STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155191	A. BUILDING -- B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE KENTUCKIANA	2210 GREENTREE N CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 11/07/22 Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130 At this Emergency Preparedness survey, Westminster Healthcare Kentuckiana was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 94 certified beds. At the time of the survey, the census was 60. Quality Review completed on 11/16/22 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0015 SS=C Bldg. --	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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

Stephanie Wise | Administrator | 11/30/2022

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health			

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	and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include at a minimum, (1) The provision of subsistence needs for staff and residents, whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical, and pharmaceutical supplies. (ii) Alternate sources of energy to maintain - (A) Temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; (B) Emergency lighting; (C) Fire detection, extinguishing, and alarm systems; and (D) Sewage and waste disposal in accordance with 42 CFR 483.73(b)(1). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Maintenance Director and Administrator present, the plan provided did not address water and pharmaceutical supplies and the loss of sewage and waste disposal to protect residents health and safety in an emergency. Based on interview at the time of records review, the Administrator confirmed the plan provided did not address water and pharmaceutical supplies and the loss of sewage and waste disposal to protect residents health and safety in an emergency. This finding was reviewed with the Administrator and Maintenance Director during the exit	E 0015	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **E015** Subsistence Needs for Staff and Patients **I. Action taken for those residents identified:** No individual resident was identified. Policies and procedures addressing water, pharmaceutical supplies were added to the manual. Policies and procedures were also added for sewage and waste disposal in an emergency. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the	12/08/2022

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	conference.		Emergency Preparedness Manual and educated staff on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
E 0023 SS=C Bldg. --	403.748(b)(5), 416.54(b)(4), 418.113(b)(3), 441.184(b)(5), 482.15(b)(5), 483.475(b)(5), 483.73(b)(5), 484.102(b)(4), 485.625(b)(5), 485.68(b)(3), 485.727(b)(3), 485.920(b)(4), 486.360(b)(2), 491.12(b)(3), 494.62(b)(4) Policies/Procedures for Medical Documentation §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5),			

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	§484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.			

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	Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Maintenance Director and Administrator present, policies and procedure that included a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records was not available for review. Based on interview at the time of record review, the Administrator confirmed the facility's Emergency Preparedness Manual does not include a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0023	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **E023** Policies and Procedures for Medical Documentation **I. Action taken for those residents identified:** No individual resident was identified. Policies and procedures addressing a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains the availability of records were added to the Emergency Preparedness manual. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness Manual and educated staff on contents and where to locate the manual, both printed and on-line for future reference.	12/08/2022

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			IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
E 0024 SS=C Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph			

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	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect	E 0024	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**.	12/08/2022

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	all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Maintenance Director and Administrator present, the facility's plan did not address the use of volunteers in an emergency. Based on interview at the time of review, the Administrator confirmed the plan provided did not address the use of volunteers in an emergency. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**E024** Policies/Procedures – Volunteers and Staffing **I. Action taken for those residents identified:** No individual resident was identified. Policies and procedures addressing the use of volunteers during an emergency were added to the Emergency Preparedness manual. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness Manual and educated staff on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan	

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			made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
E 0026 SS=C Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(6)(C)(iv), 441.184(b)(8), 482.15(b)(8), 483.475(b)(8), 483.73(b)(8), 485.625(b)(8), 485.920(b)(7), 494.62(b)(7) Roles Under a Waiver Declared by Secretary §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.			

