STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155600	A. BUILDING -- B. WING	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MULBERRY HEALTH & REHABILITATION CENTER	502 W JACKSON ST MULBERRY, IN 46058

(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: 03/16/23 Facility Number: 000470 Provider Number: 155600 AIM Number: 100289210 At this Emergency Preparedness survey, Mulberry Health and Rehabilitation Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 149 certified beds. At the time of the survey, the census was 120. Quality Review completed on 03/20/23	E 0000	Mulberry Health & Retirement Community respectfully request paper compliance in lieu of an onsite follow up survey.	
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power			

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

Heidi Wallar | Executive Director | 04/05/2023

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

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	systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain			

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

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	(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 occupants. Findings include: During record review and interview with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 10:10 a.m. and 1:15 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of (1) a three-year 4 hour test. Or (2) an annual fuel quality test report. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present.	E 0041	All residents had the potential to be affected. No residents were negatively affected. Maintenance supervisor will be responsible to ensure that an annual fuel test is completed for the generators fuel supply, and that a four hour run test occurs every 36 months. A CQI tool will be completed annually to ensure compliance. Maintenance supervisor will report annually to the facilities CQI team on the results of the audits, and any actions necessary to ensure 100% compliance.	04/04/2023
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: 03/16/23	K 0000	Mulberry Health & Retirement Community respectfully request paper compliance in lieu of an onsite follow up survey.	

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	Facility Number: 000470 Provider Number: 155600 AIM Number: 100289210 At this Life Safety Code survey, Mulberry Health and Rehabilitation Center 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 one-story facility was determined to be of Type V (111) construction and was fully sprinklered with a partial basement. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and battery powered smoke detectors in 59 resident sleeping rooms in the original portion of the facility and hard-wired smoke detectors in the other 27 resident rooms. The facility has a capacity of 149 and had a census of 120 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered including the detached records building. Quality Review completed on 03/20/23			
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:			

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	CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS 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.			

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	18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through the 400 West exit was 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 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 25, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 1:15 p.m. and 4:45 p.m., the 400 West exit door near the restrooms, marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit.	K 0222	All residents had the potential to be affected. No residents were negatively affected. The four digit access code has been posted on the key pad. A CQI audit tool will be completed quarterly that monitors the appropriate posting of key pad access codes. Maintenance Supervisor will report to the facilities Quality Assurance committee on the results of the audits, and any actions necessary to ensure 100% compliance.	04/14/2023

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	This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)			
K 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 Based on observation and interview, the facility failed to ensure 1 of 8 exit discharges had a level walking surface, were free of obstructions, and constructed of hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38. This deficient practice could affect 25 residents using the 400 West Hall exit. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 1:15 p.m. and 4:45 p.m., the exit discharge from the 400 West hall, had a 2 inch crack in the concrete and was uneven. The Maintenance Director acknowledged that the walkway was in need of repair and stated that the	K 0271	All residents had the potential to be affected. No residents were negatively affected. Repairs have been made to level out the walking surface identified in the survey. A CQI audit tool will be completed quarterly that monitors level surfaces outside of exit doors. Maintenance Supervisor will report to the facilities Quality Assurance committee on the results of the audits, and any actions necessary to ensure 100% compliance.	04/14/2023

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	crack likely appeared during the recent winter.. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)			
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 2 courtyard doors to the outside of the facility were not mistaken as a facility exit. LSC 7.10.8.3.1 states any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT. The NO EXIT sign shall have the word NO in letters 2 inches high, with a stroke width of 3/8ths inch, and the word EXIT below the word NO, unless such sign is an approved existing sign. This deficient practice could affect 25 residents. Findings include:	K 0293	All residents had the potential to be affected. No residents were negatively affected. Both doors have had permanent signage placed on the doors indicating they are “not an exit” No further monitoring is necessary as the signage was permanently placed on the doors.	04/05/2023

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	Based on observations and interview during a tour of the facility with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 1:15 p.m. and 4:45 p.m., on the (1) 400 East Hall and (2) 400 West Hall the door to the outside courtyard was not an exit door and the door was not posted with a "NO EXIT" sign. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 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 1 of 1 written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include:	K 0346	All residents had the potential to be affected. No residents were negatively affected. The facilities fire watch plan has been updated with the newly required language. No further monitoring is necessary.	04/05/2023

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	During record review and interview with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 10:10 a.m. and 1:15 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____			

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	b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 3 of 3 sprinkler heads in the laundry area were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect 3 laundry staff. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 1:15 p.m. and 4:45 p.m., 2 sprinkler heads in the laundry wash room and 1 sprinkler head behind the dryers were coved in dust or showed signs of loading. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator	K 0353	All residents had the potential to be affected. No residents were negatively affected. The sprinkler heads identified in the survey have been cleaned of dust. A CQI audit tool will be completed quarterly that monitors sprinkler heads for dust or signs of loading. Maintenance Supervisor will report to the facilities Quality Assurance committee on the results of the audits, and any actions necessary to ensure 100% compliance.	04/14/2023

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	present. 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) Based on record review and interview, the facility failed to provide 1 of 1 correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making	K 0354	All residents had the potential to be affected. No residents were negatively affected. The facilities fire watch plan has been updated with the newly required language. No further monitoring is necessary.	04/05/2023

