STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155245	A. BUILDING -- B. WING	05/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASTLETON HEALTH CARE CENTER	7630 E 86TH ST INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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: 05/31/22 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840 At this Emergency Preparedness survey, Castleton Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 109 certified beds. At the time of the survey, the census was 32. Quality Review completed on 06/02/22	E 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Castleton Health Care Center maintains the alleged deficiencies do not individually jeopardize the health and/or safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Castleton Health Care Center asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the provider's credible allegation of compliance.	
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).	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions	

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

Any deficiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Survey Date: 05/31/22 Facility Number: 000149 Provider Number: 155245 AIM Number: 100266840 At this Life Safety Code survey, Castleton Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), 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 sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 109 and had a census of 32 at the time of this visit. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 06/02/22		set forth in the Statement of Deficiencies rendered by the reviewing agency. The Plan of Correction is prepared and executed solely because it is required by the provisions of federal and state law. Castleton Health Care Center maintains the alleged deficiencies do not individually jeopardize the health and/or safety of its residents nor are they of such character as to limit the provider's capacity to render adequate resident care. Furthermore, Castleton Health Care Center asserts that it is in substantial compliance with regulations governing the operation of long-term care facilities, and this Plan of Correction in its entirety constitutes the provider's credible allegation of compliance.	
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			

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	on Form CMS-2567. Based on observation and interview, the facility failed to maintain latching hardware on 2 of 8 sets of smoke barrier doors in accordance with 4.6.12.3. LSC 4.6.12.3 requires existing life safety features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect over 20 residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the latching hardware at the top of the east door in the corridor door set by the Quiet Room and the east door in the corridor door set at the entrance to the Lake House wing each failed to latch into the door frame when tested to close multiple times. Based on interview at the time of the observations, the Maintenance Director and the Regional Maintenance Director agreed the aforementioned two doors in the corridor door sets would not latch into the door frame when tested to close multiple times. This finding was reviewed with the Administrator, Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)	K 0100	**K100** **Immediate Corrective Action** 1. The latching hardware at the top of the east door in the corridor door set by the Quiet Room was repaired on 06/01/22 so that it positively latches into the frame. 2. The latching hardware at the top of the east door in the corridor door set at the entrance to the Lake House wing was repaired on 06/01/22 so that it positively latches into the frame. **Method to Assess Others** The Maintenance Director, or designee, performed documented testing on 06/02/22 of all other cross-corridor doors to ensure the doors positively latched. All resident and non-resident areas were evaluated. **Systematic Process** The Maintenance Director, or designee, will conduct documented weekly testing of the cross-corridor doors to ensure they fully close and positively latch as part of the facility's ongoing preventative maintenance	06/13/2022

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			program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of the weekly cross-corridor latching testing will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met. DOC: 6/13/2022	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 8 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility by Room 111. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the exit door to the	K 0211	**K211** **Immediate Corrective Action** The magnetic lock securing the exit by resident room 111 was repaired in the evening by Safe Care on 05/31/2022 **Method to Assess Others** The Maintenance Director, or designee, performed documented	06/13/2022

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	outside of the facility by Room 111 was marked as a facility exit with an exit sign. The door was equipped with a magnetic locking device which could be unlocked by entering a code at the keypad by the exit door. The code to release the door to open was posted at the keypad and the posted code, when entered into the keypad, disengaged the keypad lock but the magnetic holding device was still engaged after multiple times to release the door. The door would not push to open due to the magnetic holding device not disengaging. The Maintenance Director and the Regional Maintenance Director opened the keypad and disconnected wiring in the keypad which caused the magnetic holding device to disengage because it had no electrical power. The exit door opened when the wiring was disconnected. Based on interview at the time of the observations, the Regional Maintenance Director stated the magnetic holding device was defective and needed replacement and agreed the exit door by Room 111 was not continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This finding was reviewed with the Administrator, Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		testing on 06/01/22 of all other exits with magnetic locks to ensure the magnetic lock released and allowed egress when the keypad's code was entered. All resident and non-resident areas were evaluated. **Systematic Process** The Maintenance Director, or designee, will conduct documented weekly inspections of all exits with magnetic locks to ensure the magnetic lock releases and allows egress when the keypad's code is entered, as part of the facility's ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of the weekly magnetic lock testing will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met.	
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating			