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	*[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the plan did not address the role of the LTC facility under a waiver declared by the Secretary. Based on interview at the time of record review, the Administrator acknowledged the available plan did not address the role of the LTC facility under a waiver declared by the Secretary. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0026	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **E026** Roles Under a Waiver Declared by Secretary **I. Action taken for those residents identified:** No individual resident was identified. Policies and procedures addressing the role of the LTC facility under a 1135 waiver declared by the Secretary were added to the Emergency Preparedness manual. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness Manual	12/08/2022

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			and educated staff on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c),			

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	§494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the facility's emergency preparedness plan provided did not include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws. Based on interview at the time of the record review, the Administrator acknowledged the facility's emergency preparedness plan provided did not include a plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0029	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **E029** Development of Communication Plan **I. Action taken for those residents identified:** No individual resident was identified. The facility developed a plan for emergency communications and how it will be maintained and placed in the Emergency Preparedness manual. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness Manual and educated staff on contents	12/08/2022

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	155191	A. BUILDING -- B. WING	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTMINSTER VILLAGE KENTUCKIANA	2210 GREENTREE N CLARKSVILLE, IN 47129

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			and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. Date Complete: 12/8/22	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).			

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	*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the			

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	communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, there was no documentation available to show the facility had an emergency preparedness training and testing program available. Based on interview at the time of record review, the Administrator confirmed there is no training and testing program available within the Emergency Preparedness Manual.	E 0036	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **E036** EP Training and Testing **I. Action taken for those residents identified:** No individual resident was identified. Policies and procedures addressing the development of annual emergency preparedness training and testing was placed in	12/08/2022

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		the Emergency Preparedness manual. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness Manual and educated staff on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	

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E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and			

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	existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.			

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	*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing			

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	services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated			

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	policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the facility failed to conduct annual training for the Emergency Preparedness Program (EPP). The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of all emergency preparedness training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d) (1). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, no documentation of annual Emergency Preparedness Manual training and no documentation to show staff could demonstrate knowledge of the Emergency Preparedness Manual was available for review. Based on an	E 0037	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **E037** EP Training Program **I. Action taken for those residents identified:** No individual resident was identified. Policies and procedures addressing the documentation of annual Emergency Preparedness Manual training and staff demonstrating knowledge of the Emergency Preparedness Manual were added to the manual. **II. How other residents are identified:**	12/08/2022

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	interview at the time of record review, the Administrator confirmed there was no documentation of annual Emergency Preparedness Manual training and no documentation to show staff could demonstrate knowledge of the Emergency Preparedness Manual was available for review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness Manual and educated staff on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: V. The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. VI. Date Complete: 12/8/22	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(2), 441.184(d)(2), 482.15(d)(2), 483.475(d)(2), 483.73(d)(2), 484.102(d)(2), 485.625(d)(2), 485.68(d)(2), 485.727(d)(2), 485.920(d)(2),			

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	486.360(d)(2), 491.12(d)(2), 494.62(d)(2) EP Testing Requirements §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is			

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	led by a facilitator and includes a group discussion 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group			

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	discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion 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 hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.			

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	*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.			

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	*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises			

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	to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, 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] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the			

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	following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise			

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	is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, 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 HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of			

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	problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is 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. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.			
	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.	E 0039	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible	12/08/2022

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	b. 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 its next required full-scale in a community-based or individual, facility-based full-scale functional 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 an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, 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 in the facility. Findings include: Based on review of the Emergency Preparedness Manual on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the facility was unable to provide documentation of a community based exercise or a second exercise during the past 12 month period. This was confirmed by the Administrator at the time of record review. This finding was reviewed with the Administrator and Maintenance Director during the exit		allegation of compliance **E039** EP Training Requirements **I. Action taken for those residents identified:** No individual resident was identified. The facility located the Active Shooter and Work Place Violence tabletop exercise that was conducted by the Indiana State Police on July 25, 2022. This exercise and test were performed at the facility. The facility also scheduled a Dec 5, 2022 tabletop tornado exercise based on the HVA. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness Manual and educated staff on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The	

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	conference.		results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA			

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	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. 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			

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	_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 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..			
	Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42	E 0041	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence**	12/08/2022

