to ensure that all power strips are used with general precautions according to regulations. No residents were adversely affected by this alleged deficient practice. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The mentioned power strips were immediately removed. **What measures will be put into place, and what systemic changes will be made to ensure that the deficient practice does not recur;** The Director of Maintenance or its designee will educate the maintenance staff on the proper use of power cords. The maintenance Director/Designee will review both Healthcare Assembly and Service Support building during weekly rounds to ensure there any power cord is being used appropriately. He will note this in his weekly report, which will be reviewed by the Administrator/Designee. The	06/30/2023

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			weekly report will be submitted to the Quality Assurance Committee monthly for 90 days, then Quarterly thereafter or until 100% compliance is achieved. The Date by which the systemic changes will be completed is June 30, 2023.	