STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155793	A. BUILDING -- B. WING	12/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON TRACE OF FISHERS	11851 CUMBERLAND RD FISHERS, IN 46037

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/12/22 Facility Number: 012644 Provider Number: 155793 AIM Number: 201046710 At this Emergency Preparedness survey, Hamilton Trace of Fishers was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 108 certified beds. At the time of the survey, the census was 102. Quality Review completed on 12/15/22	E 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on December 12, 2022. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace credible allegation of compliance. We allege substantial compliance on January 3, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-813-4444 Sincerely, Allie Craycraft III, HFA **Executive Director** Hamilton Trace Health and Living Submission of this plan of correction in no way constitutes an admission by Hamilton Trace Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Allie Craycraft	Executive Director	12/28/2022

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			Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
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			

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	structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or 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.			

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	(1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements 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:	E 0041	**The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the facility generator had a documented 3 year 4-hour load bank test. The	12/28/2022

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	a) Based upon record review and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 9:30 a.m. and 11:55 a.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour load test. b) Based upon record review and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 9:30 a.m. and 11:55 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference.		Maintenance Supervisor has contracted with Cummins Crosspoint to do the 4-hour load bank test on December 28th. Once completed the documentation will be sent to ISDH for review. Observation B- The Community failed to ensure that the facility generator had a documented diesel fuel annual test. The Maintenance Supervisor has contracted with Cummins Crosspoint to take this sample on December 28th. Once completed the documentation will be sent to ISDH for review. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to have a 4-hour load bank test completed every 3 years. See attached TELS task labeled "Hamilton Trace Generator Maintenance"	

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			IV The facility will monitor the corrective action by implementing the following measures. CarDon Corporate Facilities is changing the contract with Cummins to include the 4- hour load bank testing every 3 years and an annual diesel fuel analysis.	
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: 12/12/22 Facility Number: 012644 Provider Number: 155793 AIM Number: 201046710 At this Life Safety Code survey, Hamilton Trace of Fishers was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard-wired smoke detectors in all resident sleeping rooms. The facility has a	K 0000	Please find enclosed the Plan of Correction for the State Licensure Survey conducted on December 12, 2022. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace credible allegation of compliance. We allege substantial compliance on January 3, 2023. We are requesting paper compliance for this plan of correction. If you have any further questions, please do not hesitate to contact me at 317-813-4444 Sincerely, Allie Craycraft III, HFA **Executive Director** Hamilton Trace Health and Living	

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	capacity of 108 and had a census of 102 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for one detached building used for storage which was not sprinklered. Quality Review completed on 12/15/22		Submission of this plan of correction in no way constitutes an admission by Hamilton Trace Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. This statement of deficiencies and plan of correction will be reviewed at the Monthly Quality Assurance/Assessment Committee meeting.	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance			

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	with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 1 separation fire doors would limit the spread of fire and restrict the movement of smoke. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect 25 residents. Findings include: Based upon a facility tour and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 11:55 a.m. and 2:45 p.m., the double set of barrier doors in the AL Dining area did not close and latch. This condition would not limit the spared of smoke from one side of the fire barrier to the other. The Facilities Support Representative acknowledged these barrier doors separated the AL and Skilled areas of the facility and did not close completely and latch. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference.	K 0131	**The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that the double fire doors from the AL Dining room to the hallway did not latch. The Maintenance Supervisor had adjusted the doors so they latch. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could have been affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance Supervisor has a current TELS task to inspect all fire doors every 3 months. See attached task labeled “Fire Door Inspection”	12/16/2022

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	3.1-19(b)		**IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities also inspects this door system during their annual CQR and annual door inspection.	
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)			

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	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) Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 5 residents, staff and visitors. Findings include: Based upon a facility tour and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 11:55 a.m. and 2:45 p.m., The Staff Development Office, greater than 50 square feet contained a number of combustible items, such as, paper, plastic, and at least 15 large cardboard boxes. The door did not self-close and latch into the door frame. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)	K 0321	**The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that the staff development office was not equipped with a self-closing devise. It was declared a hazardous area because of the excess amount of boxes. Items from this room were removed and turned back into an office. See attached picture of the staff development office. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** Maintenance Supervisor and Director of Nursing will audit this office to ensure there is not an	12/21/2022

