STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155458	A. BUILDING -- B. WING	08/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HIGHLAND NURSING AND REHABILITATION CENTER	9630 FIFTH ST HIGHLAND, IN 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --		E 0000		
	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/30/18 Facility Number: 000367 Provider Number: 155458 AIM Number: 100289280 At this Emergency Preparedness survey, Highland Nursing and Rehabilitation was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 38 certified beds. At the time of the survey, the census was 25. Quality Review completed on 09/05/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:			
E 0009 SS=C Bldg. --		E 0009	E 009 Corrective Actions: 1. Emergency Preparedness Plan is available and located in the Emergency Preparedness Plan Binder for review that includes a process for cooperation and collaboration with the local, tribal,	09/28/2018
	Based on record review and interview, the facility failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including			

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

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	documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in accordance with 42 CFR 483.73(a)(4). This deficient practice could affect all occupants. Findings include: During record review with the Administrator and Corporate Maintenance Director on 08/30/18 at 10:56 a.m. no documentation could be located ensuring the emergency preparedness plan included a process for cooperation and collaboration with local, tribal, regional, State, or Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the LTC facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. Based on interview at the time of record review, the Administrator stated she had been assigned to the facility for approximately three weeks and has not yet contacted area emergency preparedness officials and was not aware of activities prior to her arrival.		regional, state or federal emergency preparedness officials. 2. All residents has the potential to be affected by the deficient practice: No resident was affected by the alleged deficient practice 3. Director of Plant Operations will in-service the Maintenance Director on the Emergency Preparedness plan process. Maintenance Director or Administrator to in- service all staff regarding emergency preparedness plan 4. The Maintenance Director or designee will ensure that these monthly meetings will occur as well as assurance that contact names and numbers of our local officials are accurate. Maintenance Director and Administrator will ensure monthly meetings with the safety committee for 6 months to ensure compliance and that the process is being followed and documented in the safety minutes The information will be reviewed monthly in QAPI meeting for review and compliance. Completion Date: 9/28/2018	
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency	E 0039	E 0039 Corrective Actions: 1. An Emergency Preparedness	09/28/2018

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	plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: During record review with the Administrator and Corporate Maintenance Director on 08/30/18 at 11: 30 a.m. no documentation could be located indicating the facility participated in exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. Based on interview at the time of record review, the Administrator and Corporate Maintenance Director stated they were unaware of any drills the facility may have		Program has been developed, that implemented all staff training and testing on emergency preparedness including drills to ensure competency. The two hour community exercise was completed November 2017 with all management staff. Documented by sign in sheet as well as the information covered during the training with Steve Meir from the Meir Group. Theses training exercises will occur annually as required 2. How Others Identified: All resident's have the potential to be affected by the deficient practice: None of the residents were affected by this alleged deficient practice A community based exercise or an individual based exercise will be scheduled to test the emergency plan as appropriate and required. Preventative Measures: 3. Maintenance Director will be in-serviced by the Director of Plant Operations on ensuring that all exercises are documented in accordance with Life Safety Code Standards. Maintenance Director and or Administrator along with a facilitator will conduct an Emergency Preparedness exercise to test the emergency plan at least annually, including unannounced staff drills using the	

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	participated in, and could provide no documentation of participation.		emergency procedures to include one full scale exercise that is community based. Monitored: 4. Maintenance Director/Designee will provide the Administrator with documentation of all required emergency exercises to ensure the exercises are to test the emergency preparedness plan at least annually. All exercises that occurred will be discussed in the safety committee meeting and reviewed monthly for 6 months Any identified concerns from audits will be discussed in QAPI meetings Completion Date: 9/28/2018	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/30/18 Facility Number: 000367 Provider Number: 155458 AIM Number: 100289280 At this Life Safety Code survey, Highland Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a),	K 0000		

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	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 II (222) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors and battery powered smoke detectors in all resident rooms. The facility has the capacity for 38 and had a census of 25 at the time of this survey. All areas with resident access are sprinklered. Three detached storage sheds are unsprinklered. Quality Review completed on 09/04/18 - DA			
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 maintain 1 of 4 corridors from obstructions per 19.2.1 LSC 19.2.1 states that every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. LSC 7.1.10. Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in	K 0211	K 211 Corrective Actions: 1. The non-wheeled dresser was removed from the corridor immediately by Corporate Maintenance once identified on 8/30/18. Maintenance will continue to ensure that all means of egress are continuously free of all obstructions in case of an	09/28/2018

