STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING -- B. WING	11/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

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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: 11/29/21 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Emergency Preparedness survey, Garden Villa-Bloomington was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 224 certified beds. At the time of the survey, the census was 73. Quality Review completed on 12/02/21	E 0000		
E 0006 SS=C Bldg. --	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2),			

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

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

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	§491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:			

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	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the facility failed to maintain a complete emergency preparedness plan that was (1) based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients and (2) included strategies for addressing emergency events identified by the risk assessment in accordance with 42 CFR 483.73(a) (1) and 42 CFR 483.73(a) (2). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Manual on 11/29/21 between 9:15 a.m. and 1:45 p.m. with the Director of Plant Operations present, facility-based and community-based risk hazards were addressed in the plan, however, there was no	E 0006	**E006** **Emergency Plan-Risk Assessment** **This facility does have an Emergency Plan and an All-Hazards Risk Assessment is completed as indicated.** **Corrective actions taken:** The Executive Director had an all-hazards risk assessment completed but was not placed in the Emergency Manual. Members of the committee have updated our all-hazard risk assessment. (**Attachment A**). **Measures in place/system changes:** The Director of	12/09/2021

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	facility-based and community-based risk assessment utilizing an all-hazards approach available. Based on interview at the time of record review, the Director of Plant Operations said he knows the facility has a risk assessment for the Emergency Manual but it could not be found. This finding was reviewed with the Director of Plant Operations, Director of Nursing, and the Maintenance Assistant during the exit conference.		Maintenance or designee has provided a copy of the All-hazards risk assessment and it will be attached to the plan of correction. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of E006 Emergency Plan-All hazards Risk assessment for (6) six months at the scheduled QI meetings. Following six (6) monthly quality assurance compliance reviews and if no concerns are noted, the committee will file the audits. **See attached Quality Assurance and Process Improvement audits. (Attachment B)** Date of Compliance December 8, 2021.	
E 0041 SS=C 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			

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	implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C.			

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	552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October			

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	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 observation, record review and interview; the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 12 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the	E 0041	**E041** **Emergency Power** **This facility does have Emergency Power system inspection, testing, and maintenance requirements in accordance with NFPA 110.** **Corrective actions taken:** The Director of maintenance or designee completes weekly emergency generator testing and documents the weekly testing. (**Attachment A)**. **Measures in place/system changes:** The Director of Maintenance or designee has implemented the monthly generator load testing on the emergency generator and will implement documentation of this. This form will be attached to the plan of correction. **(Attachment A)** **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of E041 Emergency Power for (6) six months at the scheduled QI meetings. Following six (6) monthly quality assurance compliance reviews and if no	12/09/2021

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	authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on record review on 11/29/21 between 9:15 a.m. and 1:45 p.m. with the Director of Plant Operations present, there was no monthly generator load test documentation available during the past 12 months. Based on interview at the time of record review, the Director of Plant Operations said the emergency generator runs under load every week, but the calculation of the load carried has not been documented during the past 12 month period. This finding was reviewed with the Director of Plant Operations, Director of Nursing, and Maintenance Assistant during the exit conference.		concerns are noted, the committee will file the audits. **See attached Quality Assurance and Process Improvement audits. (Attachment B)** Date of Compliance December 9, 2021.	
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: 11/29/21 Facility Number: 000007 Provider Number: 155019 AIM Number: 100275040 At this Life Safety Code survey, Garden Villa-Bloomington 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	K 0000		

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	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 was 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 installed in resident sleeping rooms 101 through 126, 201 through 216 and 301 through 339. The facility has smoke detectors hard wired to the fire alarm system in resident sleeping rooms on Station 4, 5, and 6. The facility has a capacity of 224 and had a census of 73 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for two detached storage buildings. Quality Review completed on 12/02/21			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 3 of over 10 battery powered emergency lights was maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall	K 0291	**K291** **Emergency lighting-Testing** **This facility does ensure that emergency lighting of at least ninety minutes in duration is completed as indicated in accordance with the requirements of NFPA 101.** **Corrective actions taken:** The	12/09/2021