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	(with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	1. Based on observation and interview, the facility failed to ensure 1 of over 11 hazardous areas such as fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0321	**K321** **Immediate Corrective Action** 1. The penetration in the ceiling of the riser room was covered with drywall the same thickness and rating as the rest of the ceiling on 06/06/22..	06/13/2022

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	Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, a two foot by two and one half foot hole was noted in the ceiling of the sprinkler riser room which was attached to the west wall of the kitchen. The sprinkler riser room also contained 5 natural gas fired tankless water heaters. Based on interview at the time of the observations, the Maintenance Director and the Regional Maintenance Director stated the whole ceiling for the room was recently replaced and agreed there was a hole in the sprinkler riser room ceiling which did not separate the room from other spaces with smoke resistant partitions. This finding was reviewed with the Administrator, Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 11 hazardous areas such as trash collection rooms (exceeding 64 gallons) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the main dining room. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director at 1:32 p.m. on 05/31/22, over two 32 gallon		2. The folded Styrofoam cup cover that was propping open the door to the kitchen from the main dining room was removed immediately. . **Method to Assess Others** 1. The Maintenance Director, or designee, performed documented inspections on 06/06/22 of all other hazardous areas to ensure no other penetrations had been made in the ceiling or wall. All resident and non-resident areas were evaluated. 2. The Maintenance Director, or designee, performed documented inspections on 06/03/22 of all other hazardous areas to ensure no other hazardous area doors were being propped open. All resident and non-resident areas were evaluated. **Systematic Process** 1. The Maintenance Director, or designee, will conduct documented monthly inspections X 2 months of all hazardous areas to ensure no penetrations have been made in the ceiling or wall.	

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	capacity portable trash containers were stored in the kitchen. The entry door to the kitchen from the main dining room was propped in the fully open position with a folded cover for a Styrofoam cup. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned hazardous area was not separated from other spaces by smoke resistant partitions and doors due to the kitchen door being propped open. This finding was reviewed with the Administrator, Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		2. The Maintenance Director, or designee, will conduct documented monthly inspections X 2 months of all hazardous areas to ensure no other hazardous area doors are being propped open. Additionally, facility staff will be in-serviced by 6/13/22 on how propping open any door to a hazardous area, or any door with a self-closer, in a health care facility is against the life safety code. **Quality Assurance** 1. The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly hazardous area inspections will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met. 2. The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly magnetic lock testing will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in			

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	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 1. Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range hood fire suppression systems was maintained in accordance with NFPA 96. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 Edition, Section 10.4.1 states upon activation of any fire-extinguishing system for a cooking operation, all sources of fuel and electrical power that produce heat to all equipment requiring protection by that system shall automatically shut off. Section 10.4.3 states any gas appliance not requiring protection but located under the same ventilating equipment shall also automatically shut off upon activation of any extinguishing system. This deficient practice could affect over two staff and visitors in the kitchen.	K 0324	**K324** **Immediate Corrective Action** 1. The facility coordinated with the kitchen hood contractor, Safe Care, to ensure the electrical appliances under the kitchen hood shutoff when the extinguishing system is activated on 6/2/22. 2. The facility is coordinating with the kitchen hood contractor, Koorsen for panel to be re-programmed by 06/13/22, n , to ensure that activation of the kitchen hood extinguishing system sets off the fire alarm system.	06/13/2022