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	sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: During record review and interview with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 10:10 a.m. and 1:15 p.m., the fire watch plan failed to include contacting the Indiana Department of Health via the ISDH Gateway link at https://gateway.isdh.in.gov as the primary method or by the secondary method when the ISDH Gateway is nonoperational by completing the Incident Reporting form and e-mailing it to incidents@isdh.in.gov. Based on interview during the record review, the Maintenance Director acknowledged the fire watch documentation provided stated to contact the Indiana Department of Health at a phone number, and not via the ISDH Gateway link or at the e-mail address listed above. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)			
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings,			

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	exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors had no	K 0363	All residents had the potential to be affected. No residents were	04/14/2023

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	impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect staff and 15 residents. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 1:15 p.m. and 4:45 p.m., the corridor door to (1) the HR office area, equipped with a self-closing device, failed to close and latch positively into the door frame. And (2) the double doors into the large group room, equipped with latching hardware failed to self-close and latch. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)		negatively affected. The two doors in the survey have been adjusted to ensure they self-latch as required. A CQI audit tool will be completed quarterly that monitors facility doors to ensure they properly close and latch. Maintenance Supervisor will report to the facilities Quality Assurance committee on the results of the audits, and any actions necessary to ensure 100% compliance.	
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 Based on observation and interview, the facility failed to ensure all electrical panels in the corridors were secured from non-authorized personnel. NFPA 70, 2011 edition states 230.62	K 0511	All residents had the potential to be affected. No residents were negatively affected. All corridor electrical panels have	04/14/2023

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	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 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 everyone. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 1:15 p.m. and 4:45 p.m., electrical panels in the corridors throughout the facility were unlocked when tested. Based on interview at the time of observation, the Administrator stated that he was unaware that electrical panels needed to be secured and locked. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)		been locked. A CQI audit tool will be completed quarterly that monitors corridor electrical panels are locked and secure. Maintenance Supervisor will report to the facilities Quality Assurance committee on the results of the audits, and any actions necessary to ensure 100% compliance.	
K 0711 SS=E Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all			

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	patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3			
	Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of residents in rooms with battery operated smoke detection to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 4.8.2.1(3) requires evacuation procedures appropriate to the building, its occupancy, emergencies and hazards. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect more than 50 occupants in the event of an emergency. Findings include:	K 0711	All residents had the potential to be affected. No residents were negatively affected. The facilities disaster preparedness plan has been updated to include written instructions referenced in the survey. No further monitoring is necessary.	04/05/2023

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	During record review and interview with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 10:10 a.m. and 1:15 p.m., a review of the fire plan within the Disaster Preparedness Plan, did not include the written instruction for prompting activation of the interconnected building fire alarm system if a battery powered isolated smoke detector is activated. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)			
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and			

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	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 and interview, the facility failed to maintain 1 of 1 Emergency Power Standby System in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Section 8.4.9, as required by NFPA 99 Health Care Facilities Code, Section 6.4.1.1.6.1. NFPA 110 Section 8.4.9 states that all Level 1 Emergency Power Systems shall be tested at least once within every three years. Where the assigned class is greater than 4 hours, it shall be permitted to terminate the test after 4 hours. NFPA 99 Section 6.4.1.1.6.1 states that Type 1 and Type 2 essential electrical system power sources shall be classified at Type 10, Class X, Level 1 generator sets. This deficient practice could affect all building occupants. Findings include: During record review and interview with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 10:10 a.m.	K 0918	All residents had the potential to be affected. No residents were negatively affected. Maintenance supervisor will be responsible to ensure that an annual fuel test is completed for the generators fuel supply, and that a four hour run test occurs every 36 months. A CQI tool will be completed annually to ensure compliance. Maintenance supervisor will report annually to the facilities CQI team on the results of the audits, and any actions necessary to ensure 100% compliance.	04/14/2023

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	and 1:15 p.m., the facility provided documentation for testing of the emergency generator, however, could not provide documentation of a three year 4 hour test. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 2. Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel-powered generator. 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 NFPA110, 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. Findings include: During record review and interview with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 10:10 a.m. and 1:15 p.m., no documentation of an annual fuel quality test for the diesel generator was available for review. Based on interview at the time of records review, the fuel quality testing for the diesel fired generator could not be located. This deficiency was reviewed with the			

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	Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)			
K 0920 SS=E 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 1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw.	K 0920	All residents had the potential to be affected. No residents were negatively affected. The power strip and multi-plug	04/14/2023

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	NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 2 residents and 2 staff in the office. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director, Administrator in Training and Administrator on 03/16/23 between 1:15 p.m. and 4:45 p.m., in the Business Office a power strip was being used to power a dorm style refrigerator and a microwave oven (high power draw equipment). This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 2. Based on observation and interview, the facility failed to ensure the 100 hall nurses station did not used multi-plug adaptors as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 10 resident near the station. Findings include: Based on observations and interview during a tour of the facility with the Maintenance Director, Administrator in Training and Administrator on		adapters identified in the survey have been removed. A CQI audit tool will be completed quarterly to monitor power strip usage and ensure no multi-plug adapters are in use. Maintenance Supervisor will report to the facilities Quality Assurance committee on the results of the audits, and any actions necessary to ensure 100% compliance.	

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	03/16/23 between 1:15 p.m. and 4:45 p.m., the 100 hall nurses station contained a multi-plug adaptor powering computer equipment. Based on interview at the time of observation, the Maintenance Director and Administrator agreed a multi-plug adaptor was in use. This deficiency was reviewed with the Maintenance Director, Administrator in Training and Administrator at the time of discovery and again at the exit with the Maintenance Director, Administrator in Training and Administrator present. 3.1-19(b)			