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	CFR 483.73(e)(2). 1. 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 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. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, there was no documentation on the emergency generator monthly test form for percentage of load during the monthly load tests during the past 12 months. The information provided always said "NA" or it was left blank. Based on interview at the time of record review, the Maintenance Director agreed there was no documentation provided on the monthly generator load test form for percentage of load during the past 12 months. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 2. Based on record review and interview, the facility failed to exercise the generator annually to meet the requirements of NFPA 110, 2010 Edition,		**of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **E041** Hospital CAH and LTC Emergency Power **I. Action taken for those residents identified:** The facility contacted the generator service provider to provide required service and training for the maintenance and upkeep of the emergency generators. This included documenting the emergency generator monthly test for percentage of load; actual load percentage to establish the required 30% of the name plate rating; annual fuel quality test. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** Maintenance personnel were educated on how to schedule, perform and document emergency generator testing. IV. **How the facility will monitor and quality assurance program**:	

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	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 (Load Bank Test) 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 occupants. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the generator load testing documentation showed the actual load percentage for the diesel powered generator was not documented. Based on interview at the time of record review, the Maintenance Director said the generator ran under load on a monthly basis but was not sure if it achieves the required 30 % of the name plate rating. Additionally, the Maintenance Director acknowledged a load bank test for the generator had not occurred within the past 12 month period.		The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	

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	155191	A. BUILDING -- B. WING	11/07/2022

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	This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, there was documentation of an annual generator inspection dated 06/08/22, however, there was no documentation of an annual fuel quality test for the diesel generator available for review. Based on interview at the time of record review, the Maintenance Director stated the facility does have a diesel generator but after having spoken with the facility's generator inspection vendor it was determined that a fuel sample has not been taken by the current vendor. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			

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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: 11/07/22 Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130 At this Life Safety Code survey, Westminster Healthcare Kentuckiana 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) and 410 IAC 16.2. The building was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 94 and had a census of 60 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 11/16/22	K 0000		

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K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS			

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	Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure 1 of 6 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall	K 0222	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K222** Egress Doors	12/08/2022

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	activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect up to 5 residents, as well as staff and visitors. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the outside exit door near the entrance to the Assisted Living corridor was equipped with a delayed egress sign, however, the sign indicated it was only a 5 second delayed egress instead of a required 15 second delayed egress sign. The door did release from the magnetic lock after pushing on the panic bar for 15 seconds. Based on interview at the time of observation, the Maintenance Director said the "1" must have gotten scratched off the sign, and he would replace the sign as soon as possible. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**I. Action taken for those residents identified:** No individual resident was identified. The outside exit door signage was corrected to state 15 second delayed egress as required. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** An audit of all outside emergency egress door signage was completed to ensure the required information was displayed. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the preventative maintenance logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits.	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) 1. Based on observation and interview, the facility failed to ensure a hazardous area outside 1	K 0321	**The filing of this plan of correction does not constitute**	12/08/2022

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	of 6 exits was enclosed by smoke resisting partitions and was separated from the exit discharge. This deficient practice could affect at least 5 residents, staff, and visitors. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, there were four large totes with bio-hazardous material stored within an approximately eight foot by six-foot metal linked fenced in area directly outside and exposed to the exit discharge near the Assisted Living entrance corridor. Based on interview at the time of observation, this was acknowledged by the Administrator and Maintenance Director. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the corridor door to 1 of over 10 hazardous area doors, such as a storage room door, was provided with a self closing device. This deficient practice could affect at least 5 residents, staff, and visitors. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the Staff Development Room was full of over 30 cardboard boxes as well as wood pallets. The corridor door to this room was not provided with a self closing device. This room was over 50 square feet in size. Based on interview at the time of observation, the Maintenance Director agreed the corridor door to this Staff Development Room was		**that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K321** Hazardous Areas - Enclosure **I. Action taken for those residents identified:** No individual resident was identified. Facility purchased and installed a storage building that is stand alone and secure for hazardous waste containers waiting for pickup. It is installed away from emergency exits. The facility removed cardboard boxes of items from the Staff Development Room and installed a self-closing device on the door to the room. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** Staff were educated on where to store Hazardous waste for pick-up. IV. **How the facility will monitor and quality assurance**	