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	Findings include: Based on review of the kitchen fire suppression system inspection contractor's "Kitchen Suppression System Inspection" documentation dated 03/16/22 with the Maintenance Director and the Regional Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 05/31/22, appliances under the range hood fire suppression system do not shut down with range hood fire suppression system activation. The "Inspection Details" section of the 03/16/22 inspection report stated "Electrical did not shut off" in response to the question "Automatic Portion of the System Operated?" In addition, the "Remarks/Comments" section of the 03/16/22 inspection report stated "appliances, exhaust, and make up air not responsive to ANSUL system when tripped". Based on interview at the time of record review, the Maintenance Director and the Regional Maintenance Director stated the facility has natural gas fuel fired appliances and electrical powered appliances under the range hood in the kitchen and stated parts are on order to make the necessary repairs and agreed automatic fuel fired and electrical appliance shut down repair documentation on or after 03/16/22 was not available for review. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure 1 of 1 kitchen range		**Method to Assess Others** The facility only has one kitchen hood extinguishing system. **Systematic Process** The Maintenance Director, or designee, will continue to coordinate semi-annual inspections by the kitchen hood contractor of the facility's kitchen hood extinguishing system, as part of the facilities ongoing preventative maintenance program. **Quality Assurance** 1. The Administrator, or designee, is responsible for the oversight of this program. Progress on the work to ensure the electrical appliances under the kitchen hood shutoff when the extinguishing system is activated will be reported to the monthly QAPI meeting until substantial compliance is met. 2. The Administrator, or designee, is responsible for the oversight of this program. Progress on the work to ensure that activation of the kitchen hood extinguishing system sets off the fire alarm system will be reported to the monthly QAPI meeting until substantial compliance is met.	

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	hood fire suppression systems was maintained in accordance with NFPA 96. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 2011 Edition, Section 10.2.6 states automatic fire-extinguishing systems shall installed in accordance with the terms of their listing, the manufacturer's instructions and the following standards where applicable: (1) NFPA 12 (2) NFPA 13 (3) NFPA 17 (4) NFPA 17A NFPA 17A, Standard for Wet Chemical Extinguishing Systems, 2009 Edition, Section 5.2.1.9 states the extinguishing system shall be connected to the fire alarm system, if provided, in accordance with the requirements of NFPA 72, so that the actuation of the extinguishing system will sound the fire alarm system as well as provide the function of the extinguishing system. This deficient practice could affect over two staff and visitors in the kitchen. Findings include: Based on review of the kitchen fire suppression system inspection contractor's "Kitchen Suppression System Inspection" documentation dated 03/16/22 with the Maintenance Director and the Regional Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 05/31/22, the fire alarm system is not activated with kitchen range hood fire suppression system activation. The "Inspection Details" section of the 03/16/22 inspection report stated "Alarm does not sound" in response to the question "Did the hood system activate the fire alarm system?" In addition, the "Remarks/Comments" section of			

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	the 03/16/22 inspection report stated "a supervisory signal goes off the alarm box but the system does not sound". Based on interview at the time of record review, the Maintenance Director and the Regional Maintenance Director stated the facility has parts are on order to make the necessary repairs for automatic fuel fired and electrical appliance shut down but agreed repair documentation for fire alarm system activation on or after 03/16/22 was not available for review. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)			
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ceiling smoke barriers in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the following ceiling mounted sprinkler locations were missing its escutcheon: a. 1 of 2 sprinklers in Room 133. b. 1 of 4 sprinklers in the Beauty/Barber Shop. c. women's restroom by the Beauty/Barber Shop. d. 2 of 2 sprinklers in the sprinkler riser room attached to the west wall of the kitchen. Based on interview at the time of the observations, the Maintenance Director and the Regional Maintenance Director agreed each of the aforementioned ceiling mounted sprinkler locations was missing its escutcheon. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)	K 0351	**K351** **Immediate Corrective Action** The following locations had sprinkler escutcheons replaced on 06/06/22 and 06/07/22 1. Resident room 133. 2. Beauty/Barber Shop. 3. Women's restroom by the Beauty Barber Shop. 4. Sprinkler riser room attached to the west wall of the kitchen. **Method to Assess Others** The Maintenance Director, or designee, performed documented inspections on 06/03/22 of all other areas to ensure sprinkler head escutcheons were in place. All resident and non-resident areas were evaluated. **Systematic Process** The Maintenance Director, or designee, will continue to coordinate with fire sprinkler contractor to perform sprinkler system inspection, testing, and maintenance in accordance with NFPA 25, as part of the facility's ongoing preventative maintenance program monthly.	06/13/2022