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	the case of fire or other emergency. LSC 7.1.10.2.1 No furnishings, decorations, or other objects shall obstruct exits or their access thereto, egress therefrom, or visibility thereof. This deficient practice could affect staff and up to 20 residents in the West smoke compartment. Findings include: During a tour of the facility with the Administrator and the Corporate Maintenance Director on 08/30/18 at 9:16 a.m. a non-wheeled dresser was in the corridor outside resident room 6. Based on interview at the time of each observation, the Corporate Maintenance Director acknowledged the dresser was a potential impediment to full use of the means of egress access corridor. 3.1-19(b)		emergency How Others Identified: 2. All residents have the potential to be affected by the deficient practice: No resident was affected by the alleged deficient practice Maintenance and Administrator rounded the facility to assure that hallways were free of any items blocking means of egress. Preventative Measures: 3. Director of Plant Operations will in service Maintenance Director on observing corridors for items obstructing egress. All staff to be in serviced on items obstructing the corridors and removing those items found by Maintenance Director /Designee Life Safety rounds has been initiated and includes visual observation of all means of egress to ensure that all areas are unobstructed. Monitored: 4. Maintenance Director will conduct daily rounds to ensure no obstruction is observed for 4 weeks then weekly for 6 months to assure compliance. Results of this audit will be presented to QAPI monthly for review Completion Date: 9/28/218	

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K 0291 SS=F 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 9 of 9 battery-operated emergency lights annual testing was properly documented in accordance with LSC 19.2.9.1. Section 19.2.9.1 states that emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility. Findings include: During record review with the Administrator and Corporate Maintenance Director on 08/30/18 at 10:21 a.m. Battery Operated Emergency Light testing, which was included on the monthly generator log, did not indicate monthly testing of the battery operated emergency lights had been conducted on a monthly basis for the most recent 12 months. Based on interview at the time of the Corporate Maintenance Director confirmed that monthly testing had not been conducted. At the time of exit, no additional information or evidence could be provided contrary to this deficient	K 0291	K 291 Corrective Actions: 1. The Battery Operated Emergency light that was cited in the 2567 was inspected immediately by Corporate Maintenance on 8/30/18 upon notification and found to be functioning properly. This inspection and testing has been documented in the facility's maintenance files and will remain on file for future inspection. How Others Identified: 2. All residents have the potential to be affected by the alleged deficient practice: No residents were affected by the alleged deficient practice Preventative Actions: 3. Director of Plant Operations will educate the Maintenance Director on the required NFPA 101 Emergency Lighting Testing for not less than 30 seconds as required Functional testing shall be conducted annually. Monitored: 4.Maintenance Director/Designee will audit the battery powered emergency lighting system monthly as required.	09/29/2018

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	practice. 3.1-19(b)		Administrator or designee will monitor weekly for 4 weeks and monthly for 6 months. The audits will be discussed monthly in QAPI meeting to ensure compliance has been achieved and maintained. All identified concerns from audits will be addresses immediately Completion Date: 9/28/2018	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having jurisdiction. NFPA 72, 14.4.5.3.1 states sensitivity shall be checked within 1 year after installation. NFPA 72, 14.4.5.3.2 states sensitivity shall be checked every	K 0345	K 345 Corrective Actions: 1. Administrator called SafeCare and Integrated Electronics on 8/30/18 to request documentation on Fire Alarm Testing and Smoke Detector Sensitivity Testing. Documentation was received via email, printed and placed in Life Safety Binder for review. How Others Identified: 2. All residents have the potential to be affected by the deficient practice No resident was affected by the	09/28/2018