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	not provided with a self-closing device. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**program**: The Administrator/Designee will be responsible for auditing the preventative maintenance logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with			

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	conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to ensure the cook top in 1 of 1 Physical Therapy room was shut off at the switch when not in use. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect at least 5 residents while in the Physical Therapy Room. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, there was a cooktop stove in the Physical	K 0324	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K324** Cooking Facilities **I. Action taken for those residents identified:** No individual resident was identified. An emergency shut off switch was installed on the cooktop stove located in the Therapy Room. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** Staff were educated on the location of the emergency shut off switch.	12/08/2022

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	Therapy room. When checked, and not in use, the stove top appliance was not deactivated from the individual cooktop power source. Based on interview at the time of observation, the Maintenance Director confirmed the cooktop stove was not deactivated when not in use. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the preventative maintenance logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
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 maintain 1 of 1 fire alarm system in	K 0345	**The filing of this plan of correction does not constitute**	12/08/2022

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	accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, there was documentation provided regarding a visual semi-annual fire alarm system inspection dated 03/29/22 by in house Maintenance Staff, however, the documentation provided only included the visual inspection of pull stations and horn/strobes, it did not include the 43 hard wired smoke detectors located throughout the facility. The most recent annual fire alarm visual/functional test/inspection was dated 09/28/22. Based on interview at the time of record review, the Maintenance Director confirmed the visual inspection of the fire alarm system's devices dated 03/29/22 did not include the facility's 43 hard wired smoke detectors. This finding was reviewed with the Administrator and Maintenance Director during the exit		**that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K345** Fire Alarm System **I. Action taken for those residents identified:** No individual resident was identified. Maintenance did a visual inspection of the 43 hard wired smoke detectors. The visual inspection was documented in preventative maintenance records. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The 43 hard wired smoke detectors were added to the semi-annual inspection list. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the preventative maintenance logs weekly for four weeks, then	

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	conference. 3.1-19(b)		bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
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 written policy for the protection of 60 of 60 residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for 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 in the facility. Findings include:	K 0346	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible	12/08/2022

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	Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the facility provided fire watch documentation from the Emergency Preparedness plan, however, it was incomplete. The plan did include the phone number for the IDOH, however, the plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway, furthermore, the fire watch did not include documentation to indicate the person conducting the fire watch has been properly trained. Based on an interview at the time of record review, the Maintenance Director confirmed the fire watch lacked the previously mentioned information. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		allegation of compliance **K346** Fire Alarm System – Out of Service **I. Action taken for those residents identified:** No individual resident was identified. The Emergency Preparedness plan was updated to include the Indiana Department of Health weblink for contacting the Incident Reporting System located on the IDOH Gateway, in the case that the fire alarm system was placed out of service for more than four hours in a 24-hour period. Training on this procedure was provided to the maintenance personnel responsible for reporting it. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness plan and educated maintenance personnel on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: V. The Administrator/Designee will be	

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			responsible for auditing the Emergency Preparedness plan weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. Date Complete: 12/8/22	
K 0351 SS=E 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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	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 ensure 1 of 1 outside entrance overhead canopy was provided with adequate sprinkler coverage in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 8.15.7.1 states unless the requirements of 8.15.7.2, 8.15.7.3, or 8.15.7.4 are met, sprinklers shall be installed under exterior roofs, canopies, porte-cocheres, balconies, decks, or similar projections exceeding 4 ft (1.2 m) in width. This deficient practice could residents, staff, and visitors while entering or exiting the Physical Therapy entrance/exit area. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. with the Administrator and Maintenance Director during a tour of the facility, the outside entrance/exit area to the Physical Therapy area was provided with a 21 foot by 6 foot overhead canvas canopy. There was a sprinkler head on the outside of the building to this area, however, it would not provide adequate sprinkler coverage to the entire canvas canopy. This was acknowledged by the Administrator and Maintenance Director at the time of observation. Furthermore, the Maintenance Director said he did not think there was documentation of a flame spread rating of the canvas canopy available for review. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0351	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K351** Sprinkler System - Installation **I. Action taken for those residents identified:** No individual resident was identified. The facility was able to contact the manufacturer/installer of the outside awning. It meets fire rating requirements and does not require additional sprinkler installation. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The maintenance supervisor will assure that any and all new install of regulated material meet this standard and documentation is keep in appropriate file.	12/08/2022