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	155245	A. BUILDING 01 B. WING	05/31/2022

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			Quality Assurance The Administrator, or designee, is responsible for the oversight of this program. Results of this sprinkler inspection will be brought to the monthly QAPI meeting for review, or until substantial compliance is met.	
K 0355 SS=D 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 1 of 2 portable fire extinguishers in the detached Laundry was inspected at least monthly and the inspections were documented including the date and initials of the person performing the inspection in accordance with NFPA 10. LSC 9.7.4.1 states portable fire extinguishers shall be selected, installed, inspected and maintained in accordance with NFPA 10. NFPA 10, the Standard for Portable Fire Extinguishers, 2010 Edition, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. Where monthly manual inspections are conducted, the date the manual inspection was performed and the initials of the person performing the inspection shall be recorded. Where manual inspections are conducted, records for manual inspections shall be kept on a tag or label attached to the fire	K 0355	**K355** **Immediate Corrective Action** The fire extinguisher in the laundry area is currently in compliance with its monthly inspections since March 2022. No further action could be taken with this fire extinguisher. The extinguisher's gauge is in the operational range, so it will continue to have monthly inspections performed and will receive a new tag from Safe Care 06/13/22 and another one in September at the annual. **Method to Assess Others** The Maintenance Director, or	06/13/2022

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	extinguisher, on an inspection checklist maintained on file, or by an electronic method. Records shall be kept to demonstrate that at least the last 12 monthly inspections have been performed. This deficient practice could affect over 2 staff and visitors in the detached Laundry. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the portable fire extinguisher located in the Laundry by the washing machines had an affixed maintenance tag indicating the annual inspection for the extinguisher was performed by the inspection contractor in September 2021. The affixed maintenance tag was missing a documented monthly inspection for the five month period of October 2021 through February 2022. Based on interview at the time of the observations, the Maintenance Director and the Regional Maintenance Director stated additional monthly inspection documentation for the aforementioned portable fire extinguisher was not available for review and agreed portable fire extinguisher documentation for the aforementioned five month period was not available for review. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		designee, performed documented inspections on 06/01/22 of all other fire extinguishers in the facility to ensure the monthly inspections were current. All resident and non-resident areas were evaluated. **Systematic Process** The Maintenance Director, or designee, will continue to perform documented monthly inspections of all fire extinguishers in the facility, as part of the facility's ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly fire extinguisher inspections will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met.	
K 0362 SS=E	NFPA 101 Corridors - Construction of Walls			

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Bldg. 01	Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7			
	Based on observation and interview, the facility failed to ensure corridor walls in 1 of 9 smoke compartments in the facility were constructed to resist the transfer of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the electric furnace room by the Physician's Office. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, an eight inch by thirty inch open ended metal grate was installed in the corridor wall above the corridor entrance door to the electric furnace room across from the	K 0362	**K362** **Immediate Corrective Action** The metal grate above the door to the electric furnace room across from the Physician's office was removed and the penetration in the corridor wall was sealed on 06/10/22. **Method to Assess Others** The Maintenance Director, or designee, performed documented inspections on 06/03/2022 of all	06/13/2022

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	Physician's Office. The open ended metal grate would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the open ended metal grate would not resist the passage of smoke. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		other corridor walls in the facility to ensure no other penetrations have occurred which would not resist smoke. All resident and non-resident areas were evaluated. **Systematic Process** The Maintenance Director, or designee, will conduct documented monthly inspections X 2 months of all corridor walls to ensure no penetrations have been made. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly corridor wall inspections will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met.	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke			

