STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155061	A. BUILDING -- B. WING	01/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

(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: 01/30/23 Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510 At this Emergency Preparedness survey, Envive of Lawrenceburg was found not 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 32. Quality Review completed on 02/06/23 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
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).			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	*[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 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.			

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	(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. *[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			

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	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 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			

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	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 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			

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	preparedness training at least every 2 years. Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a 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 roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all occupants. Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Director of Maintenance during record review from 1:35 p.m. to 3:30 p.m. on 01/30/23, documentation for staff training on emergency preparedness within the most recent twelve month period was not available for review. Based on interview at the time of record review, the Director of Maintenance agreed staff training documentation on the emergency preparedness program conducted within the most recent twelve month period was not available for review at the time of the survey. These findings were reviewed with the Executive Director, the Director of Maintenance and the Housekeeping Manager during the exit conference.	E 0037	**E037** EP Training Program **Immediate Intervention** All staff will be provided Emergency Preparedness training. **Compliance Date** 3-10-23 This deficient practice could affect all resident, staff and visitors in the facility. The Director of Maintenance will ensure all newly hired employees receive Emergency Preparedness (EP) training upon hire. All current staff will receive EP training yearly. The Director of Maintenance will audit EP training monthly x6 months and ongoing to ensure all staff are educated in Emergency Preparedness. Results of these audits will be presented by the Executive Director to the QAPI committee for further recommendations.	03/10/2023
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:			

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	(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 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			

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	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_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.			

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	(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 CFR 483.73(e)(2). This deficient practice could affect all residents, staff and visitors. Findings include: a. Based on review of "Monthly Load Test" documentation with the Director of Maintenance during record review from 1:35 p.m. to 3:30 p.m. on 01/30/23, weekly emergency generator inspection documentation for 40 weeks of the most recent twelve month period was not available for review. The "Monthly Load Test" documentation indicated the facility's emergency generator was inspected and tested once per month for the twelve month period of January 2022 through December 2022. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator, the facility only performs monthly load	E 0041	**E041** Hospital CAH and LTC Emergency power A. **Immediate Intervention** The Director of Maintenance has started weekly generator testing and documentation. B. **Immediate Intervention** The Director of Maintenance has called vendor to preform a fuel test. C. **Immediate Intervention** The Director of Maintenance has called vendor to preform a four hour run test. **Compliance Date** 2-18-23 The Director of Maintenance has been educated by the Executive Director on E041 Generators are required to be ran and	02/18/2023

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	testing and inspections on the generator and agreed weekly inspection documentation for 40 weeks of the most recent twelve month period was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the diesel fuel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 100 kW and was manufactured in November 2011. b. Based on record review with the Director of Maintenance from 1:35 p.m. to 3:30 p.m. on 01/30/23, documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed documentation of an annual fuel quality for the diesel fuel fired emergency generator was not available for review at the time of the survey. c. Based on record review with the Director of Maintenance from 1:35 p.m. to 3:30 p.m. on 01/30/23, thirty-six month period emergency generator testing documentation for four continuous hours for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed documentation of supplemental load testing for four hours within the most recent three year period was not available for review at the time of the survey. These findings were reviewed with the Executive Director, the Director of Maintenance and the Housekeeping Manager during the exit		documented weekly, ran under load monthly, and 4 hour run ever three years. Fuel testing is required annually. The Director of Maintenance will perform monthly review X6 months. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all resident, staff and visitors in the facility.	

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	conference.			
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: 01/30/23 Facility Number: 000022 Provider Number: 155061 AIM Number: 100274510 At this Life Safety Code survey, Envive of Lawrenceburg was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility with a basement was determined to be of Type II(222) construction and was fully sprinklered except. The facility has a fire alarm system with smoke detection on all levels including the basement, in the corridor, in all areas open to the corridor and in all resident sleeping rooms. Resident sleeping Rooms 302, 303, 304 and 305 on the third floor were being used as vent unit bedrooms with a total of eight vent unit bed locations. The facility has a capacity of 100 and had a census of 32 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing storage services were sprinklered.	K 0000		

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	Quality Review completed on 02/06/23			
K 0161 SS=E Bldg. 01	NFPA 101 Building Construction Type and Height Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including			

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	basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. Based on observation and interview, the facility failed to maintain the building construction type was a permitted type as listed in Table 19.1.6.1. Table 19.1.6.1 requires a sprinklered building, three stories in height, to be Type II (111), Type II (222), Type I (332) or Type I (442) construction. This deficient practice could affect over 10 residents, staff, and visitors in the basement. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, this three story sprinklered building was constructed of concrete block and was determined to be Type II (222) construction. The interior load bearing walls of the closet of the Activities storage in the basement was also concrete block. Wood framing was used to wall off a former door location in the Activities storage closet into the back wall of the salon. This results in a construction type classification of Type V (000) which is not allowed for a three story, existing sprinklered building. Based on interview at the time of the observations, the Maintenance Director stated he believed a door had been in between the back wall of the Activities storage room and the Salon which had since been removed and wood was used to wall off the former door location. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference.	K 0161	**K161** **Immediate Intervention** The Director of Maintenance has contacted vendor to repair. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K161 maintaining appropriate building construction type. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all occupants in the facility	03/10/2023

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	3.1-19(b)			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 2 of 9 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Housekeeping Supervisor Director during the initial walk through of the facility from 9:40 a.m. to 10:05 a.m. on 01/30/23, three resident sleeping room beds were placed end to end and stored in the corridor on the first floor by the elevator by the smoke barrier door set by the first floor nurse's station. The width of each bed blocked more than half of the width of the corridor. Based on observations with the Housekeeping Manager and the Director of Maintenance at 11:57 a.m. and at 3:35 p.m. on 01/30/23, the three beds were still stored in the corridor outside the first floor elevator. In addition, based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from	K 0211	**K 211** Means of Egress NFPA 101 **Immediate Intervention** The Director of Maintenance has removed the beds and carts in the halls to allow egress. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K211 maintaining a clear path of egress. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 20 resident, staff and visitors if needing to exit the facility.	03/10/2023

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	155061	A. BUILDING 01 B. WING	01/30/2023

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	10:40 a.m. to 1:35 p.m. on 01/30/23, four separate 96-gallon capacity recycling carts were stored next to one another in the basement corridor near the Main Utility closet. The carts blocked more than half the width of the corridor. Based on interview at the time of the observations, the Housekeeping Manager and the Director of Maintenance agreed the aforementioned means of egress were 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 Director of Maintenance and the Housekeeping Manager during the exit conference. 3.1-19(b)			
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			

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	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 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			