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			IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the new installation file weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
K 0353 SS=D 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 _____			

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	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 1 of 6 smoke compartments covered with lint/dirt were properly cleaned. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff in the Medical Records Office. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, there was one sprinkler head in the Medical Records Office next to the air supply vent heavily covered with dust/dirt. Based on interview at the time of observation, the Maintenance Director agreed the sprinkler head in the Medical Records Office was covered with dust/dirt and should be properly cleaned. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	K 0353	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K353** Sprinkler System – Maintenance and Testing **I. Action taken for those residents identified:** No individual resident was identified. Sprinkler head in Medical Records office was cleaned. The closet in Room 124 was cleaned and items removed to provide an 18" clearance from the sprinkler head. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility did an audit of resident room closets to identify and	12/08/2022

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the sprinkler head in 1 of 48 sprinklered resident room closets was maintained to allow the sprinkler head to function to it's full capability. This deficient practice could affect at least 2 residents. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the closet in resident room 124 had storage stacked within six inches of the sprinkler head. Based on interview at the time of observation, the Maintenance Director acknowledged the close storage within six inches of the sprinkler head. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		address any issues to ensure proper sprinkler function. Cleaning education provided to maintenance department personnel. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the preventative maintenance logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. Date Complete: 12/8/22	
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			

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	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 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 for the protection of 60 of 60 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. 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 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the facility provided fire watch documentation from the Emergency Preparedness plan, however, it was incomplete. The plan did include the phone	K 0354	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K354** Sprinkler System – Out of Service **I. Action taken for those residents identified:** No individual resident was identified. The facility The Emergency Preparedness plan was updated to include the Indiana Department of Health weblink for contacting the Incident Reporting System located on the IDOH Gateway, in the case that the sprinkler system was placed out of service for more than ten hours in a 24-hour period. Training on this procedure was provided to the maintenance personnel responsible for reporting it.	12/08/2022

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	number for the IDOH, however, the plan failed to include contacting the Indiana Department of Health (IDOH) with the web link for contacting the Incident Reporting System located on the IDOH Gateway, furthermore, the fire watch did not include documentation to indicate the person conducting the fire watch has been properly trained. Based on an interview at the time of record review, the Maintenance Director confirmed the fire watch lacked the previously mentioned information. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Emergency Preparedness plan and educated maintenance personnel on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness plan weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
K 0363 SS=B	NFPA 101 Corridor - Doors			

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Bldg. 01	Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing			

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	devices, etc. Based on observation and interview, the facility failed to ensure 1 of over 100 doors to the corridor had a clearance between the bottom of the door and floor exceeding 1 inch. This deficiency could affect over 50 residents, staff and visitors while in the main dining room. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the Pantry room door had a gap of 2.75 inches between the bottom of the door and the floor. This was confirmed by the Administrator and Maintenance Director at the time of observation. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K363** Corridor - Doors **I. Action taken for those residents identified:** No individual resident was identified. The facility installed a door sweep to the bottom of the door to the Pantry. A hardwired smoke detector was also installed in the Pantry. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility performed an audit of fire doors to ensure no other issues were found. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be	12/08/2022

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			responsible for auditing the preventative maintenance logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure a junction box in 1 of 6 smoke compartments 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 at least 5 residents, staff, and visitors. Findings include:	K 0511	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of	12/08/2022