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	compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 1 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes and similar items that pass through a floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, a two foot by two and one half foot hole was noted in the ceiling of the sprinkler riser room which is attached to the west wall of the kitchen. One layer of 5/8ths inch thick drywall was noted as the ceiling construction for the room. Based on interview at the time of the observations, the Maintenance Director and the Regional Maintenance Director stated the whole ceiling for the room was recently replaced and agreed there was a hole in the sprinkler riser room ceiling.	K 0372	**K372** **Immediate Corrective Action** The penetration in the ceiling of the riser room was covered with drywall the same thickness and rating as the rest of the ceiling on 06/06/22. **Method to Assess Others** The Maintenance Director, or designee, performed documented inspections on 06/03/22 of all other hazardous areas to ensure no other penetrations had been made in the ceiling or wall. All resident and non-resident areas were evaluated. **Systematic Process** The Maintenance Director, or designee, will conduct documented monthly inspections X 2 months of all hazardous areas to ensure no penetrations have been made in the ceiling or wall. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of	06/13/2022

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	This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		this program. Results of the monthly hazardous area inspections will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure 1 of 8 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect over 30 residents, staff and visitors. Findings include:	K 0374	**K374** **Immediate Corrective Action** An astragal was added to the corridor doors in the set by the Quiet Room on 06/13/22. **Method to Assess Others** The Maintenance Director, or designee, performed documented inspections on 06/01/22 of all cross-corridor doors to ensure no	06/13/2022

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	Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, a one half inch gap was noted at the meeting edges of the corridor doors in the corridor door set by the Quiet Room when each door was in the fully closed position. Each door was equipped with a 90 minute fire resistance rating label affixed to the hinge side of the door and each door in the smoke barrier door set was also equipped with latching hardware. Based on interview at the time of the observations, the Maintenance Director and the Regional Maintenance Director stated the door set was recently installed with an astragal being on order to fill the gap at the meeting edges of the door set. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		other doors had clearances >1/8" at the meeting edges, or clearances >1/8" between the doorframe and the top of the door and the hinge side of the door. All resident and non-resident areas were evaluated. **Systematic Process** The Maintenance Director, or designee, will continue to perform annual inspections of all cross-corridor doors to ensure no other doors had clearances >1/8" at the meeting edges, or clearances >1/8" between the doorframe and the top of the door and the hinge side of the door, as part of the facilities ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of this cross-corridor door inspection will be brought to the monthly QAPI meeting for review.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric			

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	Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on record review and interview, the facility failed to ensure electrical outlet boxes in 3 of 60 resident sleeping rooms was protected. NFPA 70, National Electric Code, 2011 Edition, Article 406.6 Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect over three residents, staff and visitors. Findings include: Based on review of "Receptacle Testing" documentation dated May 2022 with the Maintenance Director and the Regional Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 05/31/22, the wall mounted electrical outlet boxes identified as #4 and #5 in Room 116 were listed as "Fail" due to a broken cover plate. The wall mounted electrical outlet box identified as #6 in Room 130 was listed as "Fail" due to a broken cover plate. The wall mounted electrical outlet boxes identified as #4 and #5 in Room 230 were also listed as "Fail" due to a broken cover plate. Based on interview at the time of the observations, the Maintenance Director stated he performed the visual observations for the "Receptacle Testing" documentation and has not had enough time to make the corrections for the recently conducted inspections. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference.	K 0511	**K511** **Immediate Corrective Action** The following locations had electrical receptacle cover plates replaced on 06/07/22 and 06/08/22: 1. Resident room 116, outlets #4 and #5. 2. Resident room 30, outlet #6. 3. Resident room 230, outlets #4 and #5. **Method to Assess Others** The electrical receptacle inspections performed on 05/31/2022 identified all electrical receptacles at the resident bedside in the facility. Those inspections are recent enough to ensure all receptacles in the facility are still in the same condition. **Systematic Process** The Maintenance Director, or designee, will continue to perform annual inspections of all electrical receptacles, as part of the facilities ongoing preventative maintenance program. **Quality Assurance**	06/13/2022

