STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155823	A. BUILDING -- B. WING	12/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHPOINTE HEALTHCARE CENTER	4904 WAR ADMIRAL DRIVE INDIANAPOLIS, IN 46237

(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: 12/26/24 Facility Number: 013126 Provider Number: 155823 AIM Number: 300029591 At this Emergency Preparedness survey, Southpointe Healthcare Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 86. Quality Review completed on 12/30/24	E 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the allegation of noncompliance cited during a recertification survey on December 26,2024. Please accept this plan of correction as the provider's credible allegation of compliance.	
K 0000 Bldg. 01	A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/26/24 Facility Number: 013126 Provider Number: 155823 AIM Number: 300029591 At this Life Safety Code survey, Southpointe	K 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth on this statement of deficiencies. The plan of correction is prepared and executed solely because it's required by the position of federal and state law. The plan of correction is submitted in order to respond to the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sara S. Kelley	Executive Director	01/29/2025

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

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	Healthcare Center was found not in compliance with Requirements for Participation Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, in all areas open to the corridors with hard wired smoke detectors in all resident rooms. The facility has a capacity of 100 and had a census of 86 at the time of this visit. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached pipe gas system enclosure that was not sprinklered. Quality Review completed on 12/30/24		allegation of noncompliance cited during a recertification survey on December 26,2024. Please accept this plan of correction as the provider's credible allegation of compliance.	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Based on observation and interview, the facility failed to ensure 1 of 13 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 10 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Maintenance Director during the initial walk through of the facility from 8:35 a.m. to 9:00 a.m. on 12/26/24, over	K 0211	**K211 Means of Egress** – General Aisles, passageways, corridors, exit discharges,exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 **Corrective action for the**	02/01/2025

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	four resident room sleeping beds, including a hospice bed, were stored on one side of the long corridor near the corridor door set on the east side of the large Therapy room. Based on observations with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the Administrator in Training (AIT) at 1:40 p.m. and at 3:50 p.m. on 12/26/24, the hospice bed was still stored in the long corridor and projected 36 inches into the eight foot wide corridor. Based on interview at the time of the observations, the Maintenance Director stated the facility was awaiting pickup of the hospice bed which was supposed to be on 12/26/24 but agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. These findings were reviewed with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during the exit conference. 3.1-19(b)		**residents found to have been affected by the deficient practice:** There were no residents affected **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED in-serviced Maintenance Manager to ensure that he/ designee is to walk the building each day to ensure that all means of egress are clear and in compliance **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Director or his designee will audit egresses daily for 6 weeks then weekly for 6 weeks and monthly for 3 months there after.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 2 of over 17 hazardous areas such as trash collection rooms (exceeding 64 gallons) and Laundries (larger than 100 square feet) were separated from other spaces by smoke resistant partitions and doors. Doors shall be self closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the kitchen and the Laundry room.	K 0321	**K 321 Hazardous Areas** – Enclosure CFR(s): NFPA 101 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	02/01/2025

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	Findings include: Based on observations with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the Administrator in Training (AIT) during a tour of the facility from 1:15 p.m. to 3:50 p.m. on 12/26/24, the corridor door nearest the dish cleaning area in the kitchen had a 1/4 inch in diameter hole in the door above the door handle which would not resist the passage of smoke. Over three 32-gallon capacity trash collection carts were stored in the room. In addition, two separate large holes with missing drywall were noted in the wall of the washing room side of the Laundry room above the cleaning basin which would not resist the passage of smoke. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned two hazardous areas were not separated from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during the exit conference. 3.1-19(b)		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 **Corrective action for the residents found to have been affected by the deficient practice:** There were no residents affected. Laundry wall to be repaired no later than January 24, 2025. Hole in kitchen door repaired on December 27,2024. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** Continued rounding at the facility to identify potential hazards in need of repair. ED Inserviced Maintenance Manager about Hazardous areas and the attention that is needed to these areas. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Director or his designee will audit Hazardous Areas daily for 6 weeks then	