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	Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, there was an electrical junction box observed in the interstitial space above the drop ceiling at the separation fire doors between the Assisted Living and Health Care Unit with no cover plate and several exposed wires. Based on interview at the time of observation, the Maintenance Director acknowledged the junction box with several exposed electrical wires was not provided with a junction box cover. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		correction as our credible allegation of compliance **K511** Utilities – Gas and Electric **I. Action taken for those residents identified:** No individual resident was identified. The facility electrician placed a cover on the junction box. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility did an audit of junction boxes to insure there were no other issues identified. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the preventative maintenance logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with	

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WESTMINSTER VILLAGE KENTUCKIANA	2210 GREENTREE N CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			the stand down meeting audits. V. Date Complete: 12/8/22	
K 0711 SS=F 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 and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 60 of 60 residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm 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	K 0711	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K711** Evacuation and Relocation Plan **I. Action taken for**	12/08/2022

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	(8) Preparation of floors and building for evacuation (9) Extinguishment of fire Section 19.2.3.4(4) states any required aisle or corridor shall not be less than 48 inches in clear width where serving as means of egress from patient sleeping rooms. Projections into the required width shall be permitted for wheeled equipment provided the relocation of wheeled equipment during a fire or similar emergency is addressed in the written fire safety plan and training program for the facility. The wheeled equipment is limited to: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's "Fire Policy and Procedure" on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the plan did not address the following items: a. Staff response to battery powered smoke alarms located in resident sleeping rooms. c. The evacuation of the smoke compartment. Based on interview at the time of record review, the Maintenance Director acknowledged and agreed that the fire safety plan did not address the previously mentioned items. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**those residents identified:** No individual resident was identified. Education provided to staff on how to respond to battery powered smoke detector in resident sleeping rooms. Education provided to staff on how to evacuate a smoke compartment. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the Fire Safety Plan and educated staff on contents and where to locate the manual, both printed and on-line for future reference. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the fire drill logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits.	

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, all 12 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on interview at	K 0712	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K712** Fire Drills **I. Action taken for those residents identified:** No individual resident was identified. The facility updated fire drill	12/08/2022

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	the time of record review, the Maintenance Director acknowledged there was no information on all 12 fire drill reports to verify that transmission of the alarm was received by the monitoring company. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3-1.19(b)		reporting to include documentation of transmission of the fire alarm to the monitoring company. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility educated maintenance personnel on the new form. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the preventative maintenance logs weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
K 0761 SS=B Bldg. 01				

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	Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.	K 0761	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K761** Maintenance, Inspection and Testing - Doors **I. Action taken for those residents identified:** No individual resident was identified. Maintenance Supervisor immediately inspected oxygen room fire door assembly. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility updated the annual fire door inspection form to include the oxygen room door. Education was provided to maintenance personnel on fire door inspection. IV. **How the facility will monitor and quality assurance program**: I. The	12/08/2022

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	(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect up to 40 residents, as well as staff, and visitors in the 100 Unit. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly. Based on interview at the time of record review, the Maintenance Director said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly. Based on observations during a tour of the facility with the Administrator and Maintenance Director between 1:50 p.m. and 4:30 p.m., there was one oxygen transfilling room fire door assembly noted in the facility. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		Administrator/Designee will be responsible for auditing the preventative maintenance log weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	

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K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored 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 implement the emergency power system	K 0918	**The filing of this plan of correction does not constitute**	12/08/2022

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	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). 1. 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 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. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, there was no documentation on the emergency generator monthly test form for percentage of load during the monthly load tests during the past 12 months. The information provided always said "NA" or it was left blank. Based on interview at the time of record review, the Maintenance Director agreed there was no documentation provided on the monthly generator load test form for percentage of load during the past 12 months. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		**that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K918** Electrical Systems – Essential Electric Systems **I. Action taken for those residents identified:** No individual resident was identified. The facility contacted the generator service provider to provide required service and training for the maintenance and upkeep of the emergency generators. This included documenting the emergency generator monthly test for percentage of load; actual load percentage to establish the required 30% of the name plate rating; annual load bank test; and annual fuel quality test. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility educated maintenance personnel on how to perform	