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	comply with NFPA 70 National Electric Code. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 10:15 a.m. to 12:40 p.m. on 11/29/21, the following battery operated lighting system failed to illuminate when its respective test button was pushed multiple times:\ a) emergency light marked as #25 in corridor by resident room 403 b) emergency light marked as #21 in corridor by resident room 412 c) emergency light in beauty shop by station 4 Based on interview at the time of the observations, the Maintenance Assistant agreed the aforementioned battery powered emergency lights failed to illuminate when it was tested to illuminate multiple times. This finding was reviewed with the Director of Nursing, Director of Plant Operations and Maintenance Assistant during the exit conference. 3.1-19(b)		facility ensures that all 10 battery backup emergency lights are tested to ensure the lights would provide lighting during periods of power outages and a written record of the visual inspections will be provided. Emergency light #25, #21 and the beauty shop had the rechargeable batteries changed when the surveyor identified the deficiency. A photograph will be attached to the plan of correction. (**Attachment A)**. **Measures in place/system changes:** The Director of Maintenance or designee have provided the audit logs and will continue to provide audits ensuring 10 of 10 battery operated back up emergency lights are in working order and review of these audits will be completed at Quality Improvement meetings monthly for six months. **See attached Director of Maintenance or designee audits (Attachment B.)** **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K291 Emergency backup battery lighting audits monthly for (6) six months at the scheduled QI meetings. Following six (6) monthly quality assurance compliance reviews and if no concerns are noted, the	

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			committee will file the audits. **See attached Quality Assurance and Process Improvement audits (Attachment C).** Date of Compliance December 4, 2021.	
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 observation and interview, the facility failed to ensure sprinkler heads in the kitchen were not corroded 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	K 0353	**K 353** **Sprinkler System-Maintenance and Testing** **This facility does ensure that the Sprinkler System testing, and maintenance is completed in accordance with the requirements of NFPA 25.** **Corrective actions taken:**	12/09/2021

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	the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff in the kitchen. Findings include: Based on observation during of the facility with the Maintenance Assistant on 11/29/21 between 10:15 a.m. and 12:40 p.m., the following was noted: a) bent deflector on a sprinkler head by the dry storage room b) 4 sprinkler heads in the dish area with visible signs of corrosion c) a sprinkler head above the coolers was covered in grease and dust Based on interview at the time of observation, the Maintenance Assistant agreed to the conditions of the aforementioned sprinkler heads. These findings were reviewed with the Director of Nursing, Director of Plant Operations and Maintenance Assistant during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure spare sprinklers were protected within a spare sprinkler cabinet on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4		**1.** The facility does ensure sprinkler heads are tested and maintenance as indicated. The Director of Maintenance has contacted our Vendor for new sprinkler head replacement. **2.** The facility placed all spare sprinkler heads in their own compartments in the sprinkler head cabinet as indicated. Photograph will be attached to the plan of correction. **(Attachment A)** **3.** The facility applied 3M Fire Barrier Caulking around the sprinkler head in the soiled utility on Station 5 across from room 508. A photograph will be attached to the plan of correction. **(Attachment B)** **Measures in place/system changes:** The Director of Maintenance/or designee will provide audits for the sprinkler heads. The audits will be submitted at Quality Improvement meetings monthly for six months for their review. **See attached Director of Maintenance or designee audits (Attachment C.)** **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K 353 sprinkler system testing and	

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	states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility with the Maintenance Assistant on 11/29/21 from 10:15 a.m. to 12:40 p.m., there were three spare sprinkler cabinets in the riser room by the kitchen that included twenty spare sprinklers not in their own protected slot. There were eight spare sprinklers lying on top of the cabinet mounted on the wall, and the remaining were stored loose in the cabinets and not secured in holders. Based on interview at the time of the observation, the Maintenance Assistant agreed the spare sprinkler cabinets had twenty sprinklers not in a protected slots. This finding was reviewed with the Director of Nursing, Director of Plant Operations, and Maintenance Assistant at the exit conference. 3.1-19(b) 3. Based on observations and interview, the facility failed to maintain the ceiling construction in 1 of 1 soiled utility room. The ceiling traps hot		maintenance for (6) six months at the scheduled QI meetings. Following six (6) monthly quality assurance compliance reviews and if no concerns are noted, the committee will file the audits. **See attached Quality Assurance and Process Improvement audits (Attachment D).** Date of Compliance December 9, 2021.	