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	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 the means of egress through 2 of 12 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC Section 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations with the Housekeeping Supervisor Director and the Executive Director during the initial walk through of the facility from 9:40 a.m. to 10:05 a.m. on 01/30/23, the stairwell exit door on the third floor by Room 311 was marked as a facility exit with an exit sign and could be opened by entering a code into a keypad at the door. However, the code was not posted at the exit door. Based on interview at the time of the observations, the Executive Director stated two residents on the third floor were an elopement risk, not all third-floor residents have a clinical diagnosis to be in a secure wing and agreed the code to release the stairwell exit door to open by Room 311 was not posted at the keypad. Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the code was still not posted at the stairwell exit door by Room 311. In addition, the stairwell exit	K 0222	**K 222** Egress Doors NFPA 101 **Immediate Intervention** The Maintenance Director has placed the correct code for the keypads for the stairwell doors next to rooms 306 and room 311 in plain view to allow egress. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K222 maintaining the posting of the codes for egress. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 20 resident, staff and visitors if needing to exit the facility.	03/10/2023

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	door on the third floor by Room 306 was also marked as a facility exit with an exit sign and could be opened by entering a code into a keypad at the door. However, the correct code was not posted at the exit door. Based on interview at the time of the observations, the Housekeeping Manager stated an incorrect code was posted at the keypad by the stairwell exit door by Room 306 and posted the correct code which then was used to release the stairwell door to open. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 2 battery powered emergency lighting systems was maintained in accordance with LSC Section 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70, National Electric Code. This deficient practice could affect over 5 residents, staff, and visitors in the vicinity of the Therapy room on the 1st floor at the south end of the building.	K 0291	**K291** Emergency lighting NFPA 101 **Immediate Intervention** The Director of Maintenance has repaired the emergency light. The Director of Maintenance will perform monthly review X6. **Compliance Date** 3-10-23 The Director of Maintenance was educated by the Executive Director on K291 Test and maintaining emergency lighting. The Director of Maintenance will audit and log monthly X6.	03/10/2023

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	Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the battery-operated lighting system affixed to the ceiling mounted exit sign above the first-floor exit door to the outside of the facility at the south end of the facility in the lobby outside the Therapy Room failed to illuminate when its respective test button was pushed multiple times. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned battery powered emergency lighting system failed to illuminate when its respective test button was pushed multiple times. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)		Results of this audit will be presented by Executive Director to the QAPI committee for further recommendations. This deficient practice could over 5 residents, staff and visitors within the facility.	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility	K 0311	**K311**	03/10/2023

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	failed to maintain protection of 1 of 2 interior stairwells. LSC 19.3.1 requires vertical openings shall be enclosed or protected in accordance with Section 8.6. LSC 8.6.1 requires every floor that separates stories in a building shall be constructed as a smoke barrier. LSC 8.6.5 states see 7.1.3.2.1 for enclosures of exits. LSC 7.1.3.2.1 states the separation shall have a minimum 1-hr fire resistance rating where the exit connects three stories or less. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, three white data cables penetrated a one inch in diameter hole which was noted in the north wall of the second-floor landing in the stairwell by Room 205. Red fire caulk had been used to fill the hole, but the caulk had dried out and fell out of hole. Based on interview at the time of the observations, the Housekeeping Manager agreed the fire caulk fell out of the hole in the north wall of the second-floor stairwell landing which did not maintain the fire resistance rating of the stairwell vertical opening. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)		Vertical openings NFPA 101 **Immediate Intervention** The Maintenance Director has added fire caulk to the penetrations in stairwell walls next to room 205 **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K311 All fire wall penetrations must be sealed with approved fire caulk. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 20 resident, staff and visitors in the facility.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire			

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	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) Based on observation and interview, the facility failed to ensure 3 of over 10 hazardous areas such as combustible storage areas (over 50 square feet in size), boiler and fuel fired heater rooms 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	K 0321	**K321** Hazardous Areas - Enclosure NFPA 101 **Immediate Intervention** The Director of Maintenance has removed all obstacles preventing these doors from shutting and latching properly. **Compliance Date**	03/10/2023

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	residents, staff, and visitors in the basement. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the following was noted in the basement: a. the corridor door to the Laundry/Housekeeping Office in the basement was propped in the fully open position with a wedge placed on the floor under the door. The Laundry/Housekeeping Office was greater than 100 square feet in size. b. the corridor door to the Nurse's Supply room in the basement was propped in the fully open position with two hand sanitizer bottles placed on the floor up against the door. The Nurse's Supply room was greater than 50 square feet in size. c. the corridor door to the water heater room in basement was equipped with a self-closing device but the door failed to self-close and latch into the door frame when tested to close multiple times. The water heater room contained two natural gas fired water heaters. Based on interview at the time of the observations, the Director of Maintenance stated residents have customary access to the Activities Room in the basement and agreed the corridor doors did not separate the aforementioned hazardous areas from other spaces by smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Maintenance Director, and the Field Maintenance Supervisor during the exit conference. 3.1-19(b)		3-10-23 The Director of Maintenance and Laundry staff has been educated by the Executive Director on K321 Doors in hazardous areas can not be propped open preventing them form shutting and latching. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 10 resident, staff and visitors in the basement.	

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K 0341 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code, 2010 Edition. Section 10.5.5.2.1 states, the location of the dedicated branch circuit disconnecting means shall be permanently identified at the control unit. Section 10.5.5.2.2 states, for fire alarm systems the circuit disconnecting means shall be identified as "FIRE ALARM CIRCUIT." Section 10.5.5.2.3 states for fire alarm systems the circuit disconnecting means shall have a red marking. Section 10.5.5.2.4 states the circuit disconnecting means shall be accessible only to authorized personnel. Section 10.5.5.3 states the dedicated branch circuit(s) and connections shall be protected against physical damage. This deficient practice could affect all occupants. Findings include: Based on observations with the Housekeeping	K 0341	**K341** Fire Alarm System -Installation NFPA 101 **Immediate Intervention** The Director of Maintenance has locked the Electrical panel room **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K341 Doors to rooms containing electrical panels must be kept locked. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all occupants in the facility	03/10/2023

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	Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the fire alarm system circuit breaker located in the electrical panel identified as "Isolated Panel for Emergency Generator" located in the basement "Electric Shutoff" room was not locked. Based on interview at the time of the observations, the Director of Maintenance agreed the fire alarm system circuit breaker disconnecting means was not accessible only to authorized personnel. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0346 SS=F 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 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 residents, staff, and visitors.	K 0346	**K346** Fire Alarm Out of Service NFPA 101 **Immediate Intervention** The Director of Maintenance has updated the fire watch policy to meet all requirements. **Compliance Date** 3-10-23	03/10/2023

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	Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Director of Maintenance during record review from 1:35 p.m. to 3:30 p.m. on 01/30/23, a complete written fire watch policy for fire alarm system impairment was not available for review. Based on interview at the time of record review, the Director of Maintenance provided "Fire Watch Training Review" documentation which failed to state the 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. The training documentation did not expressly state when a fire watch for fire alarm system would be initiated. The plan did not state when the required fire alarm system is out-of-service 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. The plan also failed to contact the Indiana State Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview at the time of record review, the Director of Maintenance agreed the fire watch documentation for fire alarm system impairment was incomplete. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference.		The Director of Maintenance has been educated by the Executive Director on K346 on maintaining a complete and compliant fire watch policy in the EOP. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility.	