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	3.1-19(b) 2. Based on record review and interview, the facility failed to exercise the generator annually to 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 (Load Bank Test) 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 occupants. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, the generator load testing documentation showed the actual load percentage for the diesel powered generator was not documented. Based on interview at the time of record review, the Maintenance Director said the generator ran under load on a monthly basis but was not sure if it achieves the required 30 %		monthly test for percentage of load and how to establish if 30% and the name plate rating was achieved. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for auditing the Emergency Preparedness manual weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	

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	of the name plate rating. Additionally, the Maintenance Director acknowledged a load bank test for the generator had not occurred within the past 12 month period. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 diesel powered generators. NFPA 99, Health Care Facilities Code, 2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents, as well as staff and visitors. Findings include: Based on record review on 11/07/22 between 9:30 a.m. and 1:50 p.m. with the Administrator and Maintenance Director present, there was documentation of an annual generator inspection dated 06/08/22, however, there was no documentation of an annual fuel quality test for the diesel generator available for review. Based on interview at the time of record review, the Maintenance Director stated the facility does have a diesel generator but after having spoken			

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	with the facility's generator inspection vendor it was determined that a fuel sample has not been taken by the current vendor. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
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 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, the facility failed to ensure a power strip was not used as a	K 0920	**The filing of this plan of correction does not constitute**	12/08/2022

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	substitute for fixed wiring in 1 of 1 Beauty Shop and 1 of 48 resident rooms. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect one resident and staff. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, the following was noted: a. There were two curling irons and one hand held hair dryer plugged into a power strip in the Beauty Shop. b. Room 115 had a lamp and oxygen concentrator plugged into the same power strip. Based on interview at the time of observation, the Maintenance Director acknowledged the use of the power strip in the Beauty Shop and room 115. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible allegation of compliance **K920** Electrical Equipment – Power Cords and Extension Cords **I. Action taken for those residents identified:** No individual resident was identified. The facility removed the power strip in the Beauty Shop. Maintenance Supervisor unplugged the personal devices in Room 115 and plugged them into a separate outlet from the medical equipment. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility performed an audit of resident sleeping rooms to identify any issues. Education was provided to staff about the use of power strips and outlets in a health care facility. IV. **How the facility will**	

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(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
			monitor and quality assurance program: The Administrator/Designee will be responsible for auditing resident rooms/public areas for electrical equipment cords weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	
K 0923 SS=D 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			

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	155191	A. BUILDING 01 B. WING	11/07/2022

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	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 cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 6 smoke compartments. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section	K 0923	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. Please accept this plan of correction as our credible	12/08/2022

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	11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff in the 200 Unit Clean Utility room. Findings include: Based on observations on 11/07/22 between 1:50 p.m. and 4:30 p.m. during a tour of the facility with the Administrator and Maintenance Director, there was one small E size oxygen cylinder on the counter in the 200 Unit Clean Utility room freestanding and was not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Maintenance Director acknowledged the small E size oxygen cylinder freestanding on the counter in the 200 Unit Clean Utility room not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		allegation of compliance **K923** Gas Equipment – Cylinder and Container Storage **I. Action taken for those residents identified:** No individual resident was identified. The facility immediately removed small O2 cylinder from the 200 Hall clean utility room and placed it in the appropriate O2 storage room. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility educated staff on how O2 storage and proper procedure. IV. **How the facility will monitor and quality assurance program**: The Administrator/Designee will be responsible for O2 auditing rounds weekly for four weeks, then bi-weekly for four weeks. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive	

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			months of finding no issues with the stand down meeting audits. V. Date Complete: 12/8/22	