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	3.1-19(b)		The Administrator, or designee, is responsible for the oversight of this program. Results of these receptacle repairs will be brought to the monthly QAPI meeting for review.	
K 0711 SS=C Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review, observation and interview; the facility failed to provide 1 of 1 written emergency fire safety plan that incorporated all items listed in NFPA 101, Section 19.7.2.2. 1. Use of alarms. 2. Transmission of alarms to fire department. 3. Emergency phone call to fire department 4. Response to alarms. 5. Isolation of fire. 6. Evacuation of immediate area. 7. Evacuation of smoke compartment. 8. Preparation of floors and building for evacuation. 9. Extinguishment of fire. This deficient practice affects all residents, staff	K 0711	**K711** **Immediate Corrective Action** The fire safety floor plan was updated on 06/07/22 to reflect the presence of 1-hour smoke barriers at the separations in the following locations: 1. Corridor at resident room 101. 2. Corridor at resident room 123. 3. Corridor at resident room 207. 4. Corridor at resident room 216. 5. Corridor at resident room 225.	06/13/2022

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	and visitors. Findings include: Based on review of "Emergency Preparedness Policy Manual: Fire Plan" documentation dated 05/24/22 with the Maintenance Director and the Regional Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 05/31/22, the written fire safety plan floor plan documentation did not correctly identify the location of fire doors in the facility. Fire doors on the floor plan documentation were identified as corridor door sets by Rooms 101, 123, 207, 216 and 225. Review of the fire door inspection contractor's annual fire door inspection documentation dated 06/11/21 indicated the corridor door sets by Rooms 101, 123, 207, 216 and 225 had "no fire protection rating" and stated "NA" in response to the question "label is legible and visible". Based on interview at the time of record review, the Regional Maintenance Director stated the five fire door locations identified on the floor plan documentation are not fire doors and the floor plan should be updated. Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the corridor door sets by Rooms 101, 123, 207, 216 and 225 each had no fire protection rating labels affixed to the doors. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		**Method to Assess Others** The fire safety floor plan was reviewed after the changes were made and no other elements required alteration. **Systematic Process** The Maintenance Director, or designee, will continue to provide the fire safety plan and floorplan for annual review by the local Authority Having Jurisdiction, as part of the facilities ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of the changes to the fire safety floor plan will be brought to the monthly QAPI meeting for review.	

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K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review, observation and interview; the facility failed to ensure nonhospital-grade electrical receptacles in 12 of 60 resident sleeping rooms that failed annual inspection and testing were replaced with hospital-grade receptacles. NFPA 70, The National Electrical Code, 2011 Edition, at Article 517.18(B) states each patient bed location shall be provided with a minimum of four receptacles. They shall be permitted to be of the single, duplex, or quadruplex type, or any combination of the three. All receptacles,	K 0914	**K914** **Immediate Corrective Action** The following locations had select electrical receptacles replaced with hospital grade receptacles on 06/07/22, 06/08/22 and 06/09/22	06/13/2022

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	whether four or more, shall be listed "hospital grade" and so identified. It is not intended that there be a total, immediate replacement of existing non-hospital grade receptacles. It is intended, however, that non-hospital grade receptacles be replaced with hospital grade receptacles upon modification of use, renovation, or as existing receptacles need replacement. This deficient practice could affect over 12 residents. Findings include: Based on review of "Receptacle Testing" documentation dated May 2022 with the Maintenance Director and the Regional Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 05/31/22, select electrical receptacles in Room 102, 105, 107, 109, 111, 122, 124, 131, 133, 134, 201 and 227 failed annual testing and either need to be replaced or repaired. Based on interview at the time of the observations, the Maintenance Director stated he performed the visual observations and testing for the "Receptacle Testing" documentation and has not had enough time to make the corrections for the recently conducted inspections and tests. The Maintenance Director stated the outlet box receptacles in one location in Room 124 needed immediate replacement which he did do but stated it was not replaced with a hospital-grade receptacle. Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the receptacles in the wall mounted outlet box near the window in Room 124 which was replaced was not replaced with hospital grade receptacles.		1. Resident room 102. 2. Resident room 105. 3. Resident room 107. 4. Resident room 109. 5. Resident room 111. 6. Resident room 122. 7. Resident room 124. 8. Resident room 131. 9. Resident room 133. 10. Resident room 134. 11. Resident room 201. 12. Resident room 227. **Method to Assess Others** The electrical receptacle inspections performed on 05/31/2022 identified all electrical receptacles at the resident bedside in the facility. Those inspections are recent enough to ensure all receptacles in the facility are still in the same condition. **Systematic Process** The Maintenance Director, or designee, will continue to perform annual inspections of all electrical receptacles, as part of the facilities ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of	

