STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING -- B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

(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: 04/17/23 Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330 At this Emergency Preparedness survey, The Waters of Clifty Falls was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 138 certified beds. At the time of the survey, the census was 92. Quality Review completed on 04/24/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
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)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Bowling	Administrator	05/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING -- B. WING	04/17/2023

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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 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). Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 04/17/23 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test. This was confirmed by the Maintenance Supervisor at	E 0041	**E041**– It is the intent of the facility to ensure 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) to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 04/20/2023 the Maintenance Supervisor conducted the three-year four-hour test on the emergency generator and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work 4/20/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 4/18/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that a three-year four-hour test on the emergency generator must be	04/20/2023

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	the time of record review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.		conducted and documented in the facilities Life Safety Binder to meet set standards. b. The Maintenance Supervisor/designee will ensure a three-year four-hour generator test is conducted and documented in the life safety binder to meet set standards. c. The Administrator will monitor adherence to the Emergency Preparedness Policy Manual and validate the documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. At least every three years the four-hour load test will be completed to ensure compliance, the Administrator and Maintenance Supervisor/designee will review the Emergency Preparedness Policy Manual and make changes as necessary to meet set standards. Those reviews will be documented as appropriate. The Administrator will present the training results at the Quality Assurance/ Performance Improvement (QA/PI) meeting. Results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of compliance is 4/20/23.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/17/23 Facility Number: 000116 Provider Number: 155209 AIM Number: 100266330 At this Life Safety Code survey, The Waters of Clifty Falls was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridor. The facility has battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 138 and had a census of 92 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has two detached wooden storage buildings which were	K 0000		

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	not sprinkled. Quality Review completed on 04/24/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Based on observation and interview, the facility failed to ensure 1 of 1 laundry area dryer room enclosure was free of lint. NFPA 101 at 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect mostly laundry staff, plus residents in the same smoke compartment. Findings include: Based on observations on 04/17/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the floor and equipment in the back of the dryer enclosure within the laundry area was substantially covered with dryer lint. Based on interview at the time of observation, the facility Maintenance Supervisor agreed there was a substantial amount of dryer lint on the floor and equipment within the enclosure behind the dryers, and further said they would increase the cleaning schedule. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit	K 0100	**K100**– It is the intent of the facility to ensure laundry area dryer room enclosures are free of lint to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 04/21/23 the Maintenance Supervisor/Housekeeping Supervisor/designee cleaned the floor and equipment in the back of the dryer enclosure in the laundry area that was covered with dryer lint to meet set standards. The Administrator verified the work on 04/21/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 04/18/23 the Administrator inserviced the Maintenance	04/21/2023

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	conference. 3.1-19(b)		Supervisor/Housekeeping Supervisor/Laundry Staff/designee on the requirement that the floor and equipment in the laundry area must be clear of dryer lint to meet set standards. b. Maintenance Supervisor/ Housekeeping Supervisor/designee will inspect the laundry area weekly to ensure the floor and equipment in the laundry area is free of dryer lint as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with	

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			subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 04/21/2023.**	
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 travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to maintain the walking surface for 1 of 9 exit discharge areas. This deficient practice could affect at least 10 residents, as well as staff and visitors. Findings include: Based on observations on 04/17/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the outside exit sidewalk from the Living Well Unit 200 back hall had two, one to two inch level changes in the concrete sidewalk leading to the public way. The level changes in the concrete sidewalk to the public way could be a tripping hazard while exiting from this area in the event of an emergency. Based on interview at the time of observation, the	K 0271	**K271**– It is the intent of the facility to ensure to maintain the walking surface for exit discharge areas to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On or by 5/17/23 the Maintenance Supervisor/Concrete Contractor will replace the two sections of the outside exit sidewalk from the Living Well Unit 200 back hall with concrete to meet set standards. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were.	05/17/2023