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	alternate year thereafter unless otherwise permitted by compliance with 14.4.5.3.3. This deficient practice could affect all occupants. Findings include: During record review with the Administrator and Corporate Maintenance Director on 08/30/18 at 10:34 a.m., no documentation for a fire alarm sensitivity test was available for review. Based on interview at the time of record review, the Corporate Maintenance Director acknowledged the aforementioned condition and confirmed no other documentation was available for review. 3.1-19(b)		alleged deficient practice Preventative Measures: 3. Director of Plant Operations will in-service the Maintenance Director on maintaining documentation regarding Smoke Detector Sensitivity Testing Monitored: 4. Maintenance Director or Designee will audit Sensitivity Testing inspection and documentation monthly for 6 months to assure documentation has been obtained and maintained in the Life Safety Binder. Audit will be reviewed by QAPI Committee monthly to assure compliance. Completion Date: 9/28/2018	
K 0346 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 Based on record review and interview, the facility failed to provide a complete 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for	K 0346	K 346 Corrective Actions: 1. Insurance Company information and a link to the ISDH Gateway has been added to the Fire Watch Plan	09/28/2018

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	four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include: Based on record review with the Administrator and the Corporate Maintenance Director on 08/30/18 at 9:41 a.m., the facility provided fire watch documentation but it was incomplete. The plan failed to include contacting the Indiana State Department of Health via the Web Portal. Based on an interview at the time of record review, the Administrator and the Corporate Maintenance Director acknowledged fire watch policy failed to include the web link for contacting the Incident Reporting System located on the Indiana State Department of Health (ISDH) Gateway. 3.1-19(b)		How Others Identified: 2. All residents have the potential to be affected by this deficient practice: No resident was affected by the alleged deficient practice Preventative Measures: 3. Director of Plant Operations will in-service Maintenance Director on the Fire Watch Policy and required notification Administrator will in-service all staff on Fire Watch Policy and the required notification. Monitored: 4. To ensure compliance, Maintenance Director, Administrator or Designee will do random staff education on Fire Watch Policy for 4 weeks and monthly for 6 months. QAPI minutes are submitted to regional and corporate teams for review monthly Completion Date: 9/28/2018	
K 0353 SS=C 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 _____			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1) Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants. Findings include: During record review with the Administrator and the Corporate Maintenance Director on 08/30/18 at 10:02 a.m., no documentation could be located for the First Quarter (January, February, March) or the Second Quarter (April, May, June) of 2018. Based on interview at the time of record review, the Administrator and the Corporate Maintenance Director acknowledged the lack of documentation. 3.1-19(b) 2) Based on observation and interview, the facility failed to maintain the ceiling construction in four areas throughout the facility. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance	K 0353	K 353 Corrective Actions: 1. Call placed by Administrator to SafeCare and Integrated Electronics to inquire and request the needed documentation for the Sprinkler system testing for the alleged 2 quarters cited in the 2567. Sprinkler System Maintenance and Testing documentation needed for surveyors review for the 2 quarters were not available from either company on 8/30/18. Facility will continue to have Sprinkler System inspected and tested quarterly as indicated by LSC 9.7.5. How Others Identified: 2. All residents have the potential to be affected by the deficient practice No residents were affected by the alleged deficient practice Preventative Measures: 3. The Maintenance Director to be in-serviced by the Director of Plant Operations on maintaining documentation for all inspections regarding the sprinkler system. Director of Plant Operations has implemented an audit form for	09/28/2018

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	between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: During a tour with the Corporate Maintenance Director on 08/30/18, at 9:29 a.m. a one inch gap was located around an electrical junction box in the ceiling of the MDS office. The attic space was observed through the gap in the ceiling. During interview at the time of observation, the Corporate Maintenance Director acknowledged the gap and agreed with the measurement. 3.1-19(b)		monitoring the inspection and documentation of the sprinkler system. Monitored: 4. Maintenance Director or Administrator will audit quarterly inspection and documentation of the Sprinkler System for 6 months and it will be placed in the Life Safety Binder for further review Director of Plant Operations will perform random checks of the life safety binder to assure compliance has been achieved and maintained. Audits will be discussed in the monthly QAPI meeting by Maintenance Director to check for compliance. QAPI team to review audits and address any issues immediately. Completion Date: 9/28/2018	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is			