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	This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		this program. Results of these receptacle replacements will be brought to the monthly QAPI meeting for review.	
K 0916 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator annunciator panels was in proper operating condition. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility at 9:12 a.m. on 05/31/22, the "not in auto" status indicator light for the wall mounted remote annunciator panel located at the north nurse's station in the long term care/skilled nursing area for the facility's emergency generator was illuminated indicating system trouble. In addition, none of the remaining status indicator lights illuminated when the "lamp test"	K 0916	**Immediate Corrective Action** The facility received communication from the emergency generator contractor, Safe Care, on 06/06/2022 confirming that the remote annunciator is working as intended. The manufacturer's manual confirms on page 22 that "The Not in Auto indicator light will be green and the Generator Running indicator will be off." **Method to Assess Others**	06/13/2022

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	button on the panel was pushed multiple times. The panel appeared to be in a frozen mode and could not be reset at the panel. The remote annunciator panel was identified as a "Dynagen RA400" panel. Based on interview at the time of the observations, the Maintenance Director stated the emergency generator would start if the building were to lose power. Based on observations with the Maintenance Director at 9:15 a.m. on 05/31/22, the status indicator lights for the automatic transfer switch located in the mechanical room in the kitchen for the facility's emergency generator indicated no system trouble and the emergency generator was available for transfer. Based on observations with the Maintenance Director and the Regional Maintenance Director during the tour of the facility at 1:56 p.m. on 05/31/22, there had been no change to the "not in auto" status indicator light. The Regional Maintenance Director pushed the "lamp test" button for up to 20 seconds which unfroze and reset the panel but the "not in auto" indicator light illuminated again after the panel was reset two times. Based on interview at the time of the observations, the Maintenane Director and the Regional Maintenance Director stated the emergency generator is in the auto mode and the automatic transfer switch would transfer building power to the generator if the building were to lose power. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)		Safe Care confirmed all other functionality of the remote annunciator was working as intended in the 06/06/2022 communication. **Systematic Process** The Maintenance Director, or designee, will continue to coordinate annual inspections by the emergency generator contractor of the facility's emergency generator annunciators, as part of the facilities ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. The communication from the facility's emergency generator contractor will be brought to the monthly QAPI meeting for review	
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste			

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Bldg. 01	Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review, observation and interview; the facility failed to document emergency generator monthly load testing for 3 months of the most recent 12 month period to	K 0918	**K918** **Immediate Corrective Action**	06/13/2022

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	meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer (2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generators: Test Generator Under Load" documentation for the most recent twelve month period with the Maintenance Director and the Regional Maintenance Director during record review from 9:25 a.m. to 12:40 p.m. on 05/31/22, monthly load testing documentation for the facility's propane fired emergency generator for the three month period of January, February and March 2022 was not available for review. Based on interview at the time of record review, the		A monthly load test was performed for the emergency generator on 06/10/22 with results documented per NFPA 110 standards. **Method to Assess Others** The facility only has one emergency generator, which was load tested on 06/10/22. **Systematic Process** The Maintenance Director, or designee, will continue to perform documented monthly load tests of the facility's emergency generator, as part of the facilities ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly emergency generator load tests will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met.	

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	Regional Maintenance Director stated a backup portable generator was utilized for the facility for the six month period of July 2021 through December 2021. The Regional Maintenance Director stated the facility performed monthly load testing for January, February and March 2022 but it was not documented in TELS. The Regional Maintenance Director stated the generator inspection contractor performed monthly load testing in January and March 2022 as documented on "Invoice" documentation dated 01/31/22 and 03/31/22 but the "Invoice" documentation did not include testing documentation per NFPA 110, Section 8.4.2. Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the facility has one propane fired emergency generator located outside of the building on the west side of the property. The manufacturer's nameplate rating for the generator could not be determined. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)			
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			