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	Maintenance Supervisor agreed there were two, one to two inch level changes along the sidewalk to the public way from this exit. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**3. MEASURES TO PREVENT REOCCURRENCE**: a. Maintenance Supervisor/designee will inspect all exit discharge and paths to public way to ensure they are readily accessible and free of all obstructions or impediments as a part of the facility's Monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. b. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure	

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			compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/17/23.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire 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			

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	(over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 10 hazardous area doors, such as storage room door, was provided with a self closing device. This deficient practice could affect mostly staff in the service hall, plus any residents while in the same smoke compartment. Findings include: Based on observations on 04/17/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the Housekeeping Office was also being used as a storage room. This room was over 50 square feet in size and was full of combustible items such as cardboard boxes, paper towel rolls, and chemical and cleaning supplies. The corridor door to this room was not provided with a self closing device to ensure the door would close automatically. Based on interview at the time of observation, the Maintenance Supervisor confirmed the Housekeeping Office/Storage room was not provided with a self closing device. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0321	**K321**– It is the intent of the facility to ensure the corridor door to hazardous area doors, such as storage room door, is provided with a self-closing device to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 04/20/23 the Maintenance Supervisor/designee installed a self-closing device to the Housekeeping Office room that is being used as a storage room to meet set standards. The Administrator verified the work on 4/20/23. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. On 04/20/23 the Maintenance Supervisor/designee inspected all hazardous area doors for self-closing devices and found no other negative findings. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 04/18/23 the Administrator inserviced the Maintenance Supervisor/designee/all staff on the requirement that all hazardous area doors must be protected with a self-closing device to meet set standards. b. Maintenance	04/20/2023

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			Supervisor/designee will inspect all hazardous area doors throughout the facility monthly to ensure there is a self-closing device as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with**	

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			all regulatory requirements. Our date of compliance is 04/20/23.	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood extinguishing system was maintained in proper working order. This deficient practice could affect mostly kitchen staff, plus any residents while in the adjacent dining room. Findings include: Based on record review on 04/17/23 between 9:00 a.m. and 12:00 p.m. with the Maintenance	K 0324	**K324**– It is the intent of the facility to ensure kitchen range hood extinguishing system is maintained in proper working order to meet set standards. **1. CORRECTIVE ACTIONS TAKEN**: a. On or by 5/17/23 the Facilities licensed fire alarm contractor will complete the repairs to the fire alarm panel to meet set	05/17/2023

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	Supervisor present, the 04/10/23 range hood suppression report from the facility's vendor stated "Fire Panel shows "Laundry" when system is activated.", furthermore, the 10/14/22 range hood suppression report from the facility's vendor stated "Alarm Signal On Fire Panel Shows "200 Hall Laundry"." Based on interview at the time of record review, the Maintenance Supervisor said the facility was aware of the issue with the range hood/fire alarm panel and were waiting on parts that have been ordered to fix the problem. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		standards. The Administrator will verify the work on or by 5/17/23. **2. ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. **3. MEASURES TO PREVENT REOCCURRENCE**: a. On 04/18/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the fire alarm panel must be in operating condition and free of any trouble alarms to meet set standards. b. Maintenance Supervisor/designee will ensure the fire alarm panel is in operating condition and free of any trouble alarms as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4. MONITORING CORRECTIVE ACTION**: a. The inspection results will be	

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			presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/17/23.**	
K 0345 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm system was continuously in proper operating condition. This deficient practice could affect mostly kitchen staff, plus any residents in the adjacent dining room.	K 0345	**K345**– It is the intent of the facility to ensure fire alarm systems are continuously in proper operating condition to meet set standards. 1. **CORRECTIVE ACTIONS**	05/17/2023

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	Findings include: Based on record review on 04/17/23 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, the 04/10/23 annual fire alarm system inspection and testing report from the facility's vendor stated "Kitchen Fire System when activated shows "200 Hall/Laundry Zone, Kitchen is not near the listed zone"." Based on interview at the time of record review, the Maintenance Supervisor said the facility was aware of the issue with the range hood/fire alarm panel and were waiting on parts that have been ordered to fix the problem. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		**TAKEN**: a. On or by 5/17/23 a certified fire alarm contractor/designee repaired the fire alarm panel to meet set standards. The Administrator will verify the repair on or by 5/17/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 04/18/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that fire alarm systems must be maintained in proper operating condition to meet set standards. b. Maintenance Supervisor/designee will ensure fire alarm systems are maintained in proper operating condition as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place.	