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			weekly for 6 weeks and monthly for 3 months thereafter.	
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen range hood exhaust systems was maintained in proper working order. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011 Edition, Section 4.1.3 states the following equipment shall be kept in working condition: (1) Cooking equipment (2) Hoods (3) Ducts (if applicable) (4) Fans (5) Fire-extinguishing equipment (6) Special effluent or energy control equipment Section 4.1.3.1 states maintenance and repairs shall be performed on all components at intervals necessary to maintain good working condition. Section 10.4.1 states upon activation of any fire-extinguishing system for a cooking operation, all sources of fuel and electric power that produce heat to all equipment requiring protection by that system shall automatically shutoff. This deficient practice could affect over two kitchen staff. Findings include: Based on review of the kitchen range hood fire suppression system inspection contractor's "Kitchen Suppression System Inspection" documentation dated 12/03/23 and 06/21/24 with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the	K 0324	**K 324 Cooking Facilities** CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: Continued From page 5 K 324 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3,or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 **Corrective action for the residents found to have been**	02/01/2025

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	Administrator in Training (AIT) during record review from 9:00 a.m. to 1:15 p.m. on 12/26/24, deficiencies were noted with the kitchen range hood fire suppression system. The "Remarks/Comments" section of the 12/03/23 and 06/21/24 inspection reports stated "Garland Hot Plate did not shut off during trip test". The "Inspection Details" section of the 12/03/23 and 06/21/24 inspection reports stated "No" in response to "Automatic Portion of the system operate properly?" Based on interview at the time of record review, the Divisional Facilities Manager stated kitchen range hood fire suppression system repairs on or after 06/21/24 was not available for review. Based on observations with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during a tour of the facility from 1:15 p.m. to 3:50 p.m. on 12/26/24, a Garland Hot Plate was installed under the kitchen range hood and was plugged into an electrical outlet in the wall near the floor under the kitchen range hood. Based on interview at the time of the observations, the cook stated grease laden vapors can be produced by cooking with the hot plate but it depends on the type of food cooked or heated. These findings were reviewed with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during the exit conference. 3.1-19(b)		**affected by the deficient practice:** There were no residents affected. Safecare contacted to resolve. Parts ordered and will be installed week of 2025. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED in-serviced Maintenance Manager of the importance of following up on any items deemed defective from inspection services. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Manager will provide copies to Executive Director or Designee of inspections for audits one time every 6 months when inspections are completed and or at any time that there is an intermittent concern or needs	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review, observation and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25.	K 0353	**K 353 Sprinkler System** -	02/01/2025

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	NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. Section 5.1.2 states valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 13. Section 13.3.2.1 states all valves shall be inspected weekly. Section 13.3.2.1.1 states valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Fire Sprinkler System: In-House Fire Sprinkler Visual Inspection" documentation with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the Administrator in Training (AIT) during record review from 9:00 a.m. to 1:15 p.m. on 12/26/24, monthly wet sprinkler system gauge inspection documentation for the six month period of February 2024 through July 2024 was not available for review. Review of the aforementioned documentation also indicated monthly wet sprinkler system control valve inspection documentation for the six month period of February 2024 through July 2024 was also not available for review. Based on interview at the time of record review, the Maintenance Director		Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 **Corrective action for the residents found to have been affected by the deficient practice:** There were no residents affected. Sprinkler Gauge and main valve PM were added to the Facilities TELS Preventative Maintenance Program to ensure timely inspection and documentation. **Measures/systemic changes put into place to ensure the**	