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	155019	A. BUILDING 01 B. WING	11/29/2021

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	air gases around the sprinkler and causes the sprinkler to operate at a specified temperature. This deficient practice could affect up to 25 residents and staff. Findings include: Based on observations with the Maintenance Assistant during a tour of the facility from 10:15 a.m. to 12:40 p.m. on 11/29/21, the soiled utility room across the corridor from resident room #508 had a one half inch gap around a sprinkler head that was open to the attic space above. Based on interview at the time of observation, the Maintenance Assistant agreed there was a gap around the the sprinkler head. This finding was reviewed with the Director of Nursing, Director of Plant Operations and Maintenance Assistant during the exit conference. 3.1-19(b)			
K 0372 SS=E 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 compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control			

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	system in REMARKS. Based on observation and interview, the facility failed to ensure 1 of 12 smoke barrier walls was protected to maintain the smoke resistance of the smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect up to 50 residents, as well as staff and visitors. Findings include: Based on observation on 11/29/21 at 12:25 p.m. during a tour of the facility with the Maintenance Assistant, the smoke barrier wall in the attic above the smoke barrier doors in the hall outside resident room 419 and the beauty shop had missing drywall of a 2 foot by 3 foot area. Based on interview at the time of observation, the Maintenance Assistant said he was not aware of the hole in the attic that penetrated the smoke barrier wall, and would repair the area as soon as possible. This finding was reviewed with the Director of Nursing, Director of Plant Operations and Maintenance Assistant during the exit conference. 3.1-19(b)	K 0372	**K372** **Smoke Barrier** **This facility does ensure that Smoke Barrier walls are in accordance with the requirements of NFPA 101.** **Corrective actions taken:** The facility had a pipe being repaired in the attic above the beauty shop and the 2 feet by 3 feet area of the smoke barrier wall that had been removed for pipe repair has now been replaced and photo will be attached to the plan of correction. **(Attachment A).** **Measures in place/system changes:** The Director of Maintenance or designee provided the picture of the Smoke barrier wall repair and ongoing any repairs to the facility that affect the smoke barrier wall will be repaired in a timely manner to ensure the safety of the residents and staff of the facility. Any new repairs that require disruption of the smoke barrier wall will be identified at the Quality Improvement meetings and will be reviewed monthly for six months. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K 372 Smoke Barriers monthly for (6) months at the scheduled QI meetings. Following six (6) monthly quality assurance compliance review and if no	12/09/2021

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			concerns are noted, the committee will file the audits. **See attached Quality Assurance and Process Improvement audits (Attachment B).** Date of Compliance December 8, 2021	
K 0918 SS=C Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained			

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	and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)			
	Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 1 of 1 generator during 12 of the past 12 months. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. Chapter 6-4.4.1.3 of 2012 NFPA 99 requires batteries for on-site generators shall be maintained in accordance with NFPA 110, 2010 Edition, Standard for Emergency and Standby Power Systems. 8.3.7 requires storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.2 states defective batteries shall be repaired or replaced immediately upon discovery of defects. Chapter 6.5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include:	K 0918	**K918** **Emergency Power** **This facility does have Emergency Power system inspection, testing, and maintenance requirements in accordance with NFPA 110.** **Corrective actions taken:** The Director of maintenance or designee completes weekly emergency generator testing and documents the weekly testing. (**Attachment A)**. **Measures in place/system changes:** The Director of Maintenance or designee has implemented the monthly generator load testing on the emergency generator and will implement documentation of this. This form will be attached to the plan of correction. **(Attachment A)** **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of E041 Emergency Power for (6) six months at the scheduled QI	12/09/2021

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	Based on record review on 11/29/21 between 9:15 a.m. and 1:45 p.m. with the Director of Plant Operations present, there was no monthly generator load test documentation available during the past 12 months. Based on interview at the time of record review, the Director of Plant Operations said the emergency generator runs under load every week, but the calculation of the load carried has not been documented during the past 12 month period. This finding was reviewed with the Director of Plant Operations, Director of Nursing, and Maintenance Assistant during the exit conference.		meetings. Following six (6) monthly quality assurance compliance reviews and if no concerns are noted, the committee will file the audits. **See attached Quality Assurance and Process Improvement audits. (Attachment B)** Date of Compliance December 9, 2021.	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in			