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K 0353 SS=F Bldg. 01	3.1-19(b) NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25. 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 13.1.1.2 states Table 13.1.1.2 shall be utilized for inspection, testing and maintenance of valves, valve components and trim. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the	K 0353	**K353** Sprinkler System- Maintenance and Testing NFPA 101 #1 **Immediate Intervention** The Director of Maintenance has started documenting gauge pressures monthly **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K353 inspecting and documenting gauge pressure of the suppression system monthly. The Director of Maintenance will perform monthly review X6.	03/10/2023

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	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. Findings include: Based on record review with the Director of Maintenance from 1:35 p.m. to 3:30 p.m. on 01/30/23, monthly sprinkler system gauge and valve inspection documentation for the most recent twelve-month period was not available for review. Based on interview at the time of record review, the Director of Maintenance agreed monthly sprinkler system gauge and valve inspection documentation for the most recent twelve-month period was not available for review. Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the sprinkler system inspection contractor had affixed a hanging tag to the facility's supervised wet sprinkler system riser in the basement sprinkler riser room documenting monthly sprinkler system gauge and valve inspections were conducted for four months of the most recent twelve month period on 04/18/22, 07/20/22, 10/24/22 and 01/29/23. Based on interview at the time of the observations, the Director of Maintenance agreed additional monthly sprinkler system gauge and valve inspection documentation for the most recent twelve-month period was not available for review. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)		Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility #2 **Immediate Intervention** The Director of Maintenance has removed the curtain from room 202 **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K353 clearance and obstruction of suppression coverage. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 15 residents, staff and visitors in vicinity to room 202 on second floor. #3 **Immediate Intervention** The Director of Maintenance has replaced missing ceiling tiles. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K353 clearance and obstruction of suppression coverage. The Director of Maintenance will	

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	2. Based on observation and interview, the facility failed to ensure clearance of at least 18 inches was maintained below the level of the sprinkler deflectors in 1 of over 30 resident sleeping rooms. NFPA 25, 2011 Edition, Section 5.2.1.2 states the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. Further NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 edition, Section 8.6.5.2.2 states the distance from sprinklers to privacy curtains in light hazard occupancies shall be in accordance with Table 8.6.5.2.2 and Figure 8.6.5.2.2. Table 8.6.5.2.2 states suspended horizontal obstructions more than thirty inches in length shall maintain a minimum vertical distance below the sprinkler deflector of 18 inches. Section 8.6.5.2.2.1 states, in light hazard occupancies, privacy curtains shall not be considered obstructions where all of the following are met: (1) The curtains are supported by fabric mesh on ceiling track. (2) Openings in the mesh are equal to 70 percent or greater. (3) The mesh extends a minimum of 22 inches down from the ceiling. In addition, Section 8.6.6.1 states the clearance between the deflector and the top of storage shall be 18 inches or greater. This deficient practice could affect over 15 residents, staff and visitors in the vicinity or Room 202 on the second floor. Finding includes: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, two of two privacy curtains in Room 202 were hung from ceiling mounted tracks in the		perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 10 residents, staff and visitors in vicinity of the Activities Room in the basement.	

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	room. The two curtains had no mesh openings in the top of the curtains which were hung 15 inches below the ceiling. The measurements were taken with a measuring tape provided by the Housekeeping Manager. Based on interview at the time of the observations, the Housekeeping Manager agreed the privacy curtains in the aforementioned resident sleeping room location provided sprinkler spray pattern obstruction less than 18 inches from the ceiling. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 basements. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the Activities Room in the basement. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, suspended ceiling tiles were missing at numerous locations in the basement including the			

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	Activities Storage closet, the Main Utility closet by the Activities Room, the restroom by the Main Utility closet, in the corridor outside the Electric Panel Room and in the corridor above the recycling bin storage area. Based on interview at the time of the observations, the Director of Maintenance stated residents have customary access to the Activities Room in the basement, the missing ceiling tile locations were due to repair of recent water leaks above the ceiling tile locations and agreed the missing ceiling tile locations would delay sprinkler activation of the ceiling mounted sprinkler locations in the basement. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is 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)			

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	Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed for the protection of all 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 9.7.5 requires sprinkler impairment procedures comply with NFPA 25. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 15.5.2 requires nine procedures that the impairment coordinator shall follow. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on review of "Emergency Operations Plan" documentation dated 01/13/23 with the Director of Maintenance during record review from 1:35 p.m. to 3:30 p.m. on 01/30/23, a complete fire watch policy for sprinkler system impairment was not available for review. Based on interview at the time of record review, the Director of Maintenance provided "Fire Watch Training Review" documentation which failed to state the procedures to be followed in the event the sprinkler system has to be placed out-of-service for ten hours or more in a twenty-four-hour period. The training documentation did not expressly state when a fire watch would be initiated. The plan did not state when the required automatic sprinkler system is out-of-service for 10 hours or more 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 sprinkler system has been returned to service. The plan	K 0354	**K354** Sprinkler System - Out of Service NFPA 101 **Immediate Intervention** The Director of Maintenance updated the Fire watch policy with Sprinkler outage to meet all requirements. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K354 on maintaining a complete and compliant fire watch policy in the EOP. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility #2 **Immediate Intervention** The Director of Maintenance has contacted vendor to replace the sprinkler head above the kitchen dish rinsing area. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K354 on maintaining corrosion free sprinkler heads. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive	03/10/2023

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	also failed to contact IDOH, which is an authority having jurisdiction, and failed to include contacting the Indiana Department of Health via the IDOH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the IDOH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. The fire watch policy for automatic sprinkler system impairment also failed to contact the alarm monitoring company, the building owner, and the insurance company if the required automatic sprinkler system is out-of-service for 10 hours or more in a 24-hour period. Based on interview at the time of record review, the Director of Maintenance agreed the fire watch plan for sprinkler system impairment was incomplete. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b) 4. Based on observation, and interview, the facility failed to ensure 1 of 1 sprinkler heads in the kitchen dish rinsing area were replaced in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.1.1.1 states 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		Director to the QAPI committee for further recommendations. This deficient practice could affect over 2 staff members in the vicinity of the dish area.	