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			excessive amount of boxes being stored in there. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will monitor the community to ensure all areas are being used for their intended use.	
K 0353 SS=F 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 maintain 1 of 1 sprinkler system in accordance with 19.3.5.3. NFPA 25, 2011 Edition, 14.2.1 states except as discussed in 14.2.1.1 and 14.2.1.4 an inspection of piping and branch line conditions shall be conducted every 5 years by	K 0353	**The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**	12/14/2022

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	opening a flushing connection at the end of one main and by removing a sprinkler toward the end of one branch line for the purpose of inspecting for the presence of foreign organic and inorganic material. This deficient practice could affect all occupants. Findings include: Based upon record review and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 9:30 a.m. and 11:55 a.m., no documentation was provided showing the date of the most recent internal pipe inspection. The Facilities Support Representative contacted the facility's sprinkler contractor during the survey requesting the missing documentation, but no documentation was provided and it was not sent from the facility's sprinkler contractor. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 2. Based on record review 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 and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air		The community failed to ensure that the sprinkler heads in the back of the commercial dryer area were not lent and dust free. The Maintenance Supervisor has cleaned the 6 sprinkler heads. See attached picture. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff in the laundry room could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to clean the sprinkler heads in the laundry room every 3 months. We have moved that up to a monthly task. Please see attached labeled “Laundry Sprinkler Head Cleaning” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect the laundry room during their annual CQR to ensure the sprinkler heads a lent and dust	

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	pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect all occupants. Findings include: Based upon record review and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 9:30 a.m. and 11:55 a.m., there was no monthly inspection of the dry pipe sprinkler system's gauges and valves for the weeks following August 3, 2020, which were located on a clipboard in the Riser Room . During an interview at the time of record review and facility tour, the Maintenance Director stated the inspection of gauges and valves had not been done. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 3. Based on observation and interview, the facility failed to ensure 3 of 3 sprinkler heads in the laundry area 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 element (5) Loading (6) Painting unless painted by		free.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON TRACE OF FISHERS	11851 CUMBERLAND RD FISHERS, IN 46037

(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
	the sprinkler manufacturer. This deficient practice could affect 3 laundry staff. Findings include: Based upon a facility tour and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 11:55 a.m. and 2:45 p.m., 6 of 6 sprinkler heads in the laundry room area and behind the dryers were coved in dust or showed signs of loading. On a few heads the bulb color was not visible due to the accumulation of lint and dust. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 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.			

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	Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 2 staff. Findings include: Based upon a facility tour and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 11:55 a.m. and 2:45 p.m., the corridor door to 400 Hall Soiled Utility area failed to close and latch positively into the door frame. Based on interview	K 0363	**The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The Community failed to ensure the 400 Hall Soiled Utility room doors did not latch positively into their respective door frame. The Maintenance Supervisor has adjusted the door so it will latch. He audited all doors in the facility and ensured that they did latch.	12/14/2022

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	at the time of the observations, the Maintenance Director agreed the aforementioned corridor door did not close and latch into the door frame and would not resist the passage of smoke. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current monthly TELS task in place to audit all doors to ensure the latch. See attached TELS task labeled “Fire Door Inspection Task” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will inspect all doors and latching devices during their annual CQR and annual door inspection.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2			

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	Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the mechanical room was enclosed and protected. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 406.5 (F) states exposed terminals and receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 3 staff. Findings include: Based upon a facility tour and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 11:55 a.m. and 2:45 p.m., in the mechanical room near resident room #807 there was an electrical receptacle that was not enclosed and had exposed metal terminals. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)	K 0511	**The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to ensure that the light switch in the mechanical room by resident door 807 had a light switch cover on it. The Maintenance Supervisor has installed a light switch cover. See attached picture showing an installed light switch cover. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents in the 800 Hall could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor was reeducated on the deficient practice and to make sure all outlet and switch covers were installed throughout the community. **IV The facility will monitor the corrective action by implementing the following**	12/14/2022

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			measures. CarDon Corporate Facilities will inspect all outlets and switched during their annual CQR.	
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 fire drills or documented orientation training on each shift for 2 of 4 quarters. LSC 19.7.1.6 states drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. QSO-20-31 1135 temporary waiver states in lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. This deficient practice affects all staff and patients.	K 0712	**I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** The community failed to provide documentation of the 4th quarter first shift fire drill. The Maintenance Supervisor has conducted the first shift drill on Dec 21st. See attached fire drill documentation. **II. The facility will identify other residents that may potentially be affected by the deficient practice.**	12/21/2022