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	provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed during the impairment of 1 of 1 automatic sprinkler system for 10 hours or more in a 24-hour period in accordance with LSC Section 9.7. as required by LSC Section 19.3.5.1. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (6) states the insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified. This deficient practice could affect all occupants in the facility. Findings include: During record review with the Administrator and Corporate Maintenance Director on 08/30/18 at 9:41 a.m., the facility provided fire watch plan documentation but it was incomplete. The plan failed to include contacting the insurance carrier or to contact the Indiana State Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Administrator and Corporate Maintenance Director acknowledged the fire watch documentation provided named "Fire Watch" did not state to contact the	K 0354	K 354 Corrective Actions: 1. Insurance Company information and link to the ISDH Gateway has been added to the Fire Watch Plan as required How Others Identified: 2. All residents has the potential to be affected by the deficient practices. No resident was affected by the alleged deficient practice. Preventative Measures: 3. Director of Plant Operations will in-service the Maintenance Director on Fire Watch Policy Maintenance Director or Administrator will conduct an all staff in service on Fire Watch Policy Monitored: 4. To ensure compliance, Administrator or Designee will do random staff education on the Fire Watch Policy weekly for 4 weeks and the monthly for 6 months thereafter. If compliance isn't achieved, an action plan will be developed and implemented. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. Completion Date: 9/28/2018	09/28/2018

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	155458	A. BUILDING 01 B. WING	08/30/2018

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	insurance carrier and stated to contact the Indiana State Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. 3.1-19(b)			
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 2 of 5 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 affects all building occupants. Findings include:	K 0374	K 374 Corrective Actions: 1. The Director of Plant Operations re-assessed the north barrier fire door latch and fire barrier door latch near room #5 and scheduled repairs to ensure proper closure. How Others Identified: 2. All residents have the potential to be affected by the deficient practice: No resident were affected by the alleged deficient practice cited. Preventative Measures: 3. Director of Plant Operations will	09/28/2018

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	During a tour of the facility with the Corporate Maintenance Director on 08/30/18 the following conditions were found: a) At 9:09 a.m. the north set of barrier doors for the Dining Room smoke barrier did not latch due to a faulty coordinator and left a six inch gap between door leaves. b) At 9:17 a.m. the set of barrier doors near resident room 5 did not latch due to a faulty coordinator and left a six inch gap between door leaves. This was verified by the Corporate Maintenance Director at the time of observation. 3.1-19(b)		in service the Maintenance Director regarding monthly inspection on Fire Barrier Doors and proper latching. Monitored: 4. To ensure compliance, Administrator or designee will audit Fire Door latching to ensure proper closure weekly for 4 weeks and monthly for 6 months thereafter. Monthly QAPI minutes and action plans are submitted to regional and corporate teams for review. Completion Date: 9/28/2018	
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 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 observation and interview, the facility failed to ensure 1 of 1 electrical wirings in the MDS Coordinator's Office was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect staff only. Findings include: During a tour of the facility with the Corporate	K 0511	K 511 Corrective Actions: 1. Corporate Maintenance immediately replaced and repaired the cover on the bare wires 8/30/18 and conducted a facility search for any exposed wires. How Others Identified: 2. All residents have the potential to be affected by the deficient practice:	09/28/2018

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	Maintenance Director on 08/30/18 at 9:28 a.m. the MDS Coordinator's Office had an electrical receptacle box that had a flex coil conduit pulled out, exposing individual conductors. Based on interview at the time of observation, the Corporate Maintenance Director agreed the flex coil had pulled out, leaving conductors exposed. 3.1-19(b)		No residents, staff or visitors were affected by the alleged deficient practice. Preventative Measures: 3. Director of Plant Operations will in-service Maintenance Director on assuring that all bare wires are covered appropriately. Maintenance Director will inspect all areas of the facility to ensure that any bare wires will be covered as cited in the 2567. Monitored: 4. To ensure compliance, Administrator of Designee will audit the facility for any bare wires weekly for 4 weeks and monthly for 6 months thereafter. The results of the audits will be summarized and presented to QAPI monthly for review. Completion Date: 9/28/2018	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K 0712	K 712	09/28/2018