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	and the Divisional Facilities Manager stated sprinkler system gauge and valve inspection documentation for the aforementioned monthly period was not available for review due to staff turnover for the facility's maintenance position. Based on observations with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during a tour of the facility from 1:15 p.m. to 3:50 p.m. on 12/26/24, the facility has supervised wet sprinkler systems. These findings were reviewed with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during the exit conference. 3.1-19(b)		**deficient practice does not recur:** ED in-serviced Maintenance Manager on the requirement of the monthly documentation of the sprinkler system. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Director/designee will provide copies of documentation to ED monthly for 6 months for the purpose of auditing. ED/ designee will audit documentation monthly for 6 months	
K 0907 SS=E Bldg. 01	NFPA 101 Gas and Vacuum Piped Systems - Maintenance Pr Based on record review, observation and interview; the facility failed to maintain the facility's piped gas systems in accordance with NFPA 99, Health Care Facilities Code, 2012 Edition. This deficient practice could affect over 40 residents should the facility's pipe gas system not be operational. Findings include: Based on review of the piped gas system inspection contractor's "Annual Medical Gas & Vacuum System Evaluation" documentation dated 10/09/23 with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the Administrator in Training (AIT) during record review from 9:00 a.m. to 1:15 p.m. on 12/26/24, annual inspection documentation for the	K 0907	**K 907 Gas and Vacuum Piped Systems** – Maintenance Program CFR(s): NFPA 101 Gas and Vacuum Piped Systems – Maintenance Program Medical gas, vacuum, WAGD, or support gas systems have documented maintenance programs. The program includes an inventory of all source systems, control valves, alarms, manufactured assemblies, and outlets. Inspection and maintenance schedules are established through risk assessment considering manufacturer recommendations. Inspection procedures and testing methods are established through	02/01/2025

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	facility's piped gas systems within the most recent twelve month period was not available for review. In addition, the "Station Outlets/Inlets" section of the 10/09/23 annual inspection documentation stated the oxygen station outlet in resident sleeping Room 312 was listed as failing annual testing due to "outlet leaks with adapter inserted". Based on interview at the time of record review, the Divisional Facilities Manager stated contractor inspections of the facility's piped gas systems is supposed to be done annually, repair documentation of the station outlet in resident sleeping Room 312 on or after 10/09/23 was not available for review and agreed annual inspection documentation for the facility's piped gas systems within the most recent twelve month period was not available for review. Based on observations with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during a tour of the facility from 1:15 p.m. to 3:50 p.m. on 12/26/24, the facility's piped gas systems serve resident sleeping rooms in the 300, 400, 700 and 800 Halls. The station outlet in resident sleeping Room 312 was not observed due to infection control issues for the resident in the room. These findings were reviewed with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during the exit conference. 3.1-19(b)		risk assessment. Persons maintaining systems are qualified as demonstrated by training and certification or credentialing to the requirements of AASE 6030 or 6040. 5.1.14.2.1, 5.1.14.2.2, 5.1.15, 5.2.14, 5.3.13.4.2 NFPA 99) **Corrective action for the residents found to have been affected by the deficient practice:** There were no residents affected. Inspection was conducted and on file at the facility. Noted outlet in room 312 was repaired. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED in-serviced Maintenance Manager on the requirement of the annual documentation. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Director/designee will provide copies of documentation to ED annually to ensure that all testing is complete. All deficiencies noted on the testing will be repaired.	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste 1. Based on record review and interview, the	K 0918	**K 918 Electrical Systems** -	02/07/2025

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	facility failed to ensure 1 of 1 emergency power supply systems was kept in reliable operating mode in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 2010 Edition, Section 8.3.1 states the Emergency Power Supply Systems (EPSS) shall be maintained to ensure that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. This deficiency could affect all residents, staff and visitors. Findings include: Based on review of the emergency generator inspection contractor's semi-annual inspection documentation dated 07/09/24 with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the Administrator in Training (AIT) during record review from 9:00 a.m. to 1:15 p.m. on 12/26/24, problems were noted with the automatic transfer switch (ATS) for the facility's emergency generator. The "Work Description" section of the 07/09/24 inspection documentation stated, "notice the ATS keyboard was not functional so putting in a quote for that. Other than that unit ran fine. UNIT IN AUTO AND MAIN CIRCUIT BREAKER CLOSED". Based on interview at the time of record review, the Divisional Facilities Manager provided "Purchase Order" documentation dated 10/30/24 for an emergency generator contractor to "replace automatic transfer switch generator". The Divisional Facilities Manager also provided e-mail documentation from the contractor dated 12/23/24 at 5:06 p.m. which stated "we have had trouble acquiring all of the correct electrical drawing needed for the rewire of the transfer switch. Currently what the manufacturer is providing is		Essential Electric Syste CFR(s): NFPA 101 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,	