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	(3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. In lieu of replacing sprinklers that are loaded with dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. This deficient practice could affect over two staff in the vicinity of the kitchen dish rinsing area. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the upright pendant sprinkler installed in horizontal sprinkler piping above the kitchen dish rinsing area in the basement was green with corrosion. Based on interview at the time of the observations, the Director of Maintenance agreed the aforementioned automatic sprinkler location was corroded. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke			

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	compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7			
	Based on observation and interview, the facility failed to ensure corridor walls in 1 of 8 smoke compartments in the facility were constructed to resist the transfer of smoke. This deficient practice could affect over 15 residents, staff, and visitors in the vicinity of Room 307 on the third floor. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, a one inch in diameter hole was noted in the corridor wall above the corridor door to the Social Services room on the third floor identified as Room 307 for the passage of one white data cable. The hole was not firestopped and would not resist the passage of smoke. Based on interview at the time of the observations, the Housekeeping Manager agreed the opening in the corridor wall would not resist the passage of	K 0362	**K362** Corridors - Construction of Walls NFPA 101 **Immediate Intervention** The Director of Maintenance has added approved fire caulk to seal the peneration. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K362 All fire wall penetrations must be sealed with approved fire caulk. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 15 residents, staff and visitors	03/10/2023

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	smoke. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)		in the vicinity of room 307 on the 3rd floor.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors 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,			

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	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 devices, etc. Based on observation and interview, the facility failed to ensure 3 of over 10 corridor doors in the basement had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect over 10 residents, staff, and visitors in the basement. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the following was noted in the basement: a. the corridor door to the Main Shutoff Room was equipped with a door handle and a latching mechanism but the door kept hitting the door frame on the handle side of the door when tested to close and could not be closed and latched into the door frame when tested to close multiple times. b. the corridor door to the Laundry/Housekeeping Office in the basement was propped in the fully open position with a wedge placed on the floor under the door. c. the corridor door to the Nurse's Supply room in the basement was propped in the fully open position with two hand sanitizer bottles placed on	K 0363	**K363** Corridors - Doors NFPA 101 **Immediate Intervention** The Director of Maintenance has repaired all three doors. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K363 fire doors must shut and latch to prevent smoke and fire from spreading. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 10 residents, staff and visitors in the basement.	03/10/2023

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	the floor up against the door. Based on interview at the time of the observations, the Director of Maintenance stated residents have customary access to the Activities Room in the basement and agreed the aforementioned corridor doors each had an impediment to closing and latching into the door frame and would not resist the passage of smoke. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure openings through 1 of 4 ceiling smoke barriers was protected to maintain the fire resistance rating of the smoke barrier. LSC 19.3.7.3 refers to Section 8.5. Section 8.5.6.2 states penetrations for cables, conduits, pipes, and similar items that pass through a floor/ceiling	K 0372	**K372** Subdivision of Building Spaces - Smoke Barrier NFPA 101 **Immediate Intervention** The Director of Maintenance has added approved fire caulk to the ceiling penetrations	03/10/2023

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	assembly constructed as a smoke barrier, or through the ceiling membrane of a ceiling smoke barrier shall be protected by a system or material capable of resisting the transfer of smoke. Where a smoke barrier is also constructed as a fire barrier, the penetrations shall be protected in accordance with the requirements of Section 8.3.5 to limit the spread of fire for a time period equal to the fire resistance of the assembly and Section 8.5.6. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the Main Shutoff Room in the basement. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, four of four newly installed electrical conduits which penetrated the ceiling of the Main Shutoff Room in the basement were not firestopped to maintain the fire resistance rating of the basement ceiling smoke barrier. Based on interview at the time of the observations, the Director of Maintenance agreed the electrical conduit penetrations in the ceiling did not ensure the ceiling smoke barrier was protected to maintain the fire resistance rating of the smoke barrier. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)		**Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K372 All fire wall penetrations must be sealed with approved fire caulk to prevent smoke and fire from spreading. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 10 residents, staff and visitors in vicinity of the main shutoff room..	
K 0374 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie			

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	155061	A. BUILDING 01 B. WING	01/30/2023

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	Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to ensure doors in 3 of 3 smoke barrier walls would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the east door in each of the smoke barrier door sets on the first, second and third floors by the nurse's station would not fully self-close when tested to self-close multiple times. Each door in the door set was equipped with magnetic door holding devices set to release the door sets to close with fire alarm system activation but the east door in each door set	K 0374	**K374** Subdivision of Building Spaces - Smoke Barrier NFPA 101 **Immediate Intervention** The Director of Maintenance has repaired these three doors. **Compliance Date** 2-18-23 The Director of Maintenance has been educated by the Executive Director on K374 All fire and smoke doors must close fully to prevent smoke and fire from spreading. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility.	02/18/2023

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	dragged along the floor and became stuck in the nearly fully open position when tested to close multiple times. Based on interview at the time of the observations, the Housekeeping Manager and the Director of Maintenance agreed the east door in each of the three separate smoke barrier door sets would not fully self-close to ensure the door sets would restrict the movement of smoke. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0511 SS=F 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 1. Based on observation and interview, the facility failed to ensure 7 of over 7 electrical panels in the corridor were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62 Energized parts of service equipment shall be enclosed as specified in 230.62(A) or guarded as specified in 230.62(B). (A) Enclosed. Energized parts shall be enclosed so that they will not be exposed to accidental contact or shall be guarded as in 230.62(B). (B) Guarded. Energized parts that are not enclosed shall be installed on a switchboard, panelboard, or control board and guarded in accordance with 110.18 and 110.27. Where energized parts are	K 0511	**K511** Utilities - Gas and Electric NFPA 101 #1 **Immediate Intervention** The Director of Maintenance has locked all electrical panels. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K511 all electrical panels must be locked to prevent unauthorized access.	03/10/2023

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	guarded as provided in 110.27(A)(1) and (A)(2), a means for locking or sealing doors providing access to energized parts shall be provided. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the wall mounted electrical panels in the corridor outside Room 102, Room 202, Room 214, Room 302, Room 314 and in the basement corridor outside the kitchen and outside the basement water heater room were each not locked. Based on interview at the time of the observations, the Housekeeping Manager and the Maintenance Director agreed the aforementioned wall mounted electrical panels in the corridor were each not secured from non-authorized personnel. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 outlet boxes installed on the corridor wall outside Room 205 was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect over 1 staff on the second floor outside Room 205. Findings include:		The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility. #2 **Immediate Intervention** The Director of Maintenance has replaced the broken faceplate. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K511 all electrical wires must be covered to prevent accidental access. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 1 staff member on the second floor.	