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	Findings include: Based upon record review and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 9:30 a.m. and 11:55 a.m., the following Fourth Quarter First Shift was missing documentation of a completed fire drill or documented orientation training for the 2022 and 2021 calendar years. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b) 3.1-51(c)		All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is currently TELS tasks in place to manage the fire drill frequency and shift differentials. **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities will audit the fire drill schedule and ensure it meets all the NFPA standards during their annual CQR.	
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			

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	year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	1. Based on record review 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:	K 0918	**The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.** Observation A- The Community failed to ensure that the facility generator had a documented diesel fuel annual test. The Maintenance Supervisor has contracted with Cummins Crosspoint to take this sample on December 28th. Once completed the documentation will be sent to ISDH for review.	12/28/2022

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	Based upon record review and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 9:30 a.m. and 11:55 a.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three-year 4-hour test. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based upon record review and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 9:30 a.m. and 11:55 a.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the		**II. The facility will identify other residents that may potentially be affected by the deficient practice.** All residents and staff could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There is a current TELS task to have an annual fuel sample test completed. See attached TELS task labeled “Hamilton Trace Generator Maintenance” **IV The facility will monitor the corrective action by implementing the following measures.** CarDon Corporate Facilities is changing the contract with Cummins to include the 4- hour load bank testing every 3 years and an annual diesel fuel analysis.	

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	time of records review, the fuel quality testing for the diesel fired generator could not be located. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)			
K 0920 SS=E 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 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 1. Based on observation and interview, the facility failed to ensure 1 of 1 resident rooms did not used	K 0920	**The corrective actions to be accomplished for those**	12/13/2022

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	multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 residents. Findings include: Based upon a facility tour and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 11:55 a.m. and 2:45 p.m., resident room 604 contained a multi-plug adaptor powering medical IV equipment, a lamp and electronic equipment. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could affect 15 residents. Findings include:		**residents found to have been affected by the deficient practice.** The Community failed to ensure that the power trip in the Delaware Activity Room was properly secured to the wall. The Maintenance Supervisor has secured the power strip to the wall. See attached picture. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** The Maintenance Supervisor has been reeducated on what type of power strips and how they are to be mounted within a skilled community. A Monthly TELS task is in place to inspect the entire community to ensure that all power stirps are compliant and mounted correctly to the wall. See attached TELS Task Labeled “Power Strip Inspection” **IV The facility will monitor the corrective action by**	

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	Based upon a facility tour and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 11:55 a.m. and 2:45 p.m., in the "Delaware Room" a power strip used to equipment and was not secured, dangling from the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)		**implementing the following measures.** CarDon Corporate Facilities will entire community to ensure that all power strips are properly mounted during their annual CQR.	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 2 of 2 oxygen storage/transfer rooms was provided with a sign indicating that	K 0927	**The corrective actions to be accomplished for those residents found to have been**	12/22/2022

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	transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking is the immediate area is not permitted. This deficient practice could affects all residents Findings include: Based upon a facility tour and interview with the Maintenance Director, Facilities Support Representative, Executive Director and Administrator in Training on 12/12/22 between 11:55 a.m. and 2:45 p.m., the oxygen storage/transfer rooms (1 - Rehab Hall and 2 - Skilled Hall) did not have a posted sign indicating when transferring of oxygen occurs in this location. Based on interview at the time of observation, the Maintenance Director stated there was not a sign stating when trans-filling oxygen is occurring. This deficiency was acknowledged by the Maintenance Director and Facilities Support Representative at the time of discovery and again at the exit conference. 3.1-19(b)		**affected by the deficient practice.** The Community failed to maintain that the 2 oxygen transfilling rooms had the proper transfilling signage. Temporary signage has been installed until CarDon Corporate can order the proper signage for these 2 rooms. See attached picture showing the temporary signage. **II. The facility will identify other residents that may potentially be affected by the deficient practice.** All staff and residents could be affected by this deficient practice. **III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.** There will be no follow up because the solution is a permanent fix. **IV The facility will monitor the corrective action by implementing the following measures.** There will be no follow up because the solution is a permanent fix.	