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	only half of the information that we need for a successful retrofit. It was found that the wiring did not match up with the wire diagrams. We have to complete drawings as this repair is to be done with the transfer switch live. As a backup I ordered the OEM controller last week and they have a rush on it. If the wire diagrams can't be resolved, we will just install the OEM controller". Based on interview at the time of record review, the Divisional Facilities Manager stated sometime after 07/09/24 during contractor repairs, the facility lost the ability for the ATS to provide automatic transfer of building power from the normal source to the generator should the building lose normal source power. The Divisional Facilities Manager stated the facility does have the ability to perform the manual transfer of power to the generator and provided facility "In Service" documentation dated 11/01/24 for staffing on all three shifts on how to conduct the manual transfer of building power to the emergency generator. In addition, the Divisional Facilities Manager provided a letter from the emergency generator contractor dated 12/23/24 stating "this letter is to confirm...has ordered the necessary repair parts for the Automatic Transfer Switch at your facility. The repairs will be completed once the parts have arrived". These findings were reviewed with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the emergency generator was		readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) 1 **Corrective action for the residents found to have been affected by the deficient practice:** There were no residents affected. Weekly generator and monthly generator load PM were added to the Facilities TELS Preventative Maintenance Program to insure timely inspection and documentation. Facility sourced replacement transfer switch and had installation completed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED in serviced Maintenance Manager on the regulation requiring EPSS to be maintained and that the Transfer Switch is to be deemed operable during each monthly inspection. **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Director/designee will provide copies of documentation to ED monthly for 6 months for the purpose of	

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	155823	A. BUILDING 01 B. WING	12/26/2024

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	maintained for 25 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Generators: Weekly Generator Exercise and Inspection (no load)" documentation with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the Administrator in Training (AIT) during record review from 9:00 a.m. to 1:15 p.m. on 12/26/24, weekly generator inspection documentation for the 25 week period of 03/12/24 through 08/27/24 was not available for review. Based on interview at the time of record review, the Maintenance Director and the Divisional Facilities Manager stated weekly generator inspection documentation was not available for this 25 week period due to staff turnover for the facility's maintenance position. These findings were reviewed with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the AIT during the exit conference. 3.1-19(b)		auditing. ED/ designee will audit documentation monthly for 6 months. 2 **Corrective action for the residents found to have been affected by the deficient practice:** There were no residents affected. Weekly generator and monthly generator load PM were added to the Facilities TELS Preventative Maintenance Program to insure timely inspection and documentation.Facility sourced replacement transfer switch and had installation completed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED in serviced Maintenance Manager on the regulation requiring load bearing tests of Essential Electric Systems weekly **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Director/designee will provide copies of documentation to ED weekly for the period of 12 weeks and then monthly for the period of 3 months. 3. **Corrective action for the residents found to have been**	

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	3. Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 10 months of the most recent 12 month period. 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. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. 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. Findings include: Based on review of Direct Supply TELS Logbook Documentation "Emergency Power Generator: Monthly Generator Exercise and Inspection (under load)" documentation with the Executive Director, the Maintenance Director, the Divisional Facilities Manager and the Administrator in Training (AIT) during record review from 9:00 a.m. to 1:15 p.m. on 12/26/24, monthly load testing documentation after 01/31/24 was not available for review. Based on interview at the time of record review, the Maintenance Director and the Divisional Facilities Manager stated monthly generator load testing documentation was not available for this 10 month period due to staff turnover for the facility's maintenance position and recent automatic transfer switch issues on or after 07/09/24. These findings were reviewed with the Executive Director, the Maintenance Director, the Divisional		**affected by the deficient practice:** There were no residents affected. Weekly generator and monthly generator load PM were added to the Facilities TELS Preventative Maintenance Program to insure timely inspection and documentation. Facility sourced replacement transfer switch and had installation completed. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** ED in serviced Maintenance Manager on the regulation requiring load bearing tests of Essential Electric Systems weekly **Corrective actions to be monitored to ensure the deficient practice will not recur:** Maintenance Director/designee will provide copies of documentation to ED monthly for a period of 6 months	

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	Facilities Manager and the AIT during the exit conference. 3.1-19(b)			