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	Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the faceplate for the wall mounted outlet box for the two electrical receptacles outside Room 205 was cracked. Based on interview at the time of the observations, the Housekeeping Manager agreed the aforementioned faceplate location was cracked. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0531 SS=E Bldg. 01	NFPA 101 Elevators Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke			

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	detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 Based on record review, observation, and interview; the facility failed to document testing of elevator firefighter's service recall in accordance with 9.4.6, Elevator Testing. LSC 9.4.6.2 states that all elevators with fire fighters' emergency operations in accordance with 9.4.3 shall be subject to a monthly operation with a written record of the findings made and kept on the premises as required by ASME A17.1/CSA B44, Safety Code for Elevators and Escalators. This deficient practice could affect over five residents, staff, and visitors. Findings include: Based on record review with the Director of Maintenance from 1:35 p.m. to 3:30 p.m. on 01/30/23, documentation of monthly firefighter's service recall testing for the most recent twelve-month period was not available for review. Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, documentation affixed to the elevator shaft door frame in the basement indicated the elevator had "elevator recall". The elevator inspection contractor did not have documentation of monthly firefighter's service recall testing for the most recent twelve-month period on inspection documentation stored in the elevator machine room in the basement. Based on interview at the time of the exit conference, the Director of Maintenance stated the facility does not perform elevator recall testing and the inspection contractor does not perform monthly firefighter's service recall testing.	K 0531	**K531** Elevators NFPA 101 **Immediate Intervention** The Director of Maintenance has started monthly firefighter's service recall testing. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K531 If equipped with a recall feature elevators must test and document this function monthly. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 5 residents, staff and visitors in the facility.	03/10/2023

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	This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
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 document quarterly fire drills or staff training documentation on fire drill procedures on the first and second shifts for 2 of 4 quarters. This deficient practice affects all residents, staff, and visitors. Findings include: Based on review of "Fire/Disaster Drill: Fire" documentation with the Director of Maintenance during record review from 1:35 p.m. to 3:30 p.m. on 01/30/23, documentation of a first and second shift fire drill or staff training documentation on fire drill procedures in the first quarter (January, February, March) 2022 was not available for review. In addition, documentation of a first and second shift fire drill in the fourth quarter	K 0712	**K712** Fire drills NFPA 101 **Immediate Intervention** The Director of Maintenance will perform a fire drill per shift, per quarter moving forward. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K712 fire drills/fire training and transmission of alarm must be completed each shift each quater. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive	03/10/2023

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	(October, November, December) 2022 was also not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility operates two shifts per day and agreed documentation of a fire drill or staff training on fire drill procedures on the first and second shifts in the aforementioned calendar quarters was not available for review. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)		Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility.	
K 0761 SS=F Bldg. 01	Based on record review, observation, and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were 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	K 0761	**K761** Maintenance, Inspection & Testing - Doors NFPA 101 **Immediate Intervention** The Director of Maintenance has completed the annual fire door inspection. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K761 Fire doors are required to be fully inspected at least annually . The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect	03/10/2023

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	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. (6) The self-closing device is operational; that is, the active door completely closes when operated from the fully 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 all residents, staff, and visitors. Findings include: Based on record review with the Director of Maintenance from 1:35 p.m. to 3:30 p.m. on		all residents, staff and visitors in the facility.	

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	01/30/23, fire door inspection documentation for the most recent twelve-month period was not available for review. Based on interview at the time record review, the Director of Maintenance agreed fire door inspection documentation for the most recent twelve-month period was not available for review. Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, all stairwell doors on the first, second, third floor and in the basement were affixed with a 90-minute fire resistance rating label affixed to the hinge side of the door. However, the fire resistance rating label affixed to the hinge side of the stairwell door on the first floor by Room 111 was painted and was not legible. The corridor door leading to the Therapy Room and the lobby on the first floor was equipped with a 3-hour fire resistance rating label on the hinge side of the door. In addition, the corridor door to the oxygen storage and transfilling room in the basement was also equipped with a 90-minute fire resistance rating label affixed to the hinge side of the door. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0911 SS=E Bldg. 01	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or			

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	NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) 1. Based on observation and interview, the facility failed to ensure all circuits on the life safety branch supply power to circuits essential for life safety in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.2.2.3.2 states the life safety branch shall supply power for lighting, receptacles, and equipment as follows: (1) Illumination of means of egress in accordance with NFPA 101, Life Safety Code. (2) Exit signs and exit directional signs in accordance with NFPA 101, Life Safety Code. (3) Hospital communication systems, where used for issuing instruction during emergency conditions. (4) Generator set location as follows: (a) Task illumination (b) Battery charger for emergency battery-powered lighting unit(s) (c) Select receptacles at the generator set location and essential electrical system transfer switch locations (5) Elevator cab lighting, control, communications, and signaling systems. (6) Electrically powered doors used for building egress. (7) Fire alarms and auxiliary functions of fire alarm combination systems complying with NFPA 72, National Fire Alarm and Signaling Code. Section 6.4.2.2.3 states alarm and alerting systems (other than fire alarm systems) shall be connected to the life safety branch or the critical branch. Section 6.4.2.2.3.4 states load dedicated to a specific generator, including the fuel transfer pump(s), ventilation fans, electrically operated louvers, controls, cooling systems, and other generator accessories essential for generator	K 0911	**K911** Electrical Systems - Other NFPA 101 **Immediate Intervention** The Director of Maintenance has contacted SafeCare and work to separate all life safety branch curcuits from non-life safety branch circuits was completed on 1/02/2023. (Documentation attached) SERVICE COMPLETED: ¿ Installation of Supplied Transfer switch and 200 AMP generator ma in breaker ¿ Installation of required life safety outlets at each headboard ¿ Rooms 101A, 101B, 102, 103 (2 Beds each require additional 13 R eceptacles) ¿ Rooms 104,105,106 (3 Beds ea ch require additional 13 Receptacl es) ¿ Rework circuits for Egress lighti ng, Nurse call, Fire Alarms to be o n new life safety panel ¿ Walk through with local AHJ to v erify corrections are as noted on page 57-76 of Life Safety Report. 01/02/2023 Performed final walk-th rough and tested the backup powe r system to verify it is operational. Programmed new Critical branch ATS and verifie d operation. Inspected wiring and connections. Electrical Project co mplete.	03/10/2023