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	patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect up to 34 residents in one smoke compartment. Findings include:	K 0923	**K923** **Gas Equipment-Cylinder and container storage** **This facility does ensure that Gas cylinders the facility uses are stored in accordance with the requirements of NFPA 99.** **Corrective actions taken:** The maintenance director removed the cabinets from the walls in the oxygen room and the plastic containers were moved to maintain five feet distance from the oxygen cylinders. The facility Director of Maintenance will audit the cylinders on the preventative maintenance checklist to ensure storage items remain at least five feet from oxygen cylinders.	12/09/2021

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	Based on observation during the tour of the facility from 10:15 a.m. to 12:40 p.m. with the Maintenance Assistant on 11/29/21, three separate three drawer plastic containers containing plastic supplies were stored within five feet of stationary liquid oxygen containers in the oxygen storage and trans-filling room. Additionally, there were wooden cabinets mounted on the wall above the liquid oxygen containers. Based on interview at the time of observation, the Maintenance Assistant agreed combustible materials were stored within five feet of stationary liquid oxygen containers. The finding was reviewed with the Director of Nursing, Director of Plant Operations and Maintenance Assistant during the exit conference. 3.1-19(b)		(**Attachment A**). **Measures in place/system changes:** The Director of Maintenance or designee has provided a photograph of the oxygen room which indicates the cabinets have been removed and storage items remain at least five feet from the oxygen cylinders, and it will be attached to the plan of correction. The Director of Maintenance/or designee with provide audits monthly and the audits will be submitted at Quality Improvement meetings monthly for six months for their review. **See attached Director of Maintenance or designee audits (Attachment B.)** **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K923 Gas equipment cylinder and container storage for (6) six months at the scheduled QI meetings. Following six (6) monthly quality assurance compliance reviews and if no concerns are noted, the committee will file the audits. **See attached Quality Assurance and Process Improvement audits (Attachment C).** Date of Compliance December 8, 2021.	

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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 transfilling rooms had concrete or ceramic flooring. NFPA 99, Health Care Facilities Code, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated, is sprinklered, and have ceramic or concrete flooring. This deficient practice could affect up to 34 residents in 1 smoke compartments when occupied. Findings include: Based on observations during a tour of the facility from 10:15 a.m. to 12:40 p.m. with the Maintenance Assistant on 11/29/21, the oxygen transfilling room located across from resident room 417 had a floor covered with laminate flooring. Based on interview at the time of observation, the Maintenance Assistant stated before the recent renovation from a flood, a section of the room had ceramic tiles on the floor where the oxygen cylinders sat and transfilling occurred. The	K 0927	**K927** **Gas Equipment-Transfilling Cylinders** **This facility does ensure that transfilling cylinders the facility uses are stored in accordance with the requirements of NFPA 99. Corrective actions taken:** The maintenance director removed all the flooring in the oxygen room where the oxygen cylinders reside, and a concrete floor remains. A picture of the oxygen room will be attached to the plan of correction. (**Attachment A)**. **Measures in place/system changes:** The Director of Maintenance or designee has provided a photograph of the oxygen room which indicate the	12/09/2021

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	Maintenance Assistant agreed that at the time of observation, the room was covered in laminate flooring and was not ceramic or concrete. This finding was reviewed with the Director of Nursing, Director of Plant Operations and Maintenance Assistant during the exit conference. 3.1-19(b)		flooring has been removed and concrete flooring remains. Photograph will be attached to the plan of correction. **Monitoring of corrective actions taken:** The Quality Assurance and Process Improvement committee will review compliance of K927 Gas Equipment-Transfilling Cylinders for a period of (6) six months at the scheduled QI meetings. Following six (6) monthly quality assurance compliance reviews and if no concerns are noted, the committee will file the audits. **See attached Quality Assurance and Process Improvement audits. (Attachment B)** Date of Compliance December 8, 2021.	