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	Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 indoor oxygen storage areas was in accordance with NFPA 99 Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.3.1 states storage for nonflammable gases equal to or greater than 3000 cubic feet	K 0923	**K923** **Immediate Corrective Action** The door to the oxygen storage and transfilling room located	06/13/2022

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	shall comply with 5.1.3.3.2 and 5.1.3.3.3. Section 5.1.3.3.2 states, if indoors, storage locations of positive-pressure gases shall be constructed and use interior finishes of noncombustible or limited combustible materials such that all walls, floor, ceilings, and doors are of minimum 1-hour fire resistant rating. Section 11.3.4.1 states a precautionary sign, readable from a distance of 1.5 m (5 ft), shall be displayed on each door or gate of the storage room or enclosure. Section 11.3.4.2 states the sign shall include the following as a minimum: CAUTION: OXIDIZING GASES STORED WITHIN NO SMOKING. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room in the Central Supply storage room. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the entry door to the oxygen storage and transfilling room located inside the Central Supply storage room by Room 206 was equipped with a 1-hour fire resistance rating label affixed to the hinge side of the door and was also equipped with a self-closing device but the latching mechanism kept hitting the door frame which prevented the door from latching into the door frame when the door was tested to close multiple times. Five liquid oxygen containers and nine 'E' type oxygen cylinder were observed stored in the room. Based on interview at the time of the observations, the Maintenance Director agreed the latching mechanism kept hitting the door frame which prevented the door from latching into the door frame which did not		inside the Central Supply storage room by Room 206 was repaired on 06/03/22 so that it positively latches. **Method to Assess Others** This is the only door to an oxygen storage area in the facility. **Systematic Process** The Maintenance Director, or designee, will conduct documented monthly inspections X 2 months of the oxygen storage room door to ensure it positively latches, and then monthly thereafter as part of the facility's ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly oxygen storage room door inspections will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met.	

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	ensure the oxygen storage room was constructed of a minimum 1-hour fire resistant rating. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)			
K 0927 SS=E 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 1 of 1 oxygen storage locations where transfilling occurs was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.5.2.3.1 states oxygen transfilling locations shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire resistive construction. (2) The area is mechanically vented, is sprinklered, and has ceramic or concrete flooring.	K 0927	**K927** **Immediate Corrective Action** The door to the oxygen storage and transfilling room located inside the Central Supply storage room by Room 206 was repaired on 06/03/22 so that it positively latches. **Method to Assess Others** This is the only door to an oxygen	06/13/2022

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	(3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. Section 11.5.3.2.3 states in health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no smoking language shall not be required. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room in the Central Supply storage room. Findings include: Based on observations with the Maintenance Director and the Regional Maintenance Director during a tour of the facility from 12:40 p.m. to 2:45 p.m. on 05/31/22, the entry door to the oxygen storage and transfilling room located inside the Central Supply storage room by Room 206 was equipped with a 1-hour fire resistance rating label affixed to the hinge side of the door and was also equipped with a self-closing device but the latching mechanism kept hitting the door frame which prevented the door from latching into the door frame when the door was tested to close multiple times. Five liquid oxygen containers and nine 'E' type oxygen cylinder were observed stored in the room. Based on interview at the time of the observations, the Maintenance Director stated oxygen transfilling occurs in the room and agreed the latching mechanism kept hitting the door frame which prevented the door from latching into the door frame and did not ensure the oxygen storage and transfilling room was constructed of a fire barrier of 1 hour fire		storage area in the facility. **Systematic Process** The Maintenance Director, or designee, will conduct documented monthly inspections X 2 months of the oxygen storage room door to ensure it positively latches, and then annually thereafter as part of the facility's ongoing preventative maintenance program. **Quality Assurance** The Administrator, or designee, is responsible for the oversight of this program. Results of the monthly oxygen storage room door inspections will be brought to the monthly QAPI meeting X 2 months for review, or until substantial compliance is met.	

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	resistive construction. This finding was reviewed with the Administrator, the Maintenance Director and the Regional Maintenance Director during the exit conference. 3.1-19(b)			