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	operation, shall be connected to the life safety branch or the output terminals of the generator with over-current protective devices. Section 6.4.2.2.3.5 states no functions other than those in 6.4.2.2.3.2, 6.4.2.2.3.3, and 6.4.2.2.3.4 shall be connected to the life safety branch, except as specifically permitted in 6.4.2.2.3. Section 6.4.2.2.6.1 states the life safety branch shall be kept independent of all other wiring and equipment. This deficient practice could affect 8 residents. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, vent unit beds are located on the third floor in Rooms 302, 303, 304 and 305 for a total of 8 vent unit bed locations. It could not be assured all life safety branch circuits were separated from non-life safety branch circuits. The facility has one diesel fired emergency generator rated at 100 kW and the facility has two transfer switches located in the "Electrical Panel Generator Control" room in the basement near the Laundry room. Six electrical panels in the electrical room were connected to the emergency generator and to the normal source. The electrical panel identified as "Isolated Panel for Emergency Generator" had circuits identified as "Call Lights" mixed with the circuits for the fire alarm system, the emergency generator and egress lighting. The electrical panel identified as "Panel W" had "Dryer" and "AC Laundry" circuits mixed with circuits for the emergency generator and the emergency generator block heater. Two electrical panels were for PTAC circuits. The remaining two electrical panels were for newly installed critical branch circuits for newly installed electrical receptacles		**Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K911 . The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility	

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	155061	A. BUILDING 01 B. WING	01/30/2023

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	installed in Room 101A & 101B, 102, 103, 104, 105, 106 and 107. Based on interview at the time of the observations, the Director of Maintenance agreed all life safety branch circuits were not separated from non-life safety branch circuits. Based on interview at the time of the exit conference, the Executive Director stated the facility is in the process of relocating the vent unit bed locations from the third floor to the first floor. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure all circuits on the critical branch supply power to critical branch functions related to patient care in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.2.2.4.2 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states the critical branch shall supply power for task illumination, fixed equipment, select receptacles, and select power circuits serving the following areas and functions related to patient care: (1) Critical care areas that utilize anesthetizing gases, task illumination, select receptacles, and fixed equipment (2) Isolated power systems in special environments (3) Task illumination and select receptacles in the following: (a) Patient care rooms, including infant nurseries, selected acute nursing areas, psychiatric bed areas (omit receptacles), and ward treatment			

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	rooms (b) Medication preparation areas (c) Pharmacy dispensing areas (d) Nurses' stations (unless adequately lighted by corridor luminaries) (4) Additional specialized patient care task illumination and receptacles, where needed (5) Nurse call systems (6) Blood, bone, and tissue banks (7) Telephone equipment rooms and closets (8) Task illumination, select receptacles, and select power circuits for the following areas: (a) General care beds with at least one duplex receptacle per patient bedroom, and task illumination as required by the governing body of the health care facility (b) Angiographic labs (c) Cardiac cathertization labs (d) Coronary care units (e) Hemodialysis rooms or areas (f) Emergency room treatment areas (select) (g) Human physiology labs (h) Intensive care units (i) Postoperative recovery rooms (select) (9) Additional task illumination, receptacles, and select power circuits needed for effective facility operation, including single-phase fractional horsepower motors, which are permitted to be connected to the critical branch. Section 6.4.2.2.6.1 states the critical branch shall be kept independent of all other wiring and equipment. This deficient practice could affect 8 residents. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, vent unit beds are located on the third			

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	floor in Rooms 302, 303, 304 and 305 for a total of 8 vent unit bed locations. It could not be assured all critical branch circuits were separated from non-critical branch circuits. The facility has one diesel fired emergency generator rated at 100 kW and the facility has two transfer switches located in the "Electrical Panel Generator Control" room in the basement near the Laundry room. Six electrical panels in the electrical room were connected to the emergency generator and to the normal source. The electrical panel identified as "Isolated Panel for Emergency Generator" had circuits identified as "Call Lights" mixed with the circuits for the fire alarm system, the emergency generator and egress lighting. The electrical panel identified as "Panel W" had "Dryer" and "AC Laundry" circuits mixed with circuits for the emergency generator and the emergency generator block heater. Two electrical panels were for PTAC circuits. The remaining two electrical panels were for newly installed critical branch circuits for newly installed electrical receptacles installed in Room 101A & 101B, 102, 103, 104, 105, 106 and 107. Based on interview at the time of the observations, the Director of Maintenance agreed all critical branch circuits were not separated from non-critical branch circuits. Based on interview at the time of the exit conference, the Executive Director stated the facility is in the process of relocating the vent unit bed locations from the third floor to the first floor. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility			

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	failed to ensure an equipment branch was connected to equipment in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.2.2.5.1 states the equipment branch shall be connected to equipment described in 6.4.2.2.5.3 through 6.4.2.2.5.4. Section 6.4.2.2.5.2 Connection to Alternate Power Source states: (A) The equipment branch shall be installed and connected to the alternate power source, such that equipment described in 6.4.2.2.5.3 is automatically restored to operation at appropriate time-lag intervals following the energizing of the life safety and critical branches. (B) The arrangement of the connection to the alternate power source shall also provide for the subsequent connection of equipment described in 6.4.2.2.5.4. Section 6.4.2.2.5.3 Equipment for Delayed-Automatic Connection states: (A) The following equipment shall be permitted to be arranged for delayed-automatic connection to the alternate power source: (1) Central suction systems serving medical and surgical functions, including controls, with such suction systems permitted to be placed on the critical branch (2) Sump pumps and other equipment required to operate for the safety of major apparatus, including associated control systems and alarms (3) Compressed air systems serving medical and surgical functions, including controls, with such air systems permitted to be placed on the critical branch (4) Smoke control and stair pressurization systems (5) Kitchen hood supply or exhaust systems, or both, if required to operate during a fire in or under the hood (6) Supply, return, and exhaust ventilating systems for the following: (a) Airborne infectious/isolation rooms			

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	(b) Protective environment rooms (c) Exhaust fans for laboratory hoods (d) Nuclear medicine areas where radioactive material is used (e) Ethylene oxide evacuation (f) Anesthetic evacuation (B) Where delayed-automatic connection is not appropriate, the ventilation systems specified in 6.4.2.2.5.3(A)(6) shall be permitted to be placed on the critical branch. Section 6.4.2.2.5.4 Equipment for Delayed-Automatic or Manual Connection states the following equipment shall be permitted to be arranged for either delayed-automatic or manual connection to the alternate power source (also see A.6.4.2.2.5.3): (1) Heating equipment used to provide heating for operating, delivery, labor, recovery, intensive care, coronary care, nurseries, infection/isolation rooms, emergency treatment spaces, and general patient rooms; and pressure maintenance (jockey or make-up) pump(s) for water-based fire protection systems (2) Heating of general patient rooms during disruption of the normal source shall not be required under any of the following conditions: (a) Outside design temperature is higher than -6.7 C (+20 F) (b) Outside design temperature is lower than -6.7 C (+20 F), where a selected room(s) is provided for the needs of all confined patients [then only such room(s) need be heated] (3) Elevator(s) selected to provide service to patient, surgical, obstetrical, and ground floors during interruption of normal power (4) Supply, return, and exhaust ventilating systems for surgical and obstetrical delivery suites, intensive care, coronary care, nurseries, and emergency treatment spaces (5) Hyperbaric facilities			