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			4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/17/23.**	
K 0353 SS=E 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			

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	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 observation and interview, the facility failed to ensure sprinkler heads in 1 of 7 smoke compartments covered with corrosion were replaced. 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 element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect mostly staff plus any resident while in the same smoke compartment. Findings include: Based on observations on 04/17/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, there were three sprinkler heads in the Supply Room covered with corrosion. Based on interview at the time of observation, the Maintenance Supervisor agreed the three sprinkler heads in the Supply Room was covered with corrosion and should be replaced. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0353	**K353** – It is the intent of the facility to ensure sprinkler heads in smoke compartments covered with corrosion are replaced to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On or by 5/17/23 a Certified Sprinkler Contractor replaced three sprinkler heads in the Supply Room that were covered with corrosion to meet set standards. The Administrator will verify the work on 5/17/23. **2.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **3.MEASURES TO PREVENT REOCCURRENCE**: 1.On 04/18/23 the Administrator inserviced the Maintenance Supervisor/designee on the requirement that the sprinkler system must be properly maintained, and sprinkler heads must remain free of corrosion to meet set standards. 2.Maintenance Supervisor/designee will ensure the sprinkler systems are maintained and sprinkler heads remain free or corrosion as a part	05/17/2023

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			of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **4.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 5/17/23.**	

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K 0355 SS=F Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to ensure 12 of 26 portable fire extinguishers were installed in a way to prevent damage and injury. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on observations on 04/17/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, twelve portable fire extinguishers located throughout the facility in the egress corridors were freestanding on a corridor wall cut-out shelf. The portable fire extinguishers were not protected from falling which could cause damage or injury. Based on interview at the time of observations, the Maintenance Supervisor acknowledged the fire extinguishers were not properly secured from falling. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)	K 0355	**K355**– It is the intent of the facility to ensure portable fire extinguishers are installed in a way to prevent damage and injury to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: a. On 04/25/23 the facilities Maintenance Supervisor/designee installed wall mounts for the twelve portable extinguishers located throughout the facility in the egress corridors that were freestanding on a corridor wall cut out shelf to meet set standards. The Administrator verified the work on 04/25/23. **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: 1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.On 04/18/23 the Administrator inserviced the Maintenance Supervisor/designee that portable fire extinguishers must be installed in a way to prevent damage and injury to meet set standards. 2.Maintenance	04/25/2023

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			Supervisor/designee will ensure portable fire extinguishers are installed in a way to prevent damage and injury monthly as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements.**	

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			Our date of compliance is 04/25/23.	
K 0522 SS=E Bldg. 01	NFPA 101 HVAC - Any Heating Device HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 Based on observation and interview, the facility failed to ensure intake combustion air from the outside was provided in 2 of 6 rooms/areas containing fuel fired equipment. This deficient practice could create an atmosphere rich with carbon monoxide which could cause physical problems for mostly staff in the service corridor and adjacent rooms. Findings include: Based on observations on 04/17/23 between 12:00 p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The dryer room within the laundry room had three fuel fired dryers that had no fresh air vent for intake combustion air from the outside provided for this enclosed room. There was an exterior wall with a screen vent, however, the opening had been blocked up at sometime, furthermore, there was a ceiling duct, but it also	K 0522	**K522** – It is the intent of the facility to ensure intake combustion air from the outside is provided in rooms/areas containing fuel fired equipment to meet set standards. **1.CORRECTIVE ACTIONS TAKEN**: 1.On 04/21/23 the Maintenance Supervisor removed the obstruction from the air vent in the laundry room to meet set standards. The Administrator verified the work on 04/21/23. b. On 04/25/23the Maintenance Supervisor/designee installed a fresh air vent in the supply room to meet set standards. The Administrator verified the work on 04/25/23. **1.ALL OTHERS WITH POTENTIAL TO BE AFFECTED**:	04/25/2023