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	Based on record review and interview, the facility failed to conduct 1 of 12 quarterly shift fire drills during the most recent 12 month time period. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: During record review with the Administrator and Corporate Maintenance Director on 08/30/18 from 9:30 a.m. to 11:45 a.m., the facility was unable to provide documentation of a fire drill for the first shift for the fourth quarter of 2017. Based on interview at the time of record review, the Administrator and Corporate Maintenance Director acknowledged the missing fire drill and could provide no further evidence or additional information contrary to this deficient finding. 3.1-19(b) 3.1-51(c)		Corrective Actions: 1. Corporate Maintenance conducted a Fire Drill immediately on 8/30/18 upon notification of 1 missing fire drill for the year. How Others Identified: 2. All residents have the potential to be affected by the deficient practice: No residents were affected by the alleged deficient practice cited. Preventative Measures: 3. Director of Plant Operations will in service the Maintenance Director on Fire Drill procedures and monthly Fire Drill schedules Monitored: 4. To ensure compliance, Administrator or Designee will audit fire drills monthly for 6 months. If compliance isn't achieved, then an action plan will be developed and implemented. Monthly QAPI minutes and action plan are submitted to regional and corporate teams for review and further suggestions or comments Completion Date: 9/28/2018	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to			

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	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 and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 38 of 52 weeks and 7 of 12 months. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected	K 0918	K 918 Corrective Actions: 1. Corporate Maintenance immediately performed Generator load test once identified on 8/30/18 How Others Identified: 2. All residents has the potential to be affected by the deficient practice: No residents were affected by the	09/28/2018

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	weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: During record review with the Administrator and the Corporate Maintenance Director on 08/30/18 at 10:27 a.m., documentation for weekly inspections from October, 2017 to July, 2018 were unavailable for review, also documentation for monthly exercises from January, 2018 to July, 2018 were unavailable for review. Based on an interview at the time of record review, the Administrator and Corporate Maintenance Director acknowledged the missing generator inspections and exercises. 3.1-19(b)		alleged deficient practice cited. Preventative Measures: 3. Director of Plant Operations will in-service Maintenance Director on the requirements of K 918 regarding generator testing, maintenance and required documentation. Monitored: 4.Preventative Maintenance records will be submitted and reviewed by QAPI Committee at its regularly scheduled monthly meetings to ensure generator testing is completed as scheduled. Generator documentation will be reviewed by the Administrator or designee and or Director of Plant Operations weekly for 4 weeks then monthly for 6 months to ensure compliance is being maintained Completion Date: 9/28/2018	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that			

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	do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, it could not be assured 1 of 1 Relocatable Power Taps (power strips) used in patient care vicinities met UL 1363A or UL60601-1. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 feet beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 feet 6 inches above the floor. Per CMS S&C: 14-46-LSC, Power strips providing power to patient care-related electrical equipment must be Special-purpose Relocatable Power Taps (SPRPT) listed as UL 1363A or UL 60601-1. This deficient practice could affect staff and one resident in room 8. Findings include: During a facility tour with the Corporate Maintenance Director on 08/30/18 at 9:15 a.m., it	K 0920	K 920 Corrective Actions: 1. The Corporate Maintenance immediately removed the surge protector cord from the patient care area and plugged directly into wall outlet on 8/30/18. Corporate Maintenance then conducted a complete inspection of all residents rooms to ensure there were no high amperage devices plugged into surge protectors How Others Identified: 2. All residents has the potential to be affected by the deficient practice: No residents were affected by the alleged deficient practice cited Preventative Measures: 3.The Maintenance Director will be in-serviced by the Director of Plant Operations on non-usage of surge protectors in patient care areas unless it's Medical Grade as identified on the 2567. All staff members will be	09/28/2018

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	could not be assured the power strip used to power a resident bed and air mattress met UL 1363A or UL60601-1. Based on interview at the time of observation, the Corporate Maintenance Director acknowledged it could not be assured the aforementioned power strip met UL 1363A or UL60601-1. 3.1-19(b)		in-serviced by Maintenance Director on the notification to the Maintenance Director and Administrator if noted that surge protectors are being used. Monitored: 4. To ensure compliance, Administrator or Designee will audit facility to monitor high amperage items weekly for 4 weeks and monthly for 6 months thereafter. If compliance isn't achieved, then an action plan will be developed and implemented. Monthly QAPI minutes and action plan are submitted to regional and corporate teams for review. Completion Date:9/28/2018	