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	(6) Hypobaric facilities (7) Autoclaving equipment, which is permitted to be arranged for either automatic or manual connection to the alternate source (8) Controls for equipment listed in 6.4.2.2.4 (9) Other selected equipment This deficient practice could affect 8 residents. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, vent unit beds are located on the third floor in Rooms 302, 303, 304 and 305 for a total of 8 vent unit bed locations. It could not be assured all equipment branch circuits were separated from non-equipment branch circuits. The facility has one diesel fired emergency generator rated at 100 kW and the facility has two transfer switches located in the "Electrical Panel Generator Control" room in the basement near the Laundry room. Six electrical panels in the electrical room were connected to the emergency generator and to the normal source. The electrical panel identified as "Isolated Panel for Emergency Generator" had circuits identified as "Call Lights" mixed with the circuits for the fire alarm system, the emergency generator and egress lighting. The electrical panel identified as "Panel W" had "Dryer" and "AC Laundry" circuits mixed with circuits for the emergency generator and the emergency generator block heater. Two electrical panels were for PTAC circuits. The remaining two electrical panels were for newly installed critical branch circuits for newly installed electrical receptacles installed in Room 101A & 101B, 102, 103, 104, 105, 106 and 107. Based on interview at the time of the observations, the Director of Maintenance agreed all equipment branch circuits were not separated			

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	from non-equipment branch circuits. Based on interview at the time of the exit conference, the Executive Director stated the facility is in the process of relocating the vent unit bed locations from the third floor to the first floor. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b) 4. Based on observation and interview, the facility failed to ensure the minimum number of electrical receptacles were installed at 8 of 8 vent unit bed locations in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.2.6.2 states the number of receptacles shall be determined by the intended use of the patient care rooms in accordance with 6.3.2.2.6.2(A) through 6.3.2.2.6.2(E). 6.3.2.2.6.2(A) Receptacles for Patient Bed Location in General Care Areas (Category 2) states each patient bed location shall be provided with a minimum of eight receptacles. 6.3.2.2.6.2(B) Receptacles for Patient Bed Location in Critical Care Areas (Category 1) states each patient bed location shall be provided with a minimum of 14 receptacles. Section 6.4.2.2.6.2 (C) states the electrical receptacles or the cover plates for the electrical receptacles supplied from the life safety and critical branches shall have a distinctive color or marking so as to be readily identifiable. This deficient practice could affect 8 residents Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during			

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	a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, vent unit beds are located on the third floor in Rooms 302, 303, 304 and 305 for a total of 8 vent unit bed locations. Resident sleeping Room 302 had 10 receptacles for the vent unit bed location. Room 303 had 8 receptacles for the vent unit bed location and was using a UL 1363A power strip for additional receptacles at the vent unit bed location. The vent unit bed location by the corridor door in Room 304 had twelve receptacles and the vent unit bed by the wall in Room 304 had 8 receptacles and was using a UL 1363A power strip for additional receptacles at the vent unit bed location. The vent unit bed location by the corridor door in Room 305 had twelve receptacles and the vent unit bed by the wall in Room 304 had 6 receptacles and was using a UL 60601-1 power strip for additional receptacles at the vent unit bed location. Based on interview at the time of the observations, the Housekeeping Manager agreed each vent unit bed location was not provided with a minimum of 14 receptacles. Based on interview at the time of the exit conference, the Executive Director stated the facility is in the process of relocating the vent unit bed locations from the third floor to the first floor. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0914 SS=F Bldg. 01	NFPA 101 Electrical Systems - Maintenance and Testing Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed			

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	locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) Based on record review and interview, the facility failed to ensure documentation of electrical outlet receptacle testing for all resident sleeping rooms was available for review in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.3 states receptacles not listed as hospital-grade at patient bed locations and in locations where deep sedation or general anesthesia shall be tested at intervals not exceeding 12 months. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.4.1.1 states hospital-grade receptacles testing shall be performed after initial installation, replacement, or servicing of the device. Section 6.3.3.2, Receptacle Testing in Patient Care Rooms requires the physical integrity of each receptacle shall be confirmed by visual inspection. The continuity of the grounding circuit in each electrical receptacle	K 0914	**K914** Electrical Systems Maintenance and Tagging NFPA 101 Immediate Intervention The Director of Maintenance has completed the annual outlet testing. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K914 Electrical outlet testing is required to be completed annually. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive	03/10/2023

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	shall be verified. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed; and retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 grams (4 ounces). Section 6.3.4.2.1.2 states, at a minimum, the record shall contain the date, the rooms or areas tested, and an indication of which items have met, or have failed to meet, the performance requirements of this chapter. This could affect all residents. Findings include: Based on record review with the Director of Maintenance from 1:35 p.m. to 3:30 p.m. on 01/30/23, annual electrical receptacle inspection and testing documentation for the most recent twelve-month period was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility only checks receptacles at patient care vicinity locations if there is an issue with the receptacle and agreed electrical receptacle inspection and testing documentation within the most recent twelve-month period was not available for review. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)		Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility.	
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			

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	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)			
	1. Based on record review, observation, and interview; the facility failed to ensure a written record of weekly inspections for the facility's emergency generator was maintained for 40 weeks of the most recent 52-week period. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power	K 0918	**K918** Electrical Systems - Essential Electric System NFPA 101 #1 **Immediate Intervention** The Director of Maintenance has started weekly generator testing and documentation.	03/10/2023

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	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 "Monthly Load Test" documentation with the Director of Maintenance during record review from 1:35 p.m. to 3:30 p.m. on 01/30/23, weekly emergency generator inspection documentation for 40 weeks of the most recent twelve-month period was not available for review. The "Monthly Load Test" documentation indicated the facility's emergency generator was inspected and tested once per month for the twelve-month period of January 2022 through December 2022. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator, the facility only performs monthly load testing and inspections on the generator and agreed weekly inspection documentation for 40 weeks of the most recent twelve-month period was not available for review. Based on observations with the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the diesel fuel fired emergency generator for the facility located outside the building had an affixed nameplate indicating the generator was rated at 100 kW and was manufactured in November 2011. This finding was reviewed with the Executive		#2 **Immediate Intervention** The Director of Maintenance has called vendor to preform a fuel test. #3 **Immediate Intervention** The Director of Maintenance has called vendor to preform a four hour run test. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K918 Generators are required to be ran and doummented weekly, ran under load monthly, and 4 hour run ever three years. fuel testing is required annually. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect all residents, staff and visitors in the facility.	