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	had been capped at sometime. b. The Supply Room had a fuel fired water heater. There was no fresh air vent for intake combustion air from the outside provided for this room. Based on interview at the time of each observation, the Maintenance Supervisor confirmed there was no fresh air vent in either of these rooms. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		1.All residents and all staff and visitors have the potential to be affected but none were. **2.MEASURES TO PREVENT REOCCURRENCE**: 1.On 04/18/23 the Administrator inserviced laundry staff, Maintenance Supervisor/designee on the requirement that the fresh air intake must be provided and remain free obstructions to meet set standards. 2.Maintenance Supervisor/designee will ensure the fresh air intake is provided and remains free of obstructions as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. 3.The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. **3.MONITORING CORRECTIVE ACTION**: 1.The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

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			inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 04/25/23.**	
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			

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	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)			
	Based on record review and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: Based on record review on 04/17/23 between 9:00 a.m. and 12:00 p.m. with the Maintenance Supervisor present, the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test. This	K 0918	**K918** – It is the intent of the facility to ensure to maintain emergency power standby system in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 healthcare facilities code, section 6.4.1.1.6.1 to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 04/20/23 the Maintenance Supervisor conducted the three-year four-hour test on the emergency generator and documented the results in the facilities Life Safety Binder to meet set standards. The Administrator verified the work 04/20/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff and visitors have the potential to be affected but none were.	04/20/2023

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	was confirmed by the Maintenance Supervisor at the time of record review. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		3. **MEASURES TO PREVENT REOCCURRENCE**: a. The Administrator inserviced the Maintenance Supervisor/designee on the requirement that a three-year four-hour test on the emergency generator must be conducted and documented in the facilities Life Safety Binder to meet set standards. b. The Maintenance Supervisor/designee will ensure a three-year four-hour test of the emergency generator test is conducted every three years and documented in the life safety binder as a part of the facility's Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the	

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	155209	A. BUILDING 01 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 04/20/23.**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in			

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	patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as helium were properly secured from falling in 1 of 7 smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations on 04/17/23 between 12:00	K 0923	**K923** – It is the intent of the facility to ensure cylinders of nonflammable gases such as helium are properly secured from falling in smoke compartments to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. On 04/19/23 the Maintenance Supervisor/designee removed the helium tank that was in the floor of the Activity Office and moved it to the Oxygen Room and mounted it to meet set standards. The Administrator verified the work on 04/19/23. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: a. All residents and all staff	04/19/2023

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	p.m. and 2:30 p.m. during a tour of the facility with the Maintenance Supervisor, there was one medium sized helium cylinder freestanding on the floor in the Activity Office. The helium cylinder was not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Maintenance Supervisor acknowledged the helium cylinder freestanding on the floor and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference. 3.1-19(b)		and visitors have the potential to be affected but none were. On 04/19/23 Maintenance Supervisor/designee checked all areas of the facility for improperly stored helium cylinders and found no other negative findings. 3. **MEASURES TO PREVENT REOCCURRENCE**: a. On 04/18/23 the Administrator inserviced Maintenance Supervisor/Activities Director/Activities Staff on the requirement that helium cylinders must be properly secured from falling in smoke compartments to meet set standards. b. The Maintenance Supervisor/Activities Director/designee will ensure all helium cylinders are secured from falling in smoke compartments monthly as a part of the facilities Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. c. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**:	

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			a. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained. **This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is 4/19/23.**	