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	Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for the facility's two diesel fuel fired emergency 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, staff, and visitors. Findings include: Based on record review with the Director of Maintenance from 1:35 p.m. to 3:30 p.m. on 01/30/23, documentation of an annual fuel quality test for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed documentation of an annual fuel quality for the diesel fuel fired emergency generator was not available for review at the time of the survey. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit			

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	155061	A. BUILDING 01 B. WING	01/30/2023

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	conference. 3.1-19(b) 3. Based on record review and interview, the facility failed to document 36-month period emergency generator testing for 2 of 2 emergency generators in accordance with NFPA 99 and NFPA 110. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.1.1.6.1 states Type 1 and Type 2 essential electrical system power sources (EPSS) shall be classified as Type 10, Class X, Level 1 generator sets per NFPA 110. NFPA 110, the Standard for Emergency and Standby Powers Systems, 2010 Edition, Section 8.4.9 states Level 1 EPSS shall be tested at least once within every 36 months. Section 8.4.9.1 states Level 1 EPSS shall be tested continuously for the duration of its assigned class (See Section 4.2). Section 8.4.9.2 states where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 continuous hours. Section 8.4.9.5 states the minimum load for this test shall be specified in 8.4.9.5.1, 8.4.9.5.2, or 8.4.9.5.3. Section 8.4.9.5.3 states for spark-ignited EPS's, loading shall be the available EPSS load. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Director of Maintenance from 1:35 p.m. to 3:30 p.m. on 01/30/23, thirty-six-month period emergency generator testing documentation for four continuous hours for the facility's diesel fuel fired emergency generator was not available for review. Based on interview at the time of record review, the Director of Maintenance stated the facility has one diesel fuel fired emergency generator and agreed documentation of supplemental load			

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	testing for four hours within the most recent three-year period was not available for review at the time of the survey. This finding was reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0920 SS=F 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	K 0920	**K920**	03/10/2023

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	failed to ensure 7 of 7 extension cords including power strips were not used as a substitute for fixed wiring. 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. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed, and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 20 residents, staff, and visitors. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the following was noted: a. an oxygen concentrator, a vacuum pump and a cell phone charging cable were plugged into a power strip placed within three feet of the resident		Electrical Equipment - Power Cords and Extension Cords NFPA 101 **Immediate Intervention** The Director of Maintenance has removed or reconfigured all power strips to meet compliance. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K920 proper use of power strips. The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 20 residents, staff and visitors in the facility.	

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	bed in Room 304. The UL listing of the power strip was 1363A. b. a refrigerator and an air diffuser aroma device were plugged into a power strip in the Social Services office identified as Room 307. The UL listing of the power strip could not be determined. c. a refrigerator was plugged into a power strip within six feet of the patient care vicinity of the patient bed in Room 303. The UL listing of the power strip was 1363A. d. a power strip outside Room 301A was plugged into a power strip in Room 301 B which was plugged into a wall mounted receptacle in Room 301B. A television was plugged into the power strip in Room 301B. Each power strip was laying on the floor and was UL listed 1363A. e. the resident bed and a television were plugged into a power strip placed on the floor under the bed in Room 214. The UL listing of the power strip was 1363A. f. a refrigerator was plugged into a power strip in the nurse's station on the first floor. Based on interview at the time of the observations, the Housekeeping Manager and the Director of Maintenance agreed power strips were being used in the patient care vicinity for PCREE and non-PCREE and were also being used as a substitute for fixed wiring at the aforementioned locations. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag			

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	Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in 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			

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	99) 1. Based on observation and interview, the facility failed to ensure 1 of 2 indoor oxygen storage areas was in accordance with NFPA 99 Health Care Facilities Code. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet), but less than 85 cubic meters (3000 cubic feet), at STP shall comply with the requirements of 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect over 15 residents, staff, and visitors in the vicinity of Room 306. Findings include: Based on observations with the Housekeeping Manager during the initial walk through of the facility from 9:40 a.m. to 10:05 a.m. on 01/30/23, one liquid oxygen container was stored in Room 306 on the third floor. The corridor door to the room was in the fully open position. Based on observations with the Housekeeping Manager at 11:04 a.m. on 01/30/23, the liquid oxygen container was still being stored in Room 306 which was being utilized as an office area with nursing supply storage. The oxygen meter on the container indicated it was on level 5 of 7 levels which indicated the container was not empty. The room was not secured against unauthorized entry. Based on interview at the time of the observations, the Housekeeping Manager agreed an oxygen container was not being stored within an enclosed interior space of noncombustible or limited combustible construction and the storage	K 0923	**K923** Gas Equipment - Cylinder and Container Storage NFPA 101 #1 **Immediate Intervention** The Director of Maintenance has removed Oxygen container from 306 and placed it in the actual O2 room #2 **Immediate Intervention** The Director of Maintenance has locked the o2 rooms. **Compliance Date** 3-10-23 The Director of Maintenance has been educated by the Executive Director on K923 proper storage of oxygen containers The Director of Maintenance will perform monthly review X6. Results of these reviews will be presented by the Executive Director to the QAPI committee for further recommendations. This deficient practice could affect over 15 residents, staff and visitors in the vicinity of the o2 room in the basement.	03/10/2023

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	room was not secured against unauthorized entry. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect over 10 residents, staff, and visitors in the vicinity of the oxygen storage and transfilling room in the basement. Findings include: Based on observations with the Housekeeping Manager and the Director of Maintenance during a tour of the facility from 10:40 a.m. to 1:35 p.m. on 01/30/23, the corridor entry door to the oxygen storage and transfilling room in the basement was not locked to secure against unauthorized entry. The entry door to the room was equipped with a lock on the door handle but the door was unlocked. The room contained nine liquid oxygen containers and five 'E' type cylinders. Based on interview at the time of the observations, the Director of Maintenance agreed the corridor entry door to the oxygen storage and transfilling room in the basement was not locked to secure against			

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	unauthorized entry. These findings were reviewed with the Executive Director, the Director of Maintenance, and the Housekeeping Manager during the exit conference. 3